Your Guide to Protection Case Management

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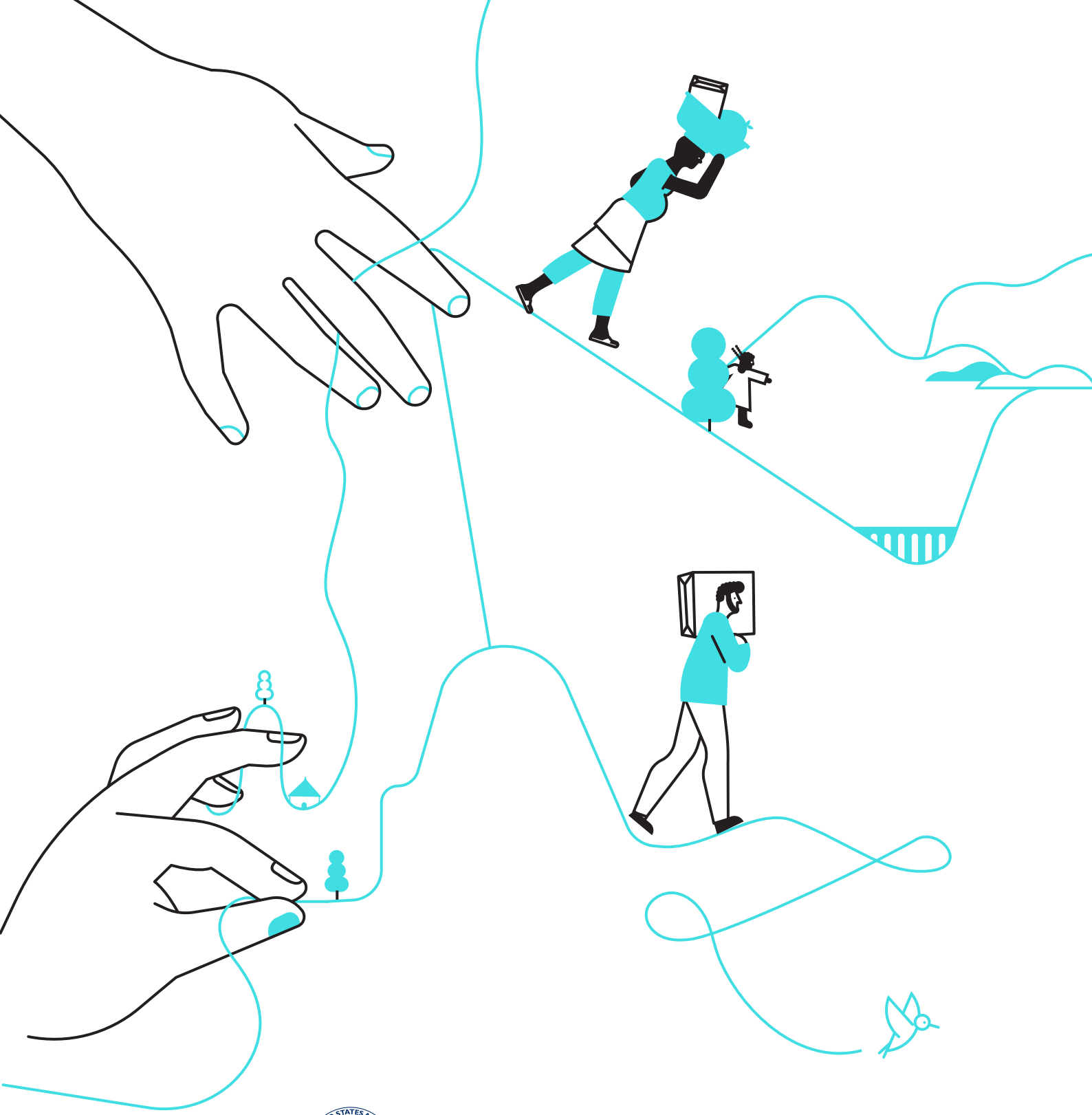
INTERNATIONAL RESCUE COMMITTEE

Global Protection Cluster



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Lead Writers Kirsty Jenatsch (NRC), Emily Krehm (IRC) and Ricardo Pla Cordero (UNHCR)

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Contributors who strengthened this resource: Dia AbouMosleh (IRC), Kara Apland (Coram International), Catherine Boland (IRC), Bernadette Castel (UNHCR), Samuel Cheung (UNHCR), Indu Chelliah (IRC), Naima Iqbal Chohan (IRC), Elodie Copin (Independent Consultant), Brandon Grey (WHO), Gretchen Emick (IRC), Colleen Fitzgerald (USAID-BHA), Patricia Grey (IRC), Priya Joshi (GBV AOR MHPSS TT), Jennifer Lee (IRC), Julien Marneffe (UNHCR), Tania Marcello (NRC), Kathryn McCallister (UNHCR), Ann Marie McKenzie (USAID-BHA), Kelly Mcbride (Independent Consultant), Lisa Monaghan (NRC), Jude Okeria (TPO), Angeliki Panagoulia (IRC), Lauraine Pfeffer (GBV AOR MHPSS TT), Vicky Samara (IRC), Leonie Tax (IRC), Josep Herreros Sala (UNHCR), Clifford Speck (UNHCR), Liliana Sorrentino (UNHCR), Clare Whitney (IMC)

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Acronyms

AoR	Area of Responsibility
BHA	Bureau for Humanitarian Assistance
CP	Child Protection
CRPD	Convention on the Rights of Persons with Disabilities
EO	Explosive Ordnance
EQUIP	Ensuring Quality in Psychosocial and Mental Health Care
GBV	Gender-based violence
IA SEARP	Interagency sexual exploitation and abuse referral procedures and abuse referral
IASC	Inter-Agency Standing Committee
IMS	Information Management System
IRC	International Rescue Committee
MEAL	Monitoring, Evaluation, Accountability and Learning
MHPSS	Mental Health and Psychosocial Support
MHPSS MSP	Mental Health and Psychosocial Support Minimum Service Package
NRC	Norwegian Refugee Council
PAF	Protection Analytical Framework
PCM	Protection Case Management
PFA	Psychological First Aid
PHQ	Patient Health Questionnaire
PSEA	Protection from Sexual Exploitation and Abuse
ToC	Theory of change
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WG-SS	Washington Group Short-Set of Questions
WHO	World Health Organization

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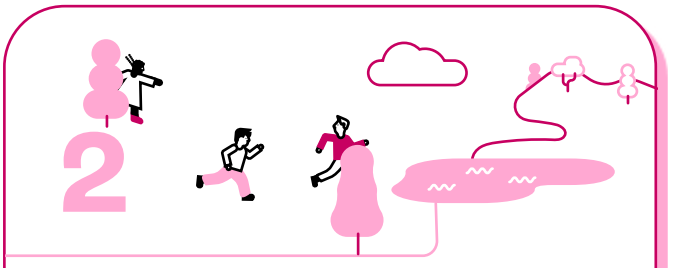

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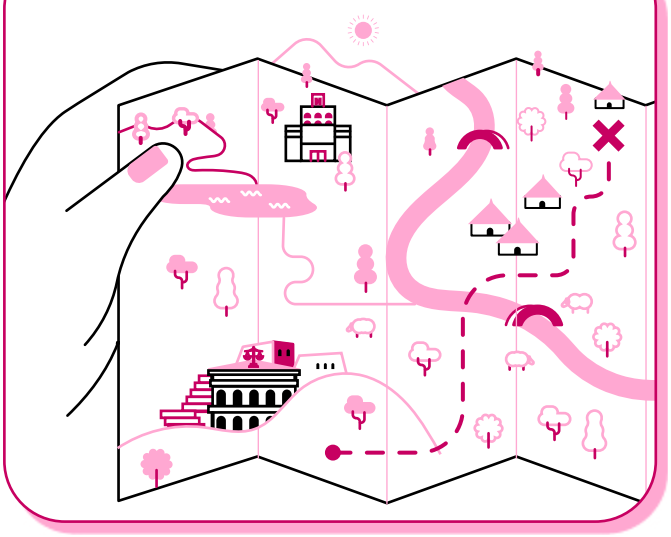

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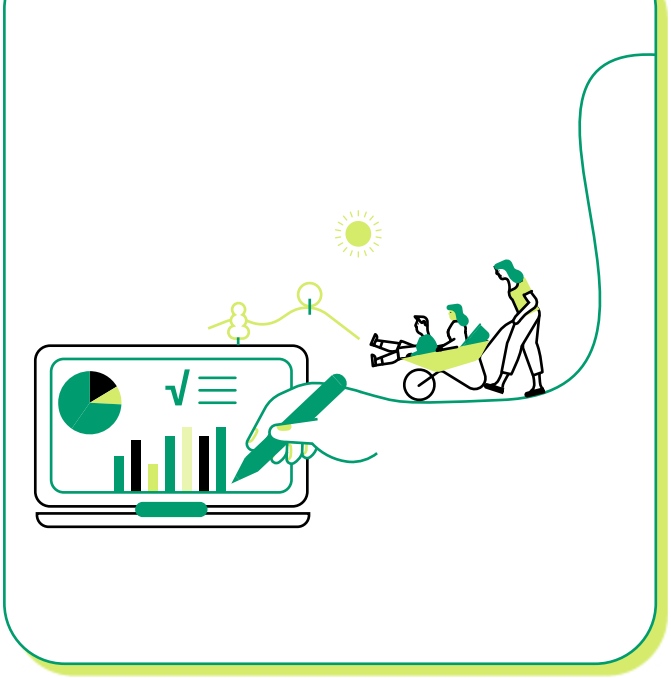

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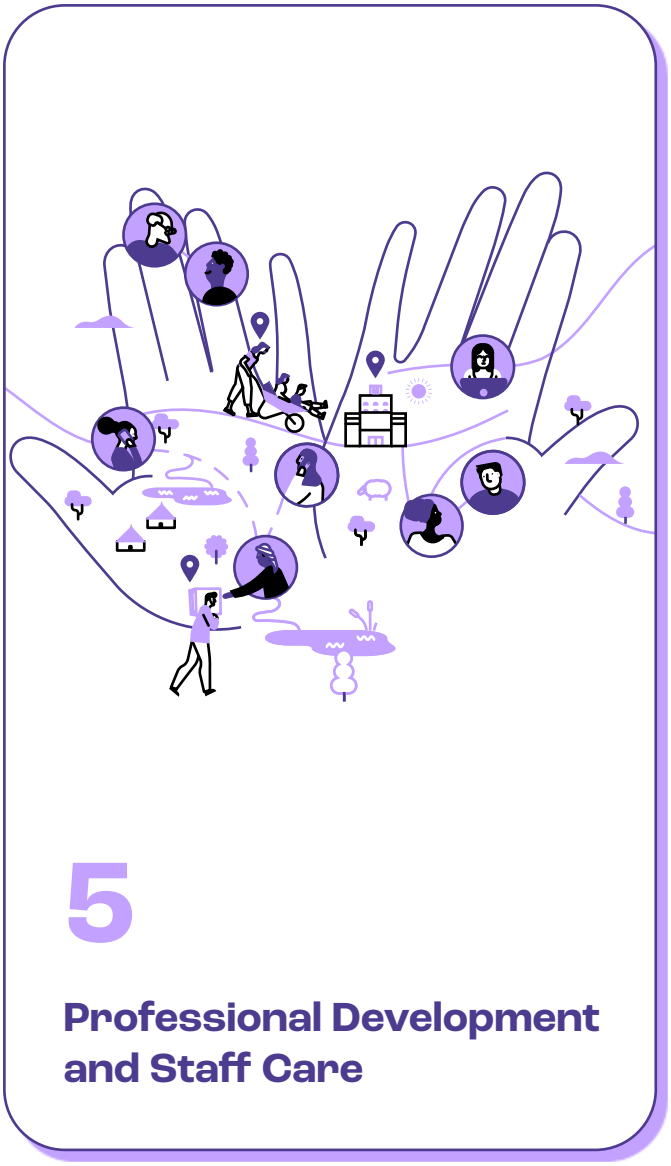

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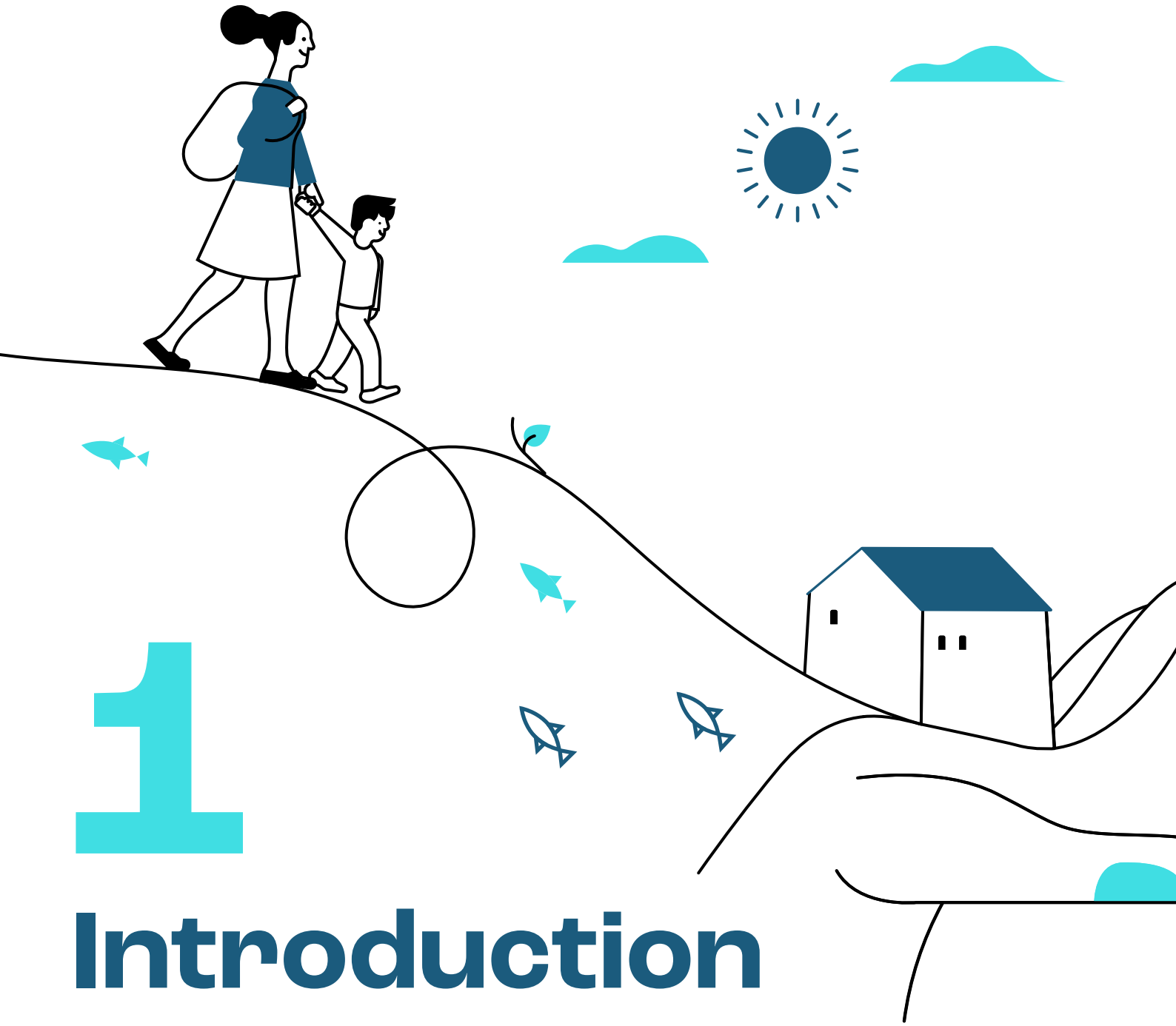


1

Introduction to Protection Case Management

Welcome to your guide on Protection Case Management. This first module provides a foundational understanding of Protection Case Management, covering its standards and how to navigate this guidance effectively.

This chapter will help you answer the following questions:

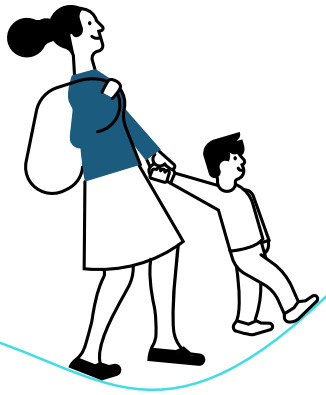
- **What is Protection Case Management?**
  Providing a foundational understanding and definition of Protection Case Management.

- **Why is Protection Case Management important?**
  Explaining the significance and impact of Protection Case Management in humanitarian settings.

- **How to coordinate Protection Case Management?**
  Detailing where Protection Case Management fits into existing systems and how to ensure clarity and complementarity.

- **What is the theory of change for Protection Case Management?**
  Outlining the theory of change (ToC) and why it is important.

- **What are the key principles and standards for Protection Case Management?**
  Sharing the core principles and standards that guide practice in this field and providing essential standards and resources for practitioners to ensure best practice.



What is Protection Case Management?

In this guidance, we use the term 'service users' to match current social work practice, as recommended by the International Federation of Social Workers and social work groups worldwide (except in the US where client is still used). For clarity, we also use the term 'client', 'individual', or 'people' when referring to those who we work with in this service. Teams implementing this guidance should decide on and agree upon the most suitable local terms to use during their work.[1]

Protection Case Management is a service model based on social work principles and case management approaches to provide individualised support. In this model, a caseworker works closely with a service user to access, coordinate, and advocate for services needed by individuals with complex or multiple protection needs related to violence, coercion, or deliberate deprivation. This approach involves one-on-one support, where the caseworker builds a supportive relationship with the service user. Case management should be delivered in a way that is sensitive to the mental health needs of the service user, promotes safety and psychological well-being, builds on a person's abilities and strengths,

and promotes family and community support.[2] Caseworkers provide essential mental health and psychosocial support (MHPSS) services to service users, including but not limited to focused, non-specialised support services. The caseworker is backed by a dedicated supervisor and a system that ensures service quality, data protection, and trend analysis.

In Protection Case Management, the people receiving the service are either at risk of or recovering from:

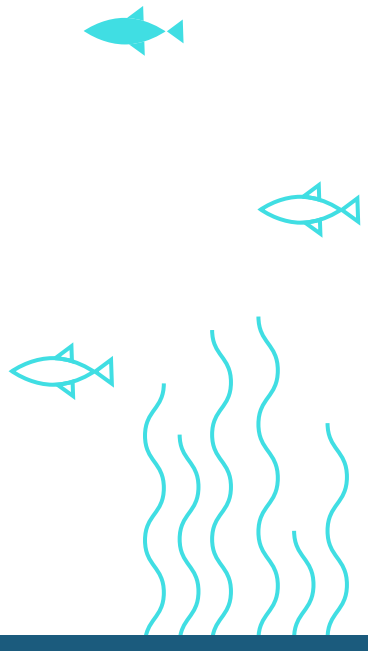
- **Violence:** The intentional use of physical force or power threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation[3].

- **Coercion:** In short, forcing someone to do something against their will[4]. Coercion in humanitarian situations can be understood as coercion-as-extortion, a demand coupled with a threat of harm or the infliction of harm, done to extract some kind of concession from the victim state. It is an act targeting the victim state's will or decision-making capacity[5].

- **Deliberate deprivation:** Intentional action to prevent people from accessing the resources, goods, or services they need and have the right to access[6].

Protection Case Management service providers are asked to develop specific, localised, and contextually appropriate intake criteria following a protection risk analysis process, ideally using the interagency Protection Analytical Framework (PAF)[7]. During or after a humanitarian situation, many individuals may benefit from Protection Case Management. However, it is important to prioritise cases based on severity of risk. Establishing clear intake criteria is crucial, and these criteria should be specific, descriptive, and based on protection analysis. Once established, good intake criteria will:

- Provide a descriptive definition of local risks to support caseworkers to determine eligibility



- Offer a timeline for speed of service provision based on their risk level
- Provide a further description of case types that qualify for a high, medium, or low risk response
- Have been developed in coordination with key stakeholders to ensure that it complements existing support and services available to the impacted population
- Provide guidance on response for individuals who do not meet the intake criteria.

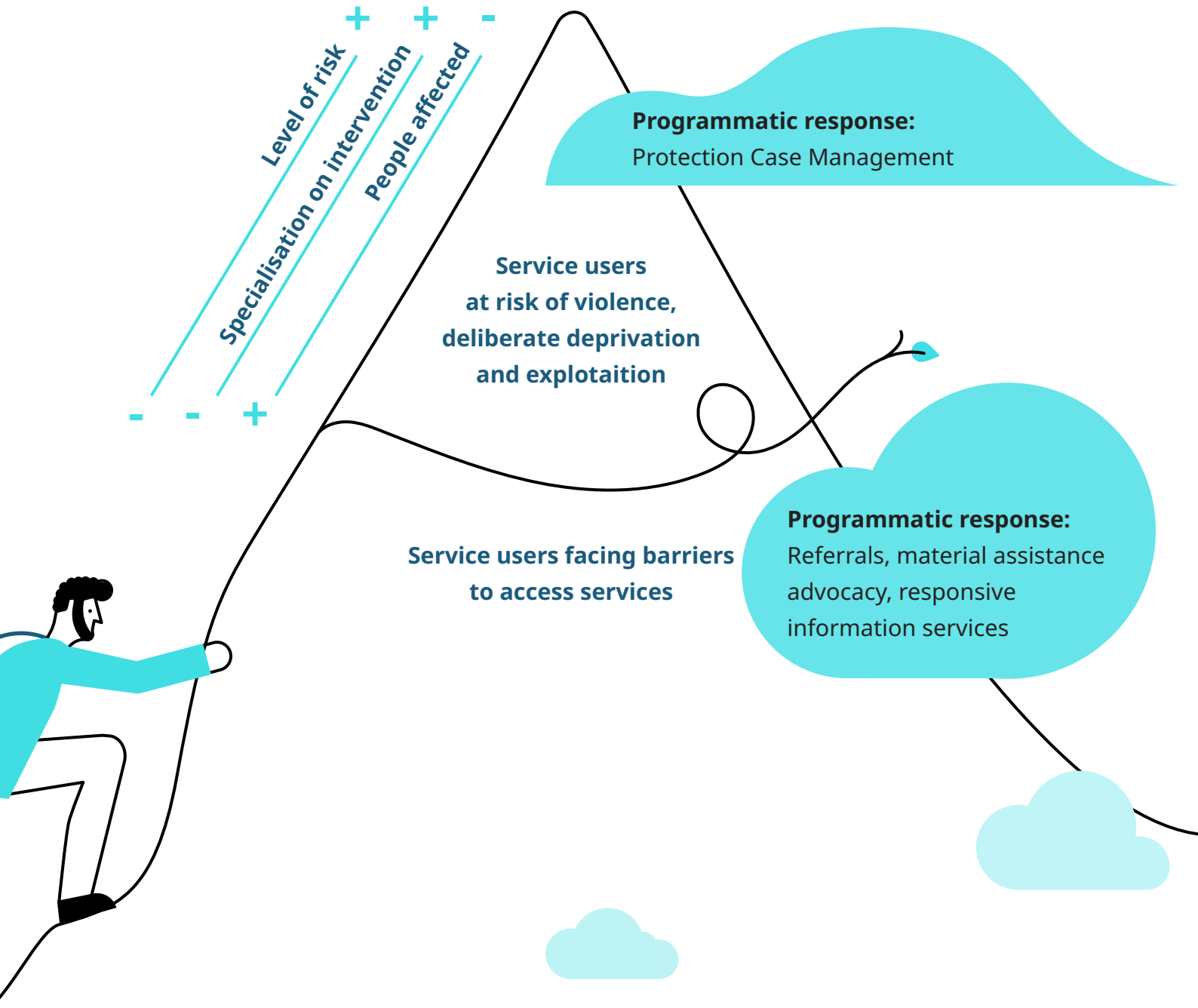
The PAF[8] offers a methodology and structure for identifying and classifying protection risks that can be addressed through Protection Case Management. Detailed guidance on protection analysis and criteria setting is available in Module 2.

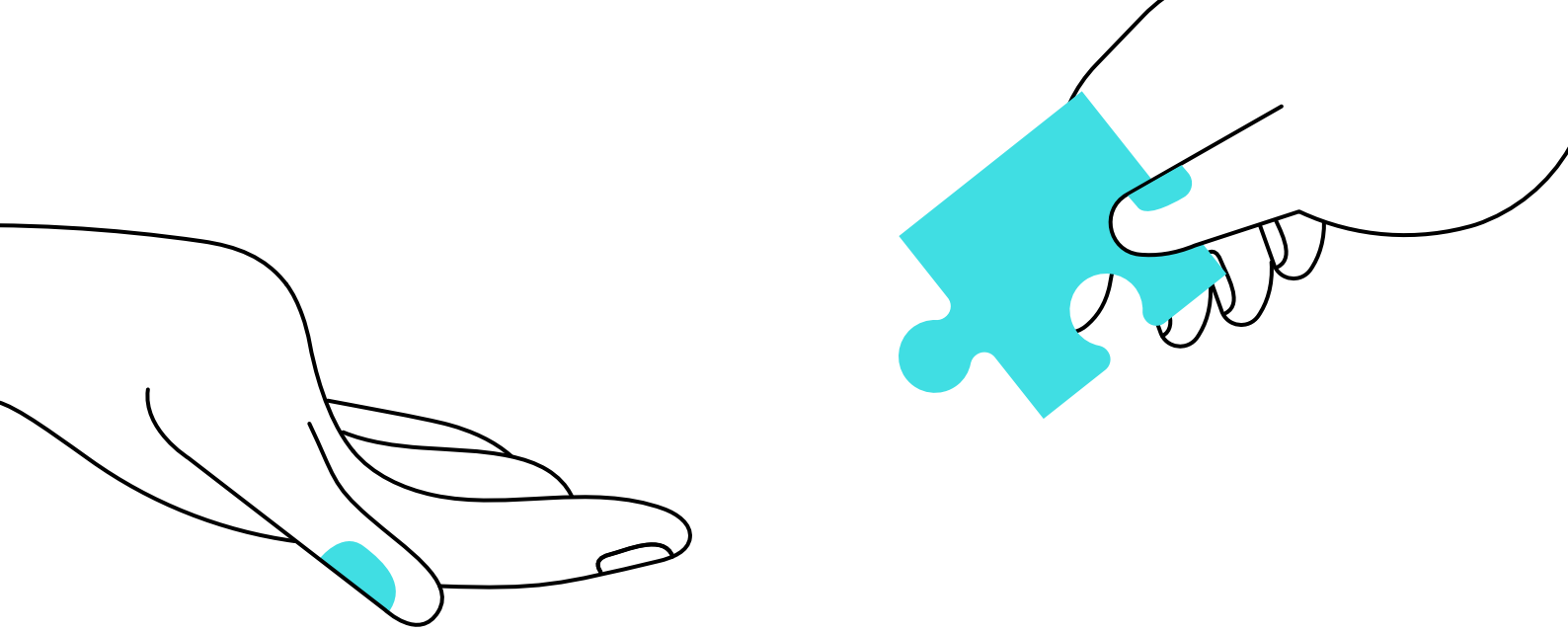
A definition of the Protection Analytical Framework
The PAF[9] guides robust, context-specific protection analysis in a harmonised manner. It informs decision making for multisectoral and multi-disciplinary strategies that reduce and prevent protection risks that may violate international human rights and humanitarian laws. It is suitable for use across humanitarian contexts. It was developed together with the full support of the Information and Analysis Working Group of the Global Protection Cluster. It has been endorsed by the Global Protection Cluster.

Annex 1.1: Protection Risk Criteria for Protection Case Management includes a list of risks that fall under violence, coercion, and deliberate deprivation that are relevant to Protection Case Management interventions. It has been adapted from the PAF to offer descriptions of Protection Case Management eligible case types. Coordination for alignment with all areas of responsibility will be required.

As Figure 1 details, there will be individuals in the community who require support to access services but who do not meet localised Protection Case Management intake criteria. These individuals can be supported to access services, normally by any frontline staff member with basic training on referrals, including individuals outside protection who would not constitute a Protection Case Management case.

Figure 1: Protection Case Management intake criteria



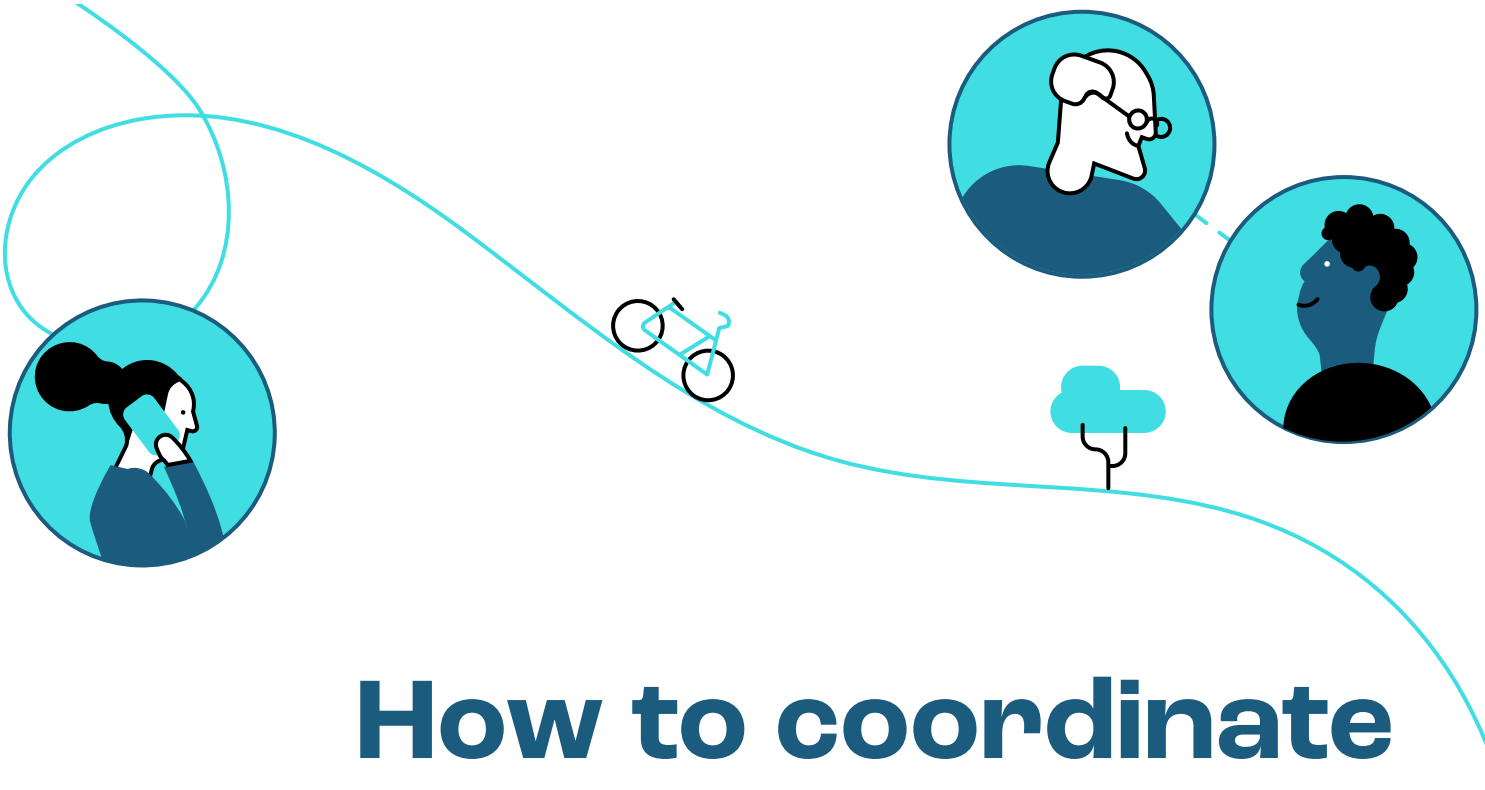


Why is Protection Case Management important?

In humanitarian crises, resources and support from the state, community, and family can quickly become scarce, while the risks of violence, coercion, and deliberate deprivation escalate rapidly. Individuals at risk may find themselves overwhelmed, disoriented, or cut off from their usual coping strategies, making it harder for them to manage their own safety and well-being when in danger or in distress. Affected populations experience a range of stressors that can have immediate and long-term consequences. Many people experience common reactions such as difficulties with sleeping, fatigue, worry, anger, and physical aches and pains. For most people, these problems are manageable and improve over time, but for others they impair daily functioning. Even when national and humanitarian services are available, these supports might be unsafe or difficult to access, leaving some individuals unable to benefit from aid without professional support.

A caseworker is essential in these situations, providing empathy and support when family and community connections are weakened. They help individuals assess their circumstances and create personalised case plans and safety plans, particularly when people are overwhelmed or unaware of available protection resources. Caseworkers also advocate for individuals to help them access services that might otherwise be out of reach or denied. Effective Protection Case Managment programming provides critical services and supports to reduce suffering and improve people's mental health and psychosocial well-being. This can lead to improvements in people's abilities to meet their basic needs to survive, recover and rebuild their lives.

In a humanitarian context, case management services are crucial for ensuring that those most at risk benefit from humanitarian efforts. Effective case management, supported by robust information systems, generates valuable data and trends. This information can guide humanitarian action by improving accessibility, closing service gaps, ensuring individuals receive necessary information, and strengthening national systems to better support at-risk individuals as they recover from crises.

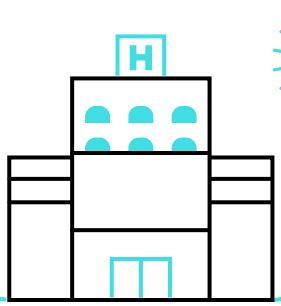


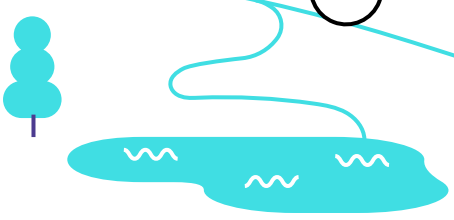
How to coordinate Protection Case Management?

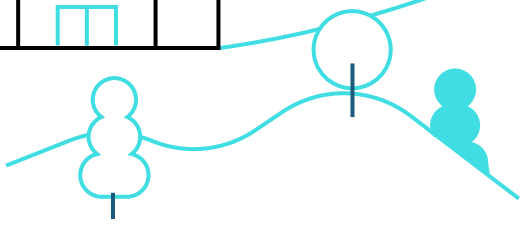
Protection Case Management actors like all humanitarian actors, should strengthen, not replace, national and local systems[10]. In your protection analysis and when developing service intake criteria, it is essential to coordinate with key stakeholders to identify individuals facing violence, coercion, or deprivation who are not receiving necessary services. With a clear understanding of the strengths and limitations of the national system, assess whether establishing Protection Case Management services is appropriate to reduce protection risks and enhance the mental health and psychosocial well-being of service users. Protection Case Management systems should be coordinated, co-designed with and validated by this social service workforce to ensure alignment with national protection systems and local ownership and leadership, including technical and material assistance to strengthen the national workforce. Protection Case Management service providers should coordinate with local gender-based violence (GBV), MHPSS, mine action, and child protection (CP) services, as well as with relevant government structures, to deliver complementary responses during complex emergencies.

Individuals injured by explosive ordnance (EO): Victims and survivors often require complex, multi-faceted short and long-term assistance, including medical care, rehabilitation, psychological and social support, and the facilitation of access to education and livelihood. Where an EO injury has lead to mutilation or other protection concerns listed in global or localised Protection Case Management intake criteria, Protection Case Management can provide the holistic support these individuals need.[11]

Protection Case Management actors, like all frontline humanitarian staff, must comply with CP and GBV legal frameworks, global standards and local operating procedures. It is important that boys and girls experiencing or at risk of violence, exploitation, abuse and neglect, as well as women and girls who face GBV, receive case management services from personnel specialising in CP and GBV case management. Protection Case Management actors should be ready to facilitate safe referrals to actors as needed according to local protocols.







Protocols for Protection Case Management should include localised guidance, developed with relevant CP and GBV actors. For more on coordination and collaboration with CP, GBV and others, see additional guidance on ensuring clarity of roles between protection and MHPSS workers.[12] As illustrated in the Inter-Agency Standing Committee (IASC) MHPSS intervention pyramid (Figure 2), Protection Case Management teams provide essential layers of MHPSS services within the case management approach. Protection Case Management teams are responsible for providing focused, non-specialised support to service users, as well as ensuring service users have access to other layers of support required to meet their needs through direct service delivery and referrals.[13]

MHPSS services must be coordinated within and across sectors. Seminal guidance and resources for Protection Case Management teams on how to coordinate MHPSS activities can be found in the MHPSS Minimum Service Package.

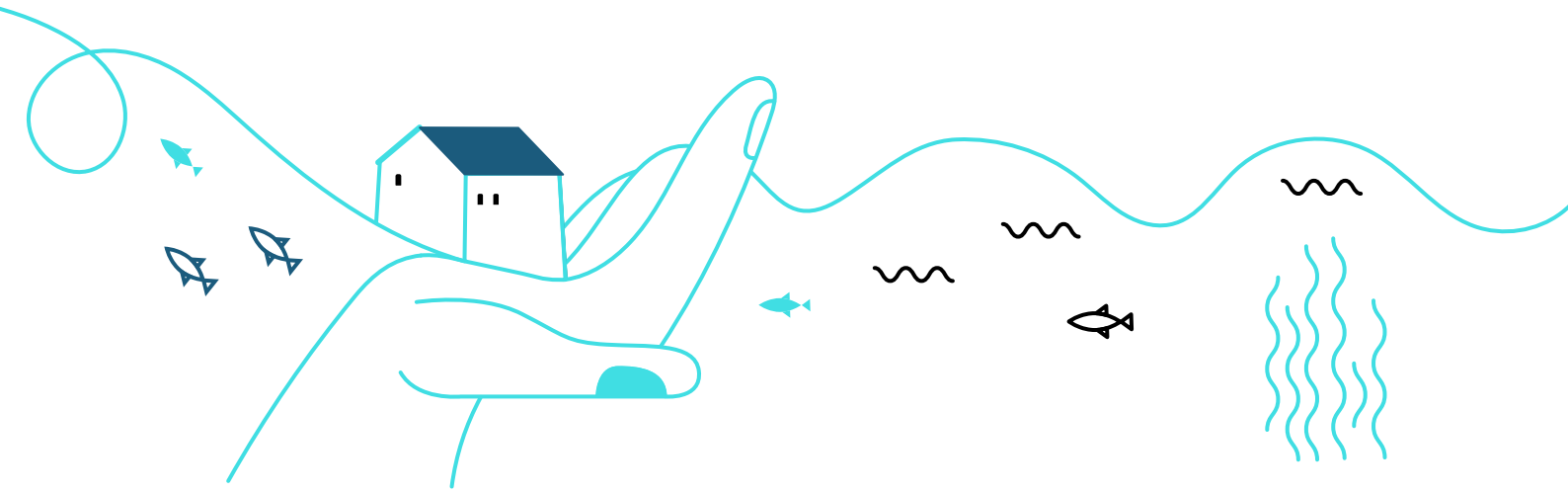
Figure 2: Inter-Agency Standing Committee MHPSS intervention pyramid

Layer 1.
Basic services and security
Provision of food, water, shelter, health care, information, etc. Advocacy for basic services that are safe, socially appropriate and protect dignity

Layer 2.
Family and community support
Community groups and networks, community centres, traditional and religious rituals

Layer 3.
Focused (person-to-person) support provided by non-specialists
Case management, structured group therapy, basic emotional support

Layer 4.
Specialised services
Mental health specialists (e.g. psychology, psychiatry), provision of medication, etc.

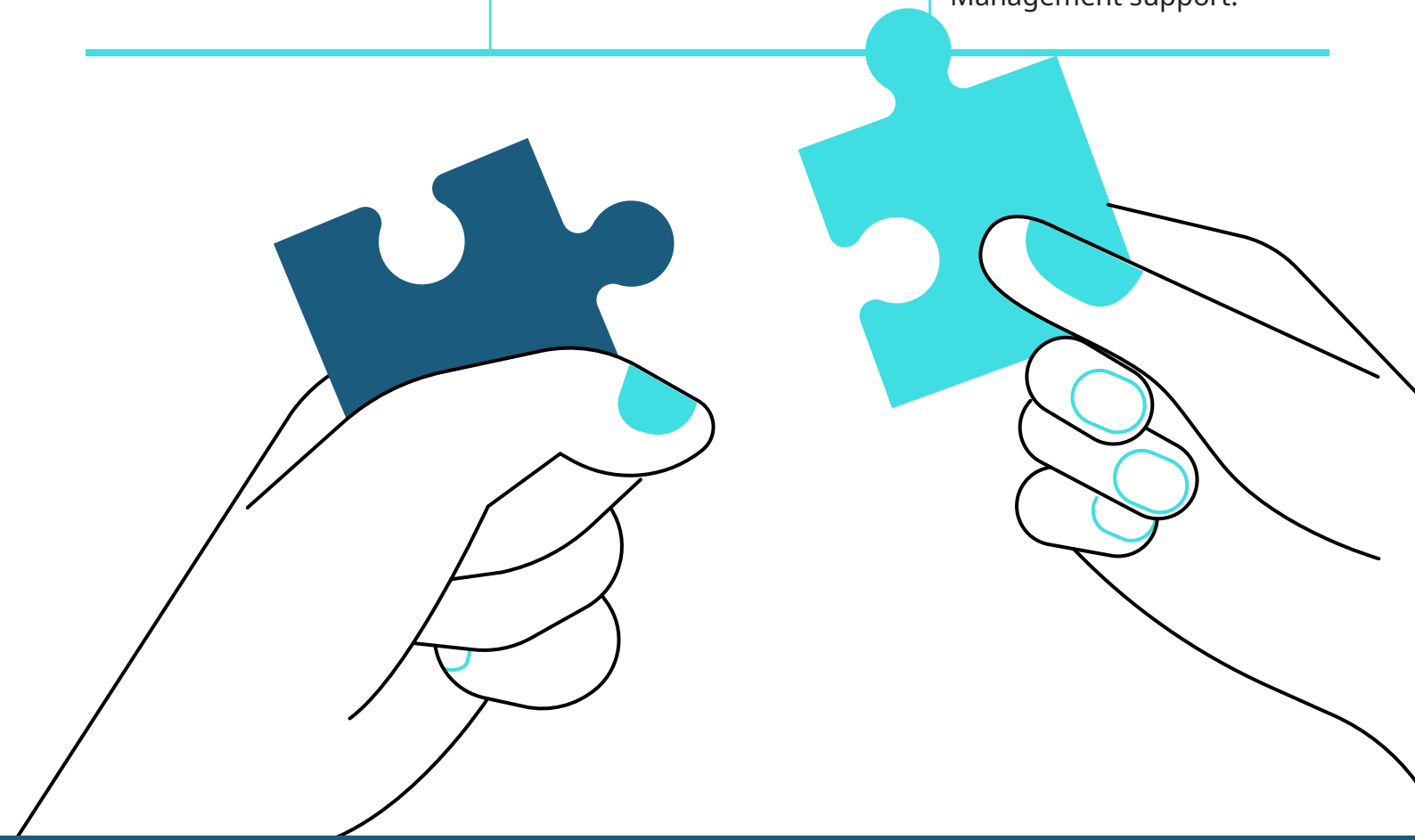


What is the theory of change for Protection Case Management?

The ToC for Protection Case Management presents a model of how it contributes to the overall protection goal: enabling people at risk in protracted and acute humanitarian crises to realise their rights and live in safety and with dignity. It is important to note that Protection Case Management is only one part of a broader protection response; other interventions will be necessary to fully achieve this goal. The ToC for Protection Case Management focuses on setting out the specific change pathways that lead from a case management intervention to outcomes for individual clients, and, ultimately, contribute to the broader protection goal (impact). The Protection Case Management ToC is set out in Table 1, and should be read from the bottom up to reflect the direction of change. The diagram illustrates the change pathway through which Protection Case Management addresses the (i) problem statement by leading to (ii) process and quality interim outcomes, to (iii) protection outcomes for individual clients, and, ultimately, to the (iv) population level impact. For a more detailed description of the ToC, see Annex 1.2: Theory of Change for Protection Case Management.

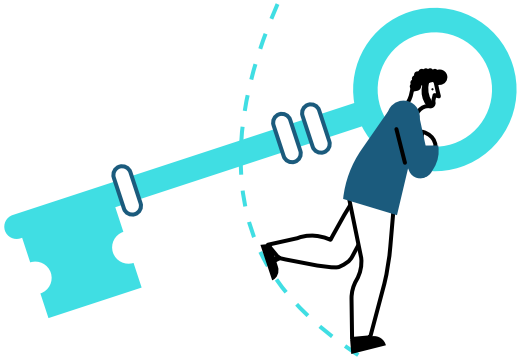
Table 1: Protection Case Management Theory of Change[14]

Impact pathway	Protection outcome (Level II)	Protection outcomes (Level I)
Protection risks are mitigated, and people at risk recover from experiences of harm, including discrimination, violence, reduced access to services, and threats to their integrity, safety, and life.	1. Service users achieve improved psychosocial wellbeing through Protection Case Management support.	1.1 Service users are less impacted by protection risks through Protection Case Management support. 1.2. Service users with mental health needs demonstrate a reduction in symptoms of severe distress through Protection Case Management support.



Process & quality pathway	Process & quality outcomes (interim)	Problem
Service users have access to quality and client-centred Protection Case Management services when they need it.	1.1 Perceive to Protection Case Management services. 1.2 Protection Case Management services are sufficiently staffed and resourced. 1.3 Caseworkers possess the skills, knowledge, and attitude necessary to support clients through Protection Case Management services. 1.4 Protection risks are mitigated, and people at risk recover from experiences of harm, including discrimination, violence, reduced access to services, and threats to their integrity, safety, and life. 1.5 Protection Case Management services are delivered in line with quality standards and protocols (as articulated in the Protection Case Management guidance). 1.6 Caseworkers establish strong relationships with cWWlients based on a foundation of empathy, inclusion, support and trust. 1.7 Protection Case Management clients are successfully referred to relevant services (including specialised mental health services, legal support, and health and education services).	During protracted and acute crises, state and/or community-based structures to mitigate and respond to environmental risk factors are often disrupted, leading to fewer resources and available support structures, leaving people at risk of experiencing safety concerns or other rights violations.

What are the key principles and standards of Protection Case Management?



Key principles

In Protection Case Management, key principles and approaches are crucial for both caseworkers and implementing teams, complimenting existing protection mainstreaming principles[15], as well as those responsible for developing or supporting the case management system. In moments of intervention design, problem solving, or in the face of ethical dilemmas, you and your teams can refer to the following key principles to ensure that actions are respectful of service users and are consistent with what is foundational about the Protection Case Management service model.

Protection mainstreaming is the process of incorporating the basics of quality programming, including meaningful and inclusive access, safety and dignity in humanitarian aid. The following elements must be taken into account in all humanitarian activities. These definitions have been adapted from the global principles to the Protection Case Management intervention:

1

Accountability

Set-up appropriate mechanisms through which service users can measure the adequacy of the Protection Case Management service, and address concerns and complaints as soon as possible.

2

Prioritise safety and dignity, avoid causing harm

Prevent and minimise any unintended negative effects of your intervention which can increase people's vulnerability to both physical and psychosocial risks. Always prioritise service users' safety, develop strong safety plans and case plans based on structured assessments.

3

Meaningful access

Recognise and consult service users on their comfort and ability to engage in the Protection Case Management process without barriers. Ensure that intake criteria and service prioritisation is based on those most at risk and underserved in your context.

4

Participation and empowerment

Support the development of self-protection capacities and assist people to increase their safety and wellbeing.

Table 2: Definitions of key principles in Protection Case Management

Principle	Definition in Protection Case Management	Examples of application of this principle
Individuals right to privacy and self-determination	Privacy brings attention to a service users' personal autonomy and boundaries throughout their engagement with the service. Service users have the right to control access to their personal information, body, and personal space. Service implementers have a duty to ensure information that is shared is treated confidentially. Self-determination respects an individual's right to define their own path, set their own goals, and make decisions about matters that affect their life, well-being, and future.	Caseworkers will ask for informed consent and assent to engage with the service users throughout the Protection Case Management process. Providing service users with options and allowing them to choose the services or interventions they feel are most appropriate for their situation. Caseworkers are required to recognise, discuss, and address barriers to comfortable participation in case management sessions.

Principle	Definition in Protection Case Management	Examples of application of this principle
Trauma-informed principles	Trauma-informed principles help create environments where individuals feel supported and understood, and they reduce the risk of re-traumatisation, fostering healing and recovery, while recognising that not all individuals who experience adverse life experiences will experience traumatic reactions. It integrates an understanding of trauma into all aspects of practice to create a supportive and empowering environment for service users. In trauma-informed services, trauma survivors are seen as unique individuals who have experienced extremely abnormal situations and have managed as best they could.	Creating a safe and welcoming physical environment for service users, maintaining a non-threatening demeanour. Prioritising service user safety by conducting thorough risk assessments and developing safety plans with service users to address immediate safety concerns. Being consistent and reliable in interactions and following through on promises or commitments made to service users. Valuing and supporting the lived experiences of trauma in case management teams. Addressing trauma within the context of the service user's cultural background and experiences.

General principles and key considerations important for the implementation of MHPSS activities by MHPSS actors, including Protection Case Management teams, are included in the MHPSS Minimum Service Package; Case Management teams and supervisors should be trained on MHPSS principles, considerations, topics, and skills.

Adopting these principles into your practice will see you establish programming that follows a client-centred (also known as person-centred) and strengths-based manner. This approach fosters a respectful, trusting relationship between caseworker and service user, promoting long-term empowerment and well-being.

Key standards

To align with the Protection Case Management approach outlined in this guidance and its modules, Table 3 outlines the key foundational, operational and resourcing standards you must meet.

Table 3: A summary of key standards in Protection Case Management

Foundational standards	Where you can find guidance to support this standard
Protection Case Management is included in organisational strategy	Module 2: Is my organisation equipped to safely deliver Protection Case Management to those most at risk?
Protection Case Management is designed based on protection and context analysis	Module 2: How do I assess the need for Protection Case Management in a humanitarian situation?
Localisation, partnerships and exit strategies are developed and implemented	Module 2: Understanding existing systems and resources

Foundational standards	Where you can find guidance to support this standard
Protection Case Management service has the staffing/budget to meet requirements	Module 3: Staffing for Protection Case Management, budgeting for Protection Case Management
The service is guided by documented process and protocols, including a detailed risk-focused criteria, roles and responsibilities for internal and external actors, and information management and data protection protocol	Module 3: What are the minimum standards of Protection Case Management?
Monitoring, evaluation, accountability and learning (MEAL) standards and processes are incorporated throughout the Protection Case Management approach	Module 3: MEAL guidelines for Protection Case Management

Practice standards	Where you can find guidance to support this standard
Communities understand intake criteria	Module 2: Protection analysis for Protection Case Management Module 3: Your staffing structure - community-based staff
Cases registered at intake consistent with criteria	Module 2: Form 0 explained Module 5: Case file check

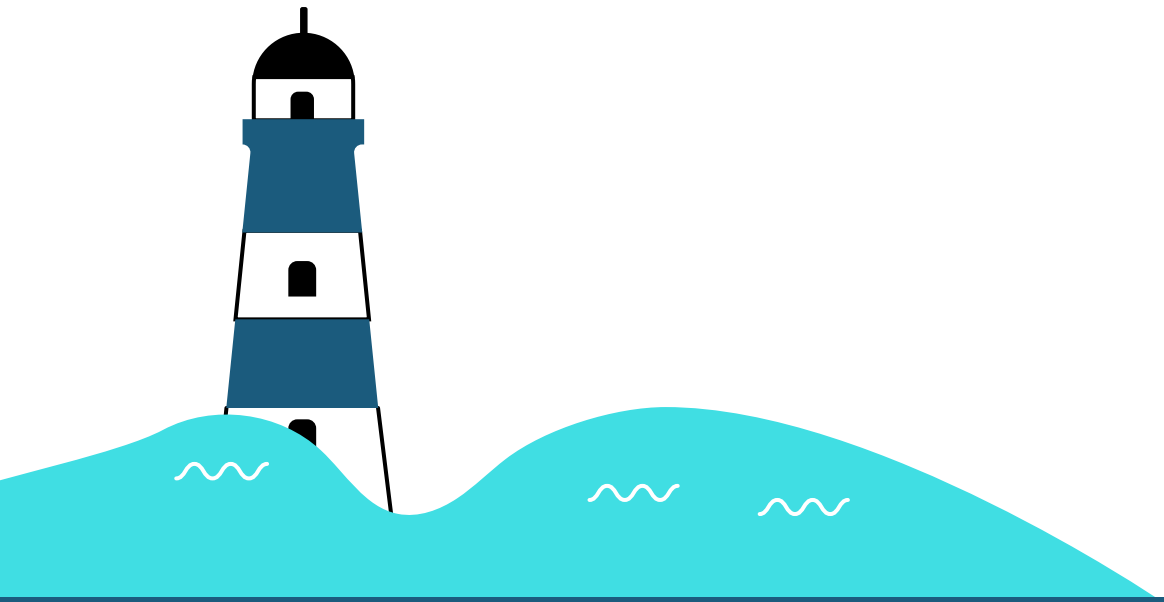
Practice standards	Where you can find guidance to support this standard
Cases workers are observed taking assent[16]/ consent (at intake and whenever relevant)	Module 4: Informed consent
Caseworkers are observed making reasonable accommodation where applicable	Module 4: Informed consent
Case file reviews demonstrate consistent care across risk levels/caseload	Module 3: Budgeting for Protection Case Management
Caseworkers are observed developing/reviewing case plans collaboratively with service users	Module 2: Form 0 explained Module 5: Case file check
Case plans are developed to include on relevant services and address the identified protection risk	Module 4: Case planning Module 5: Case file check Module 5: Observation
Caseworkers calling for documented case conferences as appropriate	Module 5: Case file check
Referral systems is functional, and any service delays are proactively addressed appropriate to risk level	Module 4: Case conferencing

Practice standards	Where you can find guidance to support this standard
Safety plans are developed and implemented as appropriate	Module 4: Safety planning
The Protection Case Management services document shares lessons learned and successful case management strategies	Module 3: MEAL guidelines for Protection Case Management
Case plan implementation is conducted according to agreed deadlines	Module 3: What are the minimum standards of Protection Case Management? Module 5: Case file check
Caseworkers observed reviewing case plans with service user as appropriate	Module 4: Case planning Module 5: Observation
Barriers to case plan implementation identified and addressed by supervisors	Module 5: Supervision
Case File reviews conducted regularly by supervisors	Module 5: Supervision

Practice standards	Where you can find guidance to support this standard
Cases closed as per standard operating procedure criteria	Module 3: What are the minimum standards of Protection Case Management? Module 5: Case file check
Service user satisfaction survey conducted with consent, when possible; service user complaints and trends in feedback are discussed and addressed regularly.	Module 3: Note about user-centred MEAL approaches Module 4: Service user satisfaction survey
Staffing and staff support	
Caseworker: Service user ratio requirement is met (1:25)	Module 3: Staffing for Protection Case Management Module 5: Supervision
Team leader : Caseworker ratio requirement is met (1:6)	Module 3: Staffing for Protection Case Management Module 5: Supervision
Staff have clear job descriptions	Module 3: Staffing for Protection Case Management

Staffing and staff support	
Staff have required trainings for their roles	Module 3: Staffing for Protection Case Management Module 5: Supervision
Team or individual staff capacity building plans are in place	Module 5: Supervision
Supervision conducted and actions/ recommendations are addressed	Module 5: Supervision
Staff and volunteers receive staff care and wellbeing support services and have access to MHPSS services	Module 5: Supervision

Teams have used Tool 1.1: Quality Standards Tools as a checklist and planning tool to develop or adjust programmes to meet these standards.



Summary of key points

Protection Case Management is a service whereby a caseworker provides individualised support to an adult at risk of or recovering from violence, coercion, and deliberate deprivation to achieve increased safety and well-being.

In establishing a Protection Case Management service, actors will need to coordinate with others to ensure they are reinforcing national systems and offering services that are complementary to preexisting services.

Children or survivors of GBV should always be referred to caseworkers that have the specialised protocol knowledge to do no harm and provide quality of case.

In humanitarian situations individuals at risk may find themselves overwhelmed, disoriented, or cut off from their usual coping strategies, making it harder for them to manage their own safety and well-being when in danger or in distress.

Protection Case Management is an effective strategy to ensure those most at risk receive essential support services, including MHPSS services.

Protection Case Management is a humanitarian intervention that upholds quality programming and centres clients safety, well-being and autonomy as paramount.

The Protection Case Management approach has minimum standards that should be followed; support and assistance is available throughout this guidance to help your programmes align to the service standards.

Up next

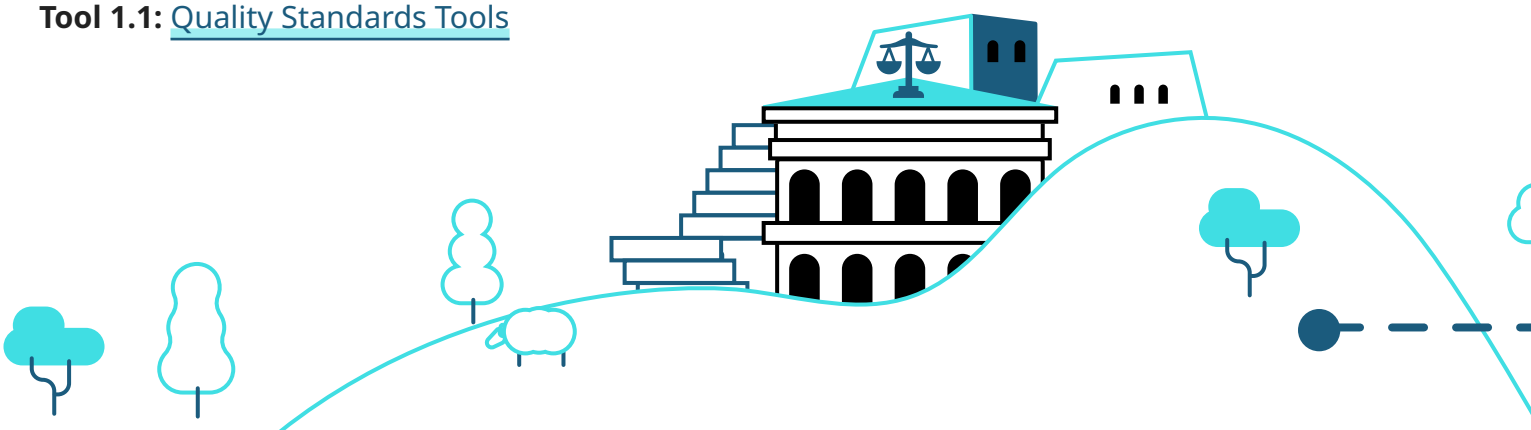
Module 2: Assessing the Need and Scope of Protection Case Management in your Context: A Practical Guide for Coordinators, Technical Teams, and Managers

Module 2 will guide you and your organisation in assessing and determining key initial considerations when exploring if Protection Case Management is the right intervention in the humanitarian situation that you are working in. By the end of this module, you will be able to answer the following questions:

- **Is my organisation equipped to safely deliver Protection Case Management to those most at risk?**
  Evaluating your organisation's capacity to meet safety and quality standards.
- **How do I assess the need for Protection Case Management in a humanitarian situation?**
  Understanding how to identify when and where Protection Case Management is required through protection analysis and coordination with other actors.
- **How do I develop intake criteria for Protection Case Management?** Learning the steps to create clear and effective intake criteria to ensure that the right cases are prioritised for support.

Tool

Tool 1.1: Quality Standards Tools



Annexes

Annex 1.1: Protection Risk Criteria for Protection Case Management

Annex 1.2: Theory of Change for Protection Case Management

Endnotes

1 For discussion on common terms, see: Hugh McLaughlin, What's in a Name: 'Client', 'Patient', 'Customer', 'Consumer', 'Expert by Experience', 'Service User'—What's Next?, The British Journal of Social Work, Volume 39, Issue 6, September 2009, Pages 1101–1117. https://doi.org/10.1093/bjsw/bcm155

2 MHPSS Minimum Service Package. https://www.mhpssmsp.org/en/activity/activity-introduction-15#page-1

3 Global Protection Cluster (2021) Protection Analytical Framework. https://globalprotectioncluster.org/sites/default/files/2023-01/paf_an-introduction.pdf

4 Ibid

5 Milanovic M. Revisiting Coercion as an Element of Prohibited Intervention in International Law. American Journal of International Law. 2023;117(4):601-650. doi:10.1017/ajil.2023.40. https://www.cambridge.org/core/journals/american-journal-of-international-law/article/revisiting-coercion-as-an-element-of-prohibited-intervention-in-international-law/CF9ED44C35C14E00D3B3AC6685861338

6 Global Protection Cluster (2021) Protection Analytical Framework. https://globalprotectioncluster.org/sites/default/files/2023-01/paf_an-introduction.pdf.
The PAF was initiated by the USAID BHA-funded IRC-DRC Results-based Protection Analysis Project to contribute to collective efforts of improving and streamlining protection analysis.

7 Ibid

8 Ibid

9 Ibid

10 IASC (2017): https://interagencystandingcommittee.org/sites/default/files/migrated/2017-02/grand_bargain_final_22_may_final-2_0.pdf

11 For more information on how to provide holistic support to individuals injured by EO, see: Victim assistance in mine action (mineactionstandards.org)

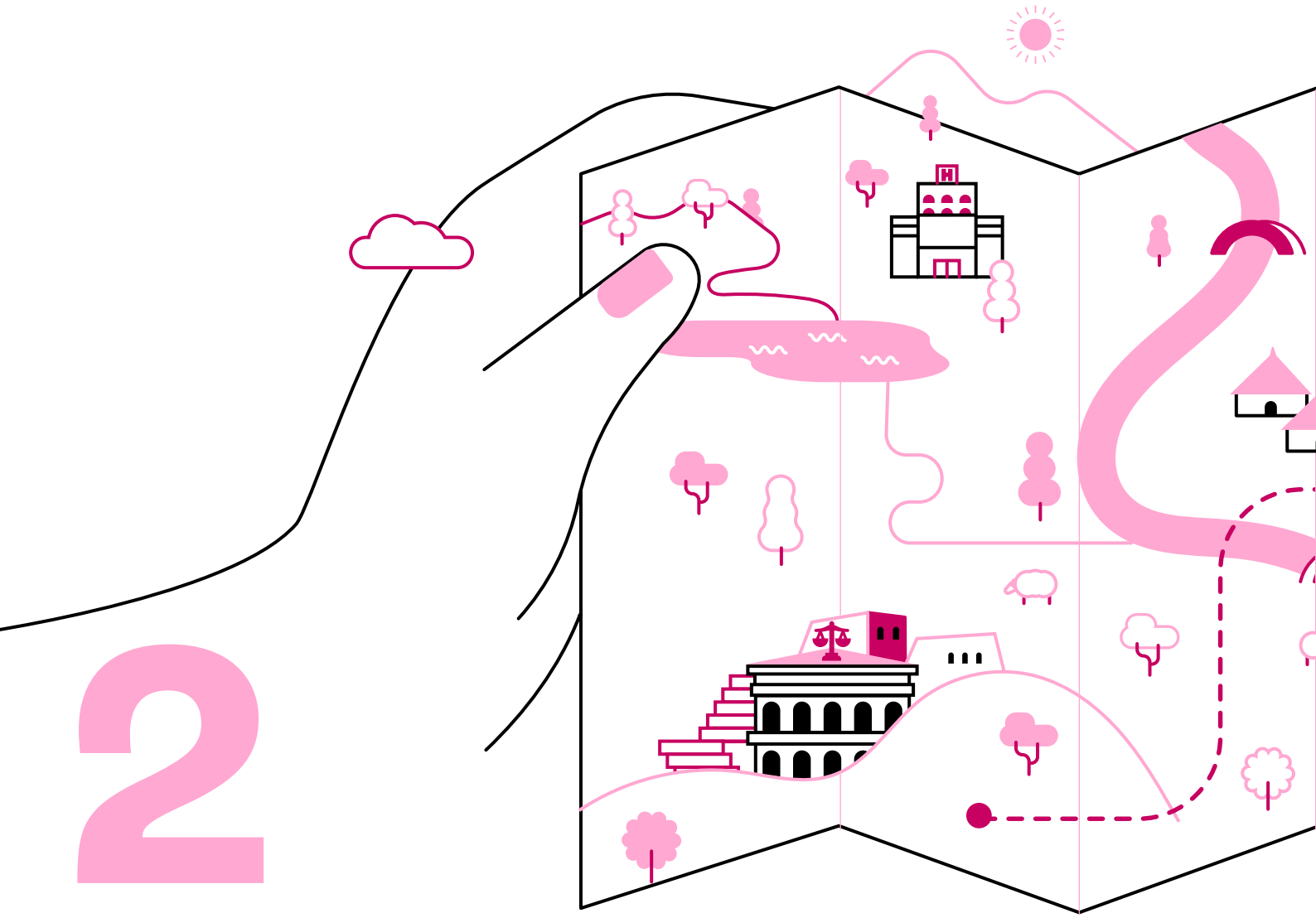
12 MHPSS MSP. https://www.mhpssmsp.org/en/activity/key-consideration-ensure-clarity-roles-between-protection-and-mhpss-workers#page-1

13 This is an adaptation of the IASC MHPSS intervention pyramid that continues to benefit from application in the field and further discussion among experts.

14 Impact refers to the long-term change(s) that result from a programme or intervention, which are often cumulative, with effects that occur gradually, over time. Outcomes refer to changes in state that result from an intervention, which we typically observe in the medium and long term. Interim outcomes refer to more immediate changes that result from an intervention in the short term. These are linked to implementation of key programme activities, and reflect initial changes in process, systems, capacity, and/or ways of working that contribute to the achievement of the overarching outcomes. See Annex 1.2 for more details.

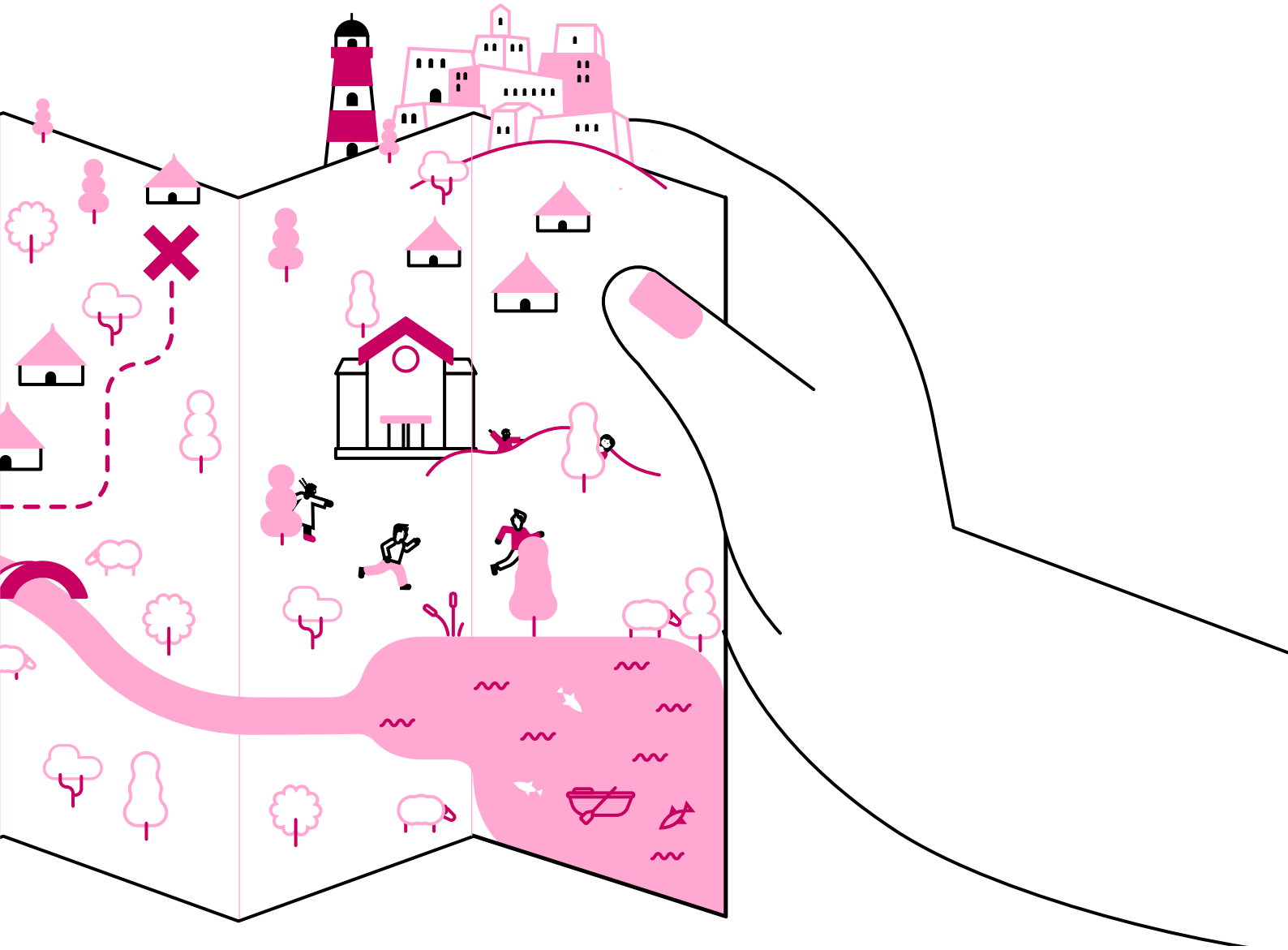
15 Global Protection Cluster (2017) Protection Mainstreaming: https://globalprotectioncluster.org/index.php/themes/protection_mainstreaming#:~:text=Protection%20mainstreaming%20is%20the%20process,account%20in%20all%20humanitarian%20activities

16 Assent refers to the agreement or approval of an individual, particularly in situations where full legal consent may not be possible. This term is commonly used in reference to a child's ability to give affirmative agreement that does not meet legal criteria for consent. In this case, it refers to adult individuals who have a reduced capacity to give legal consent. For example, because of a cognitive impairment.



2

Determining Need and Scope for Protection Case Management Programming: A Guide for Coordinators, Technical Staff and Managers



Welcome to Module 2. This module will guide you and your organisation in assessing whether Protection Case Management is the appropriate intervention in the humanitarian situation that you are working in. By the end of this module, you will be able to answer the following questions:

- **Is my organisation equipped to safely deliver Protection Case Management to those most at risk?**
  Evaluating your organisation's capacity to meet safety and quality standards.
- **How do I assess the need for Protection Case Management in a humanitarian situation?**
  Understanding how to identify when and where Protection Case Management is required through protection analysis and coordination with other actors
- **How do I develop intake criteria for Protection Case Management?**
  Learning the steps to create clear and effective intake criteria to ensure that the right cases are prioritised for support.

Is my organisation equipped to safely deliver Protection Case Management to those most at risk?

You will need to assess your organisation's internal capacity to provide quality Protection Case Management services[1] to the standards described throughout this guidance. This requires a realistic review of your human, financial and security resources, as well as your level of access to the people you aim to serve. The goal is to ensure you can safely deliver accessible services that meet minimum standards. Start by focusing on the foundational standards, use this tool to plan for how these can be achieved. Table 1 provides an overview.

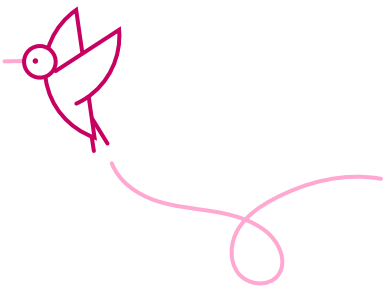
Table 1: A summary of foundational standards in Protection Case Management

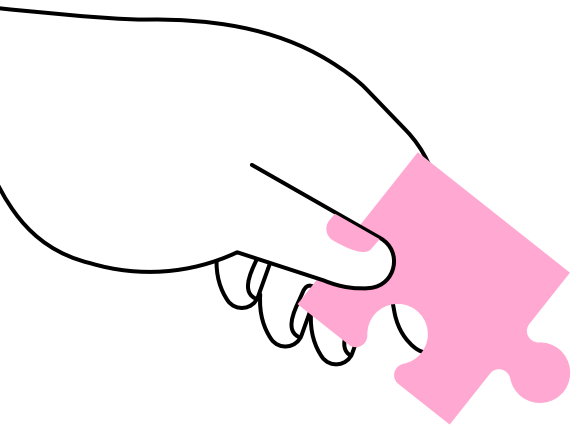
Foundational standards	Where you can find guidance to support this standard	Summary
Protection Case Management is included in organisational strategy	Module 2: Is my organisation equipped to safely deliver Protection Case Management to those most at risk?	Your organisation has a commitment to establish and support Protection Case Management over time, which should be reflected in strategy or other organisational documents. Senior management understands Protection Case Management and can champion the minimum standards internally and with donors.
Protection Case Management is designed based on protection and context analysis	Module 2: How do I assess the need for Protection Case Management in a humanitarian situation?	As part of your protection analysis, your organisation will map local systems and consider how an intervention can reinforce existing systems. Localisation, partnership, and exit strategies will be identified as part of the initial programme design/ strategy.
Localisation, partnership and exit strategies are developed and implemented	Module 2: Understanding existing systems and resources	Your organisation should engage resources to carry out a protection analysis, Protection Case Management design, and coordination with other actors.

Foundational standards	Where you can find guidance to support this standard	Summary
Protection case management service has the staffing/budget to meet requirements	Module 3: Staffing for Protection Case Management; Budgeting for Protection Case Management	Minimum staffing requirements should be met, including dedicated caseworkers (not multitasking protection roles), supervision staff, and technical support. Minimum budget requirements should be met, including the financial ability to sustain Protection Case Management for 12 months. It should include an adequate staffing structure, training, and ongoing professional development and staff care provisions [see Module 5]. When you have defined your target group, you might realise they have specific needs that have a budget implication; some budget flexibility might be required. Your budget will be influenced by your required mode of service delivery and your operational context.
The service is guided by documented processes and protocols, including a detailed risk-focused criteria, roles and responsibilities for internal and external actors, and information management and data protection protocols	Module 3: Protection Case Management protocols	Staffing/budget includes technical resources and bandwidth to take on the development of localised protocols, coordination, and quality assurance for Protection Case Management.

Foundational standards	Where you can find guidance to support this standard	Summary
MEAL standards and processes are incorporated throughout the Protection Case Management approach	Module 3: MEAL guidelines for Protection Case Management	A comprehensive MEAL guide for Protection Case Management, including suggested indicators, measurement tools and an example dashboard.

Supporting marginalised and at-risk individuals, especially when they may face threats from a dominant group, requires careful planning to ensure the safety of service users, caseworkers, and the organisation. You can use **Tool 2.1: Project Risk Matrix Template** to address potential risks and explore the concerns raised by your team, management, or other stakeholders regarding safety and security. It is essential to include the proposed service user group in these discussions to gain insights on whether case management services can be safely provided and what adjustments could improve safety (e.g. alternative locations or timings). Additionally, consult with caseworkers to assess their comfort in delivering services, as well as completing necessary training and capacity building activities. This risk assessment should be regularly revised and adapted based on client feedback during the implementation phase.





How do I assess the need for Protection Case Management in a humanitarian situation?

Understanding existing systems and resources

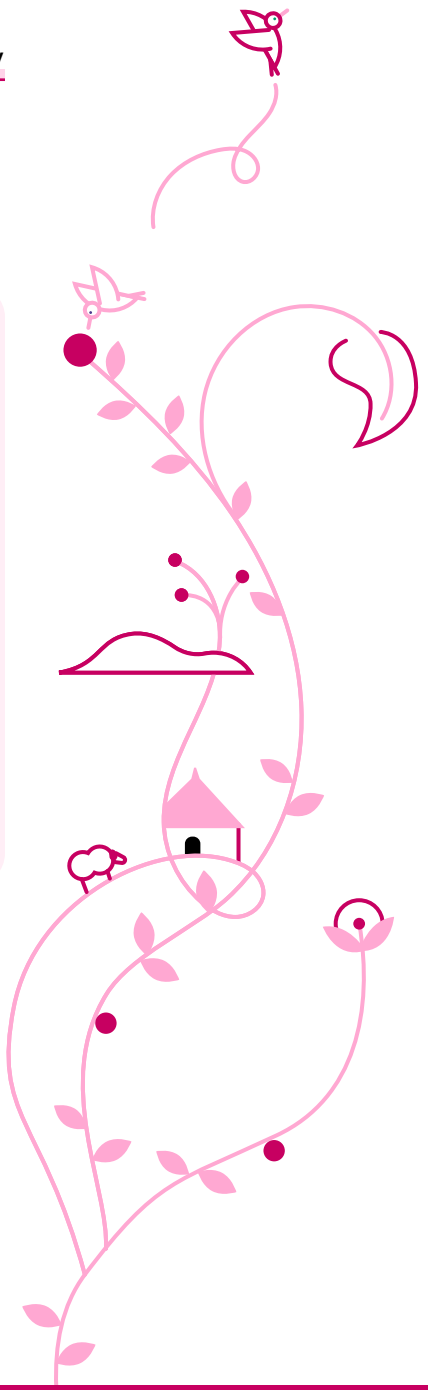
You likely came to this guidance because you see a need for a social work-aligned service that can support the safety and wellbeing of a subset of a conflict-affected population. Where possible, organisations should aim to work in collaboration with local governments, existing social work systems, and relevant authorities to deliver direct Protection Case Management or similar services. Only consider establishing new services where gaps in service provision exist.

When developing a working relationship with duty bearers, it is important not to view them as a single entity. Instead, organisations interested in reducing protection risks through Protection Case Management services must understand which bodies and institutions have a positive or negative influence on their work. Additionally, it's essential to understand how these entities communicate, as well as

analysing their outcomes concerning specific human rights risks. For instance, a country's military may have a poor human rights record, while the Ministry of Social Affairs or Welfare may be effectively providing social services for displaced and marginalised populations. Coordination with other agencies (e.g. UNHCR, UNICEF, UNFPA) is crucial to avoid duplicating efforts when supporting primary duty bearers. Remember that other agencies will also have working relationships with government ministries. Coordinate efforts to engage national systems, which are often extremely busy in a humanitarian situation, to ensure streamlined and effective collaboration

Understanding the role, strengths, and challenges of national systems will involve both secondary and primary data collection. Save the Children's Strengthening Child Protection Systems: Guidance for Country Offices provides specific steps to assess and understand a CP system, which can be adapted for use in broader Protection Case Management contexts, informing your organisation's response planning.

The Mental Health and Psychosocial Support Minimum Service Package (MHPSS MSP) includes key resources and guidance materials to support this activity, including the MHPSS MSP Gap Analysis Tool. This tool is for MHPSS Technical Working Groups (TWGs) to assess and map current MHPSS MSP implementation, and to identify gaps and prioritise activities. The results of the gap analysis can be used by protection teams to understand existing systems and resources to support the MHPSS needs of service users, as well as planning and prioritising programming. For support, contact the MSP Helpdesk and local and national MHPSS TWGs.



Responding in complex humanitarian contexts

In contexts where your protection analysis has identified that the government or specific agencies are party to the conflict, have lost territorial control, or you are working under de-facto authorities, tensions may arise between building national capacity and protecting displaced people. In such situations, you might consider establishing a separate case management system outside formal government services, while following humanitarian principles. This approach is justified because Protection Case Management aims to address human rights risks and support individuals in claiming their rights, which can challenge social imbalances favouring those in power.

While restoring rights is crucial for marginalised individuals, it can sometimes provoke backlash from those whose power is undermined. For example, supporting someone from a disenfranchised group may trigger harmful reactions within a community, potentially disrupting fragile social dynamics.

Providing Protection Case Management in these circumstances can be appropriate, but you must adopt a conflict-sensitive, 'do no harm' approach[2, 3]. This involves designing services that protect individuals rather than exposing them to further risks, such as violence, coercion, deprivation, or negative mental health and psychosocial wellbeing outcomes. Work with staff and partners who understand the context and its sensitivities, and conduct thorough risk analyses to identify potential negative consequences. Ensure that all programming is overseen and supported by appropriately qualified personnel, and adhere to safe recruitment and safeguarding procedures when engaging workers that interact with service users at heightened risk. If risks cannot be adequately mitigated, it may be necessary to reconsider establishing Protection Case Management services.

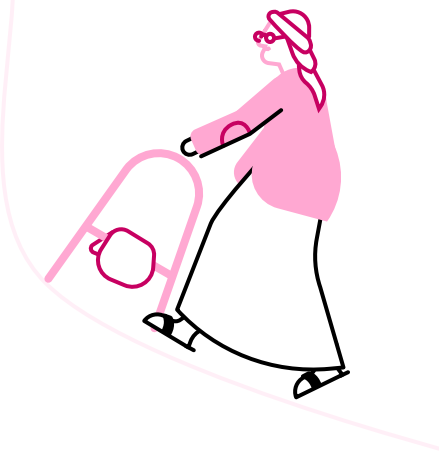
Protection analysis for Protection Case Management

It is important to define intake criteria based on the specific protection risks present in your context, rather than relying on individual or sociodemographic characteristics as automatic indicators of vulnerability, such as disabilities, MHPSS needs, older age, or female-headed households. Defining categories in this way, without understanding the actual risks individuals face, can result in some groups being overlooked while others are incorrectly assumed to be vulnerable. This approach undermines the empowering process of Protection Case Management.

Example: Do not automatically consider a person with a disability as needing Protection Case Management Services. They may have safety nets in their economic or social standing, or supportive social relationships. These factors can only be properly understood when a caseworker assesses their individual, household, community, and social capacities.

A risk-based approach using the Protection Analytical Framework

The PAF is designed to guide robust protection analysis in crisis-affected environments, helping humanitarian organisations develop risk reduction strategies through a deep understanding of the protection context. The PAF is built around four main pillars and focuses on analysing protection risks, including root causes of threats, their effects on affected individuals, and the available capacities in each context. It is used for ongoing analysis in evolving humanitarian settings, including situations of internal displacement.



The PAF supports evidence-based programming aimed at creating a safer, more favourable protection environment by informing programme adaptations, advocacy efforts, and other interventions. It allows individuals to recover from conflict and violence and ensures they can exercise their rights and entitlements.

Based on the risk equation framework, the PAF analyses three intersecting factors: threats, vulnerabilities, and capacities. It requires users to produce an accurate risk analysis by assessing individual or community vulnerabilities in relation to specific threats and available capacities.

Developed by the IRC and DRC in coordination with the Information Analysis Working Group, the PAF has been endorsed by the Global Protection Cluster. It is widely used for protection analysis initiatives, serving as interagency guidance for comprehensive, streamlined protection analysis.

There is no hierarchy among protection risks themselves. They should all be considered equal to ensure individuals receive the fullest protection. Multiple protection risks can occur simultaneously and may overlap, with different risks often having similar impacts on crisis- and displacement-affected individuals and communities.

Table 2 provides a list of examples of violence, coercion, and deliberate deprivation, using definitions adapted from the PAF that can be considered for Protection Case Management criteria. Whilst this list is non-exhaustive, without the presence of one of these risks, the minimum standard for Protection Case Management is unmet.

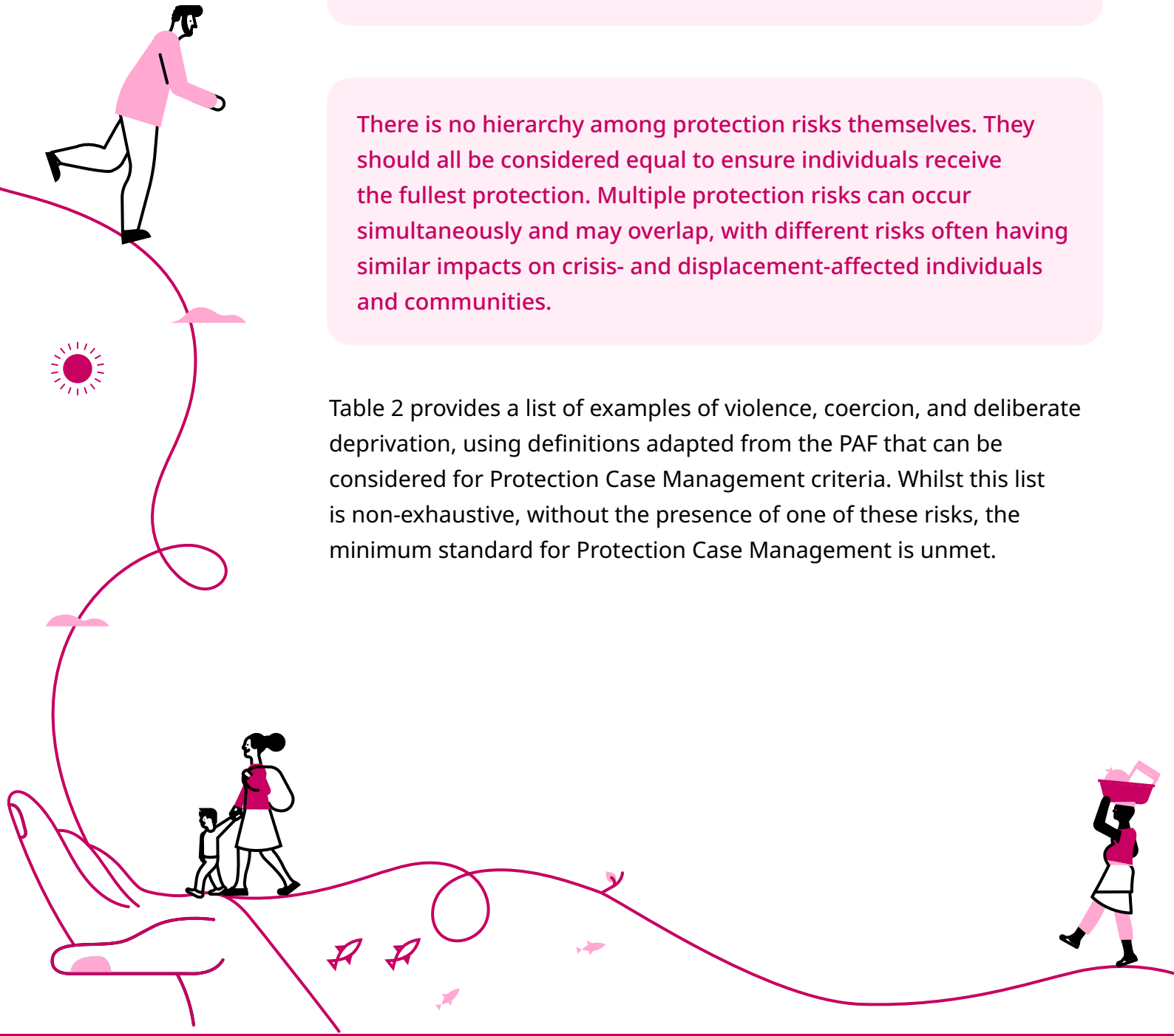


Table 2: Protection risk criteria for Protection Case Management

Sub-categories of risks faced by Protection Case Management service users[4]	Violence	Coercion	Deliberate deprivation	Example risk definitions	Comments and considerations
(Forced) family separation		✔		Adult individuals requiring a caregiver are at risk after being separated from their family or other usual caregivers.	Does not include children who are alone or separated from their families.
Abduction, kidnapping or enforced disappearance	✔	✔		Individuals are at risk of detention or have been detained or victim to enforced disappearance. Those responsible refuse to acknowledge the detention or they conceal the concerned person's fate and whereabouts, which places the person outside the protection of the law.	

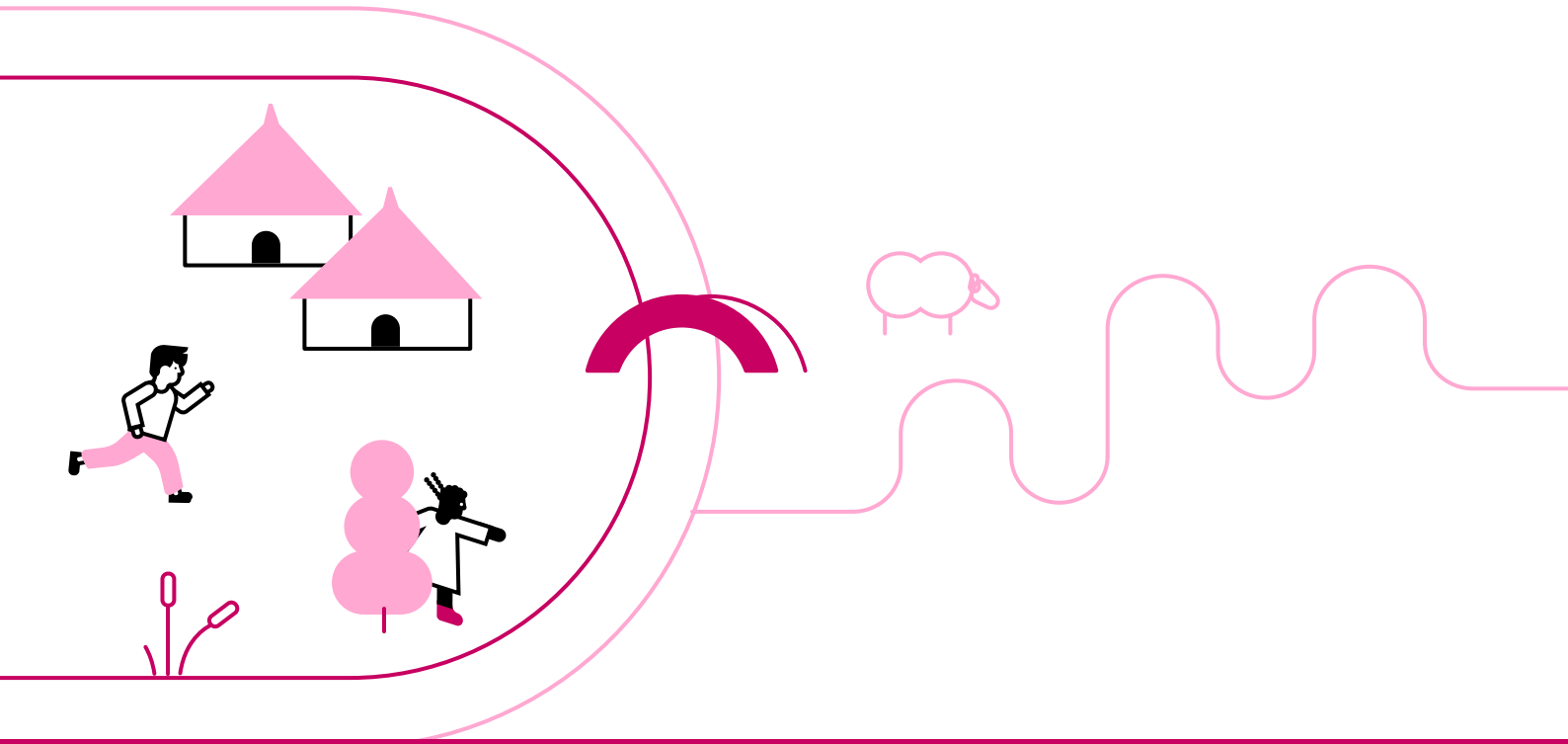
Sub-categories of risks faced by Protection Case Management service users	Violence	Coercion	Deliberate deprivation	Example risk definitions	Comments and considerations
Arbitrary or unlawful arrest and/or detention			✔	Individuals have been deprived of their freedom due to an unlawful arrest or detention. An arrest is considered unlawful if, for example, an individual is not informed immediately of the reason in a language they understand, or if they are not promptly brought before a judge to confirm the legality of the arrest or detention.	

Sub-categories of risks faced by Protection Case Management service users	Violence	Coercion	Deliberate deprivation	Example risk definitions	Comments and considerations
Death or injury through deliberate or non-deliberate attacks by armed groups	✔			Individuals are at risk of death or injury or injured during an attack, either accidentally or deliberately.	
Extortion	✔			Individuals subject to actual or threatened force, violence or intimidation to gain money or property from an individual or entity.	For instance, at checkpoints or by levying informal 'taxes' in return for safety.

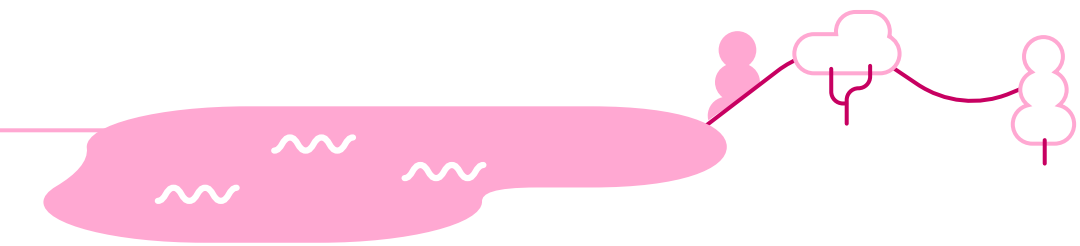
Sub-categories of risks faced by Protection Case Management service users	Violence	Coercion	Deliberate deprivation	Example risk definitions	Comments and considerations
Forced labour or slavery		✔		Adult individuals are coerced to work through the use of violence or intimidation, or by more subtle means, such as accumulated debt, retention of identity papers, or threats of denunciation to immigration authorities. This includes debt bondage and slavery. Slavery is the status or condition of a person or persons over whom any or all of the powers of ownership are exercised. It includes the purchasing, selling, lending, or bartering of a person or persons, and other similar deprivation of liberty.	Local coordination will be required to ensure there is alignment with gender-based violence responses.

Sub-categories of risks faced by Protection Case Management service users	Violence	Coercion	Deliberate deprivation	Example risk definitions	Comments and considerations
Forced recruitment into armed forces/ groups		✔		Any manner in which an adult is forced, coerced, threatened, or intimidated to join an armed force or group.	Local coordination will be required to ensure their alignment with children and armed conflict responses.
Maiming or mutilation	✔			Individuals who have been threatened with, or who have suffered, physical injuries that degrade the appearance or function of their living body. Maiming or mutilation may constitute torture or result from the presence of EOs.	In the case of maiming or mutilation as a result of explosive ordinance, coordination with mine action to ensure there is alignment with mine action responses. Coordination with health actors may also be relevant.

Sub-categories of risks faced by Protection Case Management service users	Violence	Coercion	Deliberate deprivation	Example risk definitions	Comments and considerations
Physical assault or abuse (not related to sexual and gender-based violence)	✔			Adults at risk of, or who have experienced, physical violence that is neither gender-based nor sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, or any other act that results in pain, discomfort, or injury.	Local coordination will be required to ensure there is alignment with CP and GBV responses.

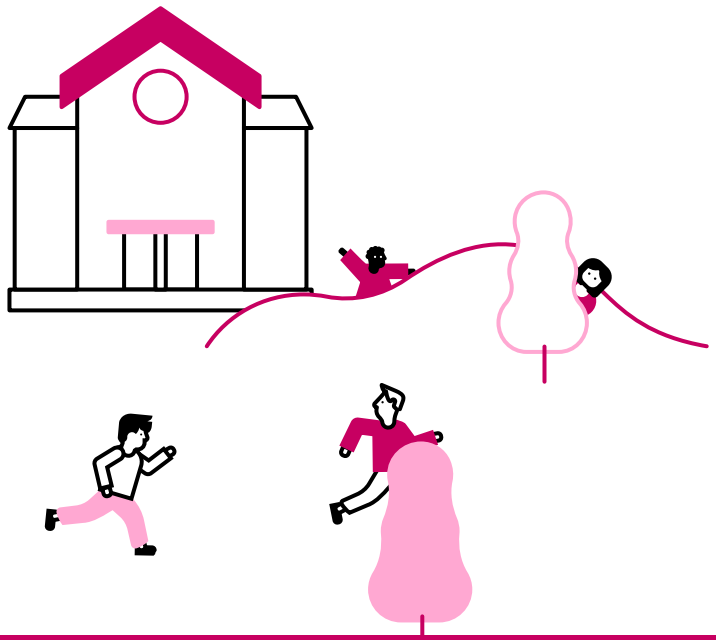


Sub-categories of risks faced by Protection Case Management service users	Violence	Coercion	Deliberate deprivation	Example risk definitions	Comments and considerations
Psychological/ emotional abuse	✔			Adult individuals who are suffering mental or emotional pain, injury or distress. Examples include: threats of violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a menacing nature, destruction of cherished things, etc.	Local coordination will be required to ensure there is alignment with gender-based violence responses.



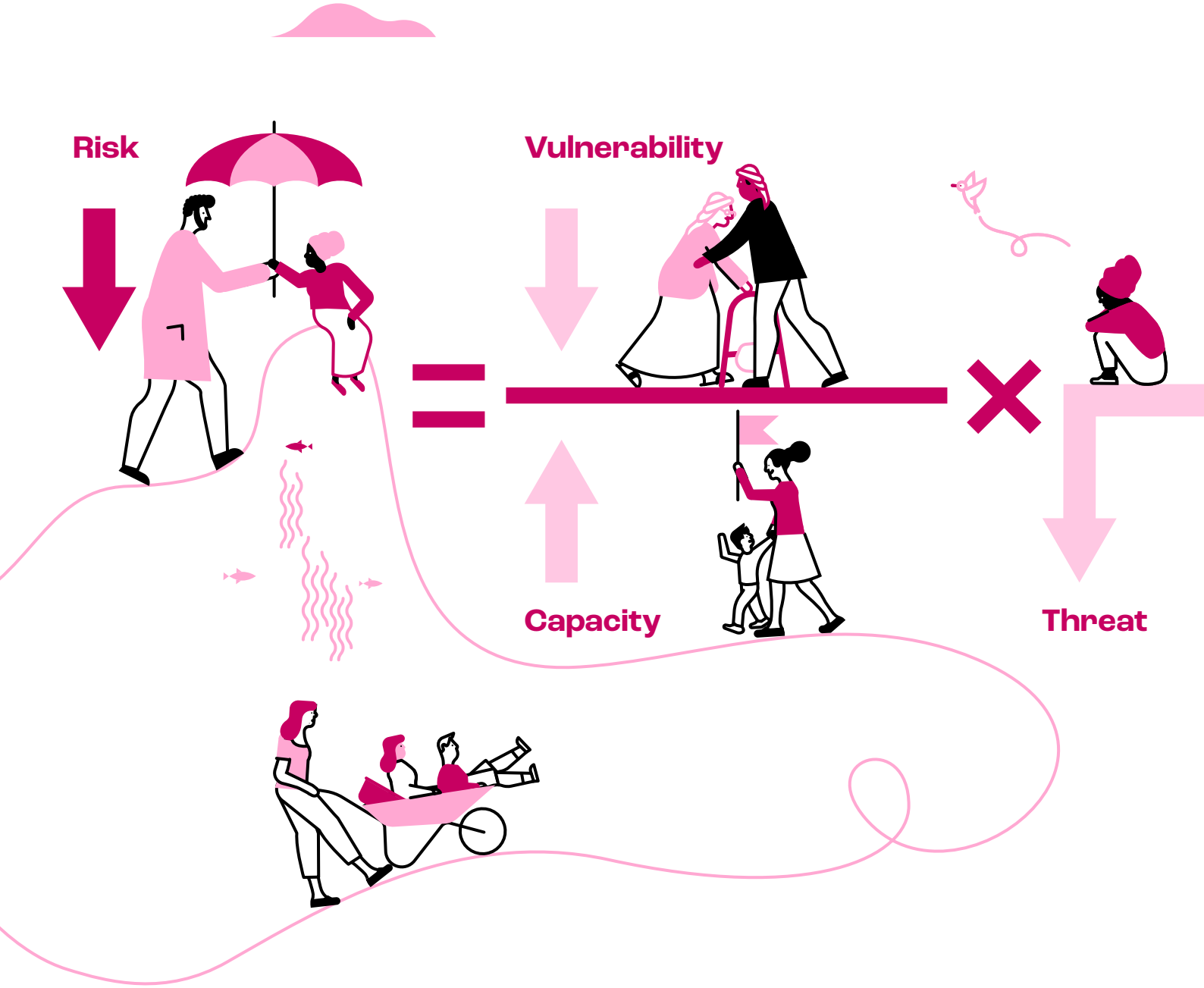
Sub-categories of risks faced by Protection Case Management service users	Violence	Coercion	Deliberate deprivation	Example risk definitions	Comments and considerations
Torture or inhuman, cruel, or degrading treatment	✔			Adult individuals who are at risk of or who have suffered severe physical and/or mental pain or suffering by a perpetrator for a specific purpose.	Although physical assault or abuse can constitute torture, it is not always torture. Torture requires the existence of a specific purpose behind the act – to obtain information, for example. Local coordination will be required to ensure there is alignment with gender-based violence responses.

Sub-categories of risks faced by Protection Case Management service users	Violence	Coercion	Deliberate deprivation	Example risk definitions	Comments and considerations
Human trafficking		✔		Adults who have been recruited, transported, transferred, or harboured through threats, coercion, abduction, fraud, deception, abuse of power or vulnerability, or payments to those controlling them, for the purpose of exploitation.	Local coordination will be required to ensure there is alignment with CP and GBV responses.



The protection equation

Figure 1: The protection risk equation (adapted from InterAction)



Risk
Reduce prevalence and severity of impact

Vulnerability
Reduce vulnerability related to the threat

Capacity
Increase capacities related to the threat

Threat
Reduce the threat

How individuals experience risks is shaped by a range of factors, including their unique characteristics, identities, and experiences. These characteristics can include age, gender, disability, mental health and psychosocial well-being, diverse sexual orientation, gender identity, gender expression and sex characteristics, language, ethnic origin, religious background, and social or political affiliations. Additionally, factors such as legal status may influence how individuals encounter and cope with risks.

Vulnerability is not a fixed state. It varies depending on the interplay of individual characteristics and capacities within a given context. Therefore, an intersectional[5] lens is essential when assessing risks, as it helps caseworkers understand how different forms of oppression and discrimination overlap, shaping individuals' experiences of risk.

Individuals may inherit certain identities or characteristics, but they can also acquire capacities that enable them to mitigate or manage threats in specific contexts. Examples of such capacities include knowledge and skills training, access to effective reporting mechanisms, access to humanitarian aid, identification documents, and cash assistance. Additional capacities to support your thinking on this are suggested in the PAF, which can be found in Annex 2.1: Protection Analysis Capacities.

Secondary data for protection analysis

Starting with the collection and analysis of secondary data is a crucial first step in protection analysis. If the correct resources and information are available, secondary data can reduce the burden on your teams and key stakeholders, possibly replacing the need for primary data collection. However, you should critically assess the data to determine if it is sufficient.

There are numerous global and local resources, including tools, assessments and academic materials that can help you better understand the risks, threats, vulnerabilities, and capacities of conflict- or emergency-affected groups. These resources can also provide insight into available responses and whether they meet the needs of the most vulnerable. The extent of your secondary data collection may depend on

factors such as availability of data, the urgency of the situation, the level of risk, and your team's capacity to gather new information.

The PAF can guide you in assessing the information landscape, identifying data gaps, and determining additional information needed to support a more in-depth and integrated protection analysis.

Examples of secondary data sources:

1. Government statistics, demographic data, and official statements
2. Advocacy and monitoring reports from local organisations, including women-led or special interest initiatives
3. Local media and academic publications
4. Reports on international human rights conventions ratified by the state, as well as related reports
5. Policy and advocacy briefs, including those from country-level international non-governmental and non-govermental organisation forums
6. Humanitarian Country Strategies, Protection Sector Strategies, Humanitarian Needs Overviews, and Humanitarian Response Plans
7. Sector-specific assessments such as Rapid Protection Assessments, service maps, protection monitoring and analysis products, and reports from actors focused on CP, GBV, MHPSS and disability inclusion.

The CP Area of Responsibility (AoR) has developed a desk review template that can be adapted to your context. This template provides guidance on how to structure and present data collected during secondary data collection.

The MHPSS MSP includes key resources and guidance materials to support this activity, including the multi-sectoral MHPSS Needs and Resource Assessments Toolkit. For support, contact the MSP Help Desk. Protection Case Management teams should consult with local and national multi-sectoral MHPSS TWGs for access to updated local MHPSS assessments, service maps, reports, and tools.

Primary protection data

Based on the experiences of Protection Case Management implementers, programmes with access to good, validated protection data from secondary sources have often been able to proceed directly to protection analysis. However, some found that crucial details were missing and needed to return to collect additional data, while others recognised from the outset that secondary data was inadequate and prepared to gather the necessary information themselves.

Here are some tools and resources you can use to collect and analyse protection and context data:

- Appendix 1: PAF Analysis Tools[6] and the Protection Analysis Roadmap
- Annex 2.3: Protection Risk Identification
- Disability Inclusion Risk Analysis Tips
- MHPSS Needs and Resource Assessments Toolkit

Protection analysis findings can be shared in your protection table analysis. Primary protection data collected by your project should be shared with the protection sector, as well as with local and national MHPSS TWGs, to contribute to monitoring protection issues as a collective effort. It is important to continue out the inputs from a broad range of stakeholders, as well as include your protection and other

teams. If service providers or authorities are available and it's safe to have a discussion about protection risks externally, consider including:

- Relevant authorities, including informal and de facto decision makers.

- If this is an onset of a new emergency and a cluster system has already been established, Protection Case Management service providers should coordinate with the AoR to conduct joint assessments wherever possible. Other relevant service providers, particularly those likely to collaborate during Protection Case Management, include CP, GBV, legal assistance, health (including MHPSS), MHPSS service providers, in particular the CP, GBV and Mine Action AoRs, and others. Reference local protocols for these services where appropriate and understand any gaps in service provision.

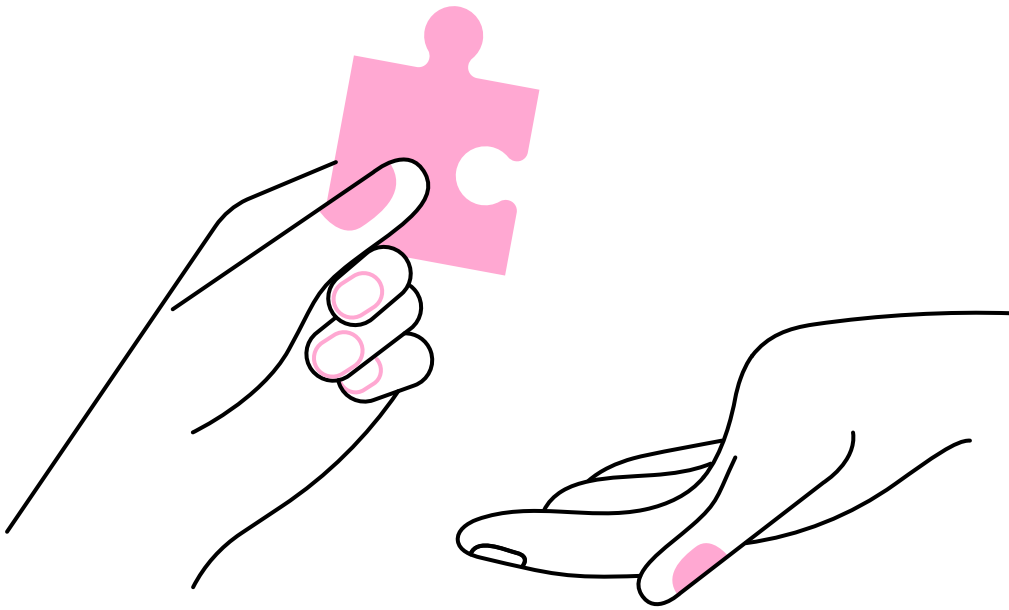
- Mainstreaming and supporting resources, such as inclusion, gender, security, information management, monitoring and evaluation teams, and senior management.

Protection analysis

When you're ready to do your protection analysis, use these questions in Annex 2.2: Key Questions for Protection Analysis to guide your team in discussing and unpacking your findings during the protection analysis exercise. They will help you organise and analyse the information effectively. You can use Annex 2.3: Protection Risk Identification to organise your answers.

Define the specific threat, identify who is most vulnerable to the threat, and assess the capacity of individuals to cope with or address the threat. If you find the process overwhelming due to many identified risks, don't worry, analysis typically becomes faster once you move past the initial two to three risks. Aim to include all risks that are present in your operational location, even if there are safety or technical concerns, you can return to these concerns in the next step. It's crucial to remember that Protection Case Management, like all humanitarian interventions, aims to reach the most at-risk individuals, not just the easiest to reach.

Once you have this information, you and your team will understand the prevalent risks, the specific threats, and who is most at risk, along with existing capacities to manage these risks at various levels (society, community, household, individual)[7]. The next step is to decide which risks to prioritise for your case management services.



How do I develop intake criteria for Protection Case Management?

Organising a workshop to discuss your protection findings with your team, along with colleagues from other service providers — such as national social welfare and protection services, and representatives from relevant sectors and local and national multi-sectoral working groups (e.g. MHPSS TWGs) — can enhance the quality of your analysis. Validating these findings with local representatives will further enrich your assessment and allow local organisations, leaders, and others to prioritise risks and challenges faced by crisis-affected populations.

This process should take place in a safe, non-judgmental environment, enabling staff to openly analyse findings shared by the community, as well as insights from your primary and secondary data review. In some cases, due to the sensitivity of protection profiles, public discussion may not be appropriate. If your team requires additional training on protection issues to engage effectively, include that in your planning.

Annex 2.4: Workshop Agenda aims to validate your protection analysis and start to develop your intake and response criteria. Following your protection analysis and workshops, you should be able to articulate who is eligible for intake into Protection Case Management in your location/context. This should include a description of presentations by risk, categorising them as high, medium, or low priority. This information will help caseworkers prioritise their responses within their caseload and assist supervisors in ensuring that individual caseworkers are not supporting an overwhelming amount of high-risk cases.

Form 0 explained

Form 0: Intake and Response Criteria is a tool your team can use to define your intake criteria, exclusion criteria, and assign timeframes for responses at each Protection Case Management step, relating it to their level of priority or 'risk level'. Caseworkers/supervisors use Form 0 on a daily basis to help them determine eligibility of individuals at intake, as well as a guide to determine their priority level throughout the process. This will be a guide only and individuals may present with protection risks that are not represented in Form 0. Where caseworkers are unsure of a service user's eligibility or priority level, they should discuss with their supervisor. If supervisors are unsure, they should seek support of senior staff (determine a local focal point).

You can either develop this form in advance and use the workshop as a validation exercise, or you can develop it together with your team in the workshop. During the pilot, teams reported that staff involved in developing the intake criteria had a better understanding of it once it was implemented.

In your protection analysis and the drafting of Form 0, it is not uncommon for discussions to raise concerns about whether individuals with certain risks or profiles are beyond the organisation's reach, unsafe for caseworkers to support, or too complex for your team's technical capacity. You can reassure teams that their safety is paramount and omitting risks or certain profiles due to concerns is an option, as is further safety planning and protocol development. However, do not omit certain profiles from your criteria without a rigorous examination, which may need to take place outside any initial workshops or planning sessions.

Finalising your criteria

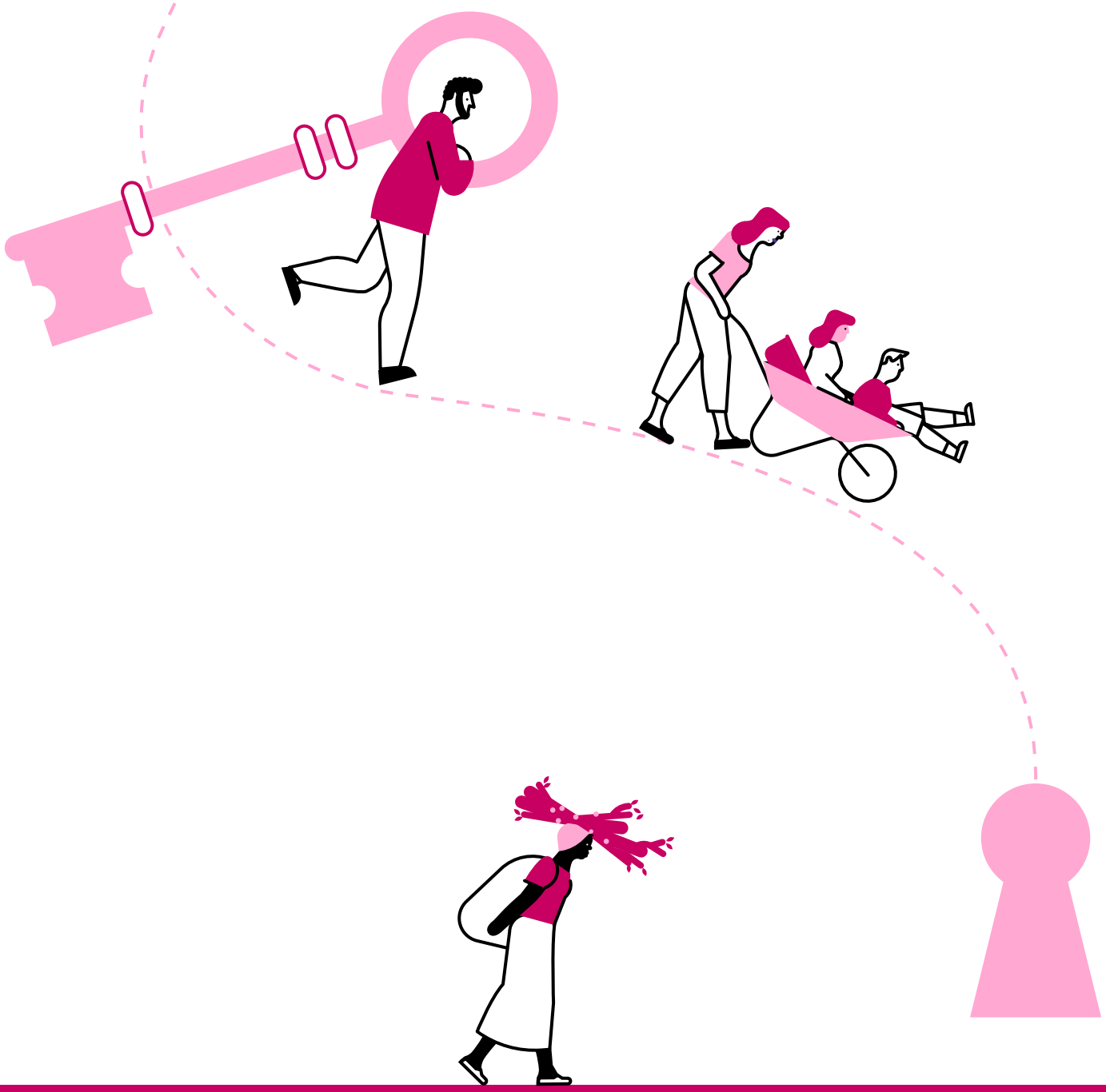
Now that you have a draft Form 0 developed with your team and/or interagency group, it is important to continue proactively seeking feedback from the workshop participants and key stakeholders who were not present, allowing them to reflect on the draft.

Whenever possible, include all groups at every stage before drafting Form 0. If any organisations or authorities have not been involved in the process, engage them before implementation and allow them to provide feedback on your draft criteria.

When there is access, safety, or technical concerns over providing Protection Case Management to people with certain risks or other profile factors, work with your teams to articulate those concerns, and workshop any mitigations or design accommodations that could be made. You can use this document to think through this. Where it is ultimately not possible to access, deemed unsafe, or beyond the team's current capacity to provide quality care to certain groups, omit these groups from your criteria for now and revisit later. When the capacity of teams is a barrier, ensure the issues are addressed in professional development plans (see Module 5).

In humanitarian and protracted crises, the context is not static. It is critical to regularly update your protection analysis and review case prioritisation. This should be done within the first six months after initial implementation, and at least annually in stable contexts. Most importantly, reassess your response in the event of major changes, such as new policies, outbreaks of violence, or economic shifts.

Once you've made internal decisions and consulted externally to define the intake criteria for your Protection Case Management Service, you can design a programme and response standards that meet the needs of the risks identified in your context. This will be covered in Module 3.



Summary of key points

Your initial consideration, if Protection Case Management is right for your programming, includes:

- Examination of your organisations technical capacity and resources to set up and sustain Protection Case Management programming to the standards set out in this guidance, including do no harm.
- Conducting a protection analysis for Protection Case Management in collaboration with key stakeholders (where safe and appropriate).
- Use of your protection analysis to identify and articulate your intake criteria, defining the characteristics of a high, medium and low risk case. This will support caseworkers and supervisors to manage their response times and caseloads.

This process takes time and effort, impacting the design of your Protection Case Management service delivery, so be mindful of including this in your project cycle.

Up next

Module 3: Designing and Maintaining Quality Protection Case Management Service: A Guide for Technical Staff

Module 3 will help you consider aspects of setting up and maintaining a quality Protection Case Management service by helping you to answer the following questions:

- **What are the minimum standards of Protection Case Management?**
  Understanding the minimum required standards to offer Protection Case Management services and where can you find further guidance on how to meet this standard throughout this guidance.

- **What are the main design decisions I need to make with my team to establish a Protection Case Management service?**
  Addressing mode of delivery, understanding budget, and how to approach cash in Protection Case Management, staffing, and standard operating protocol development.

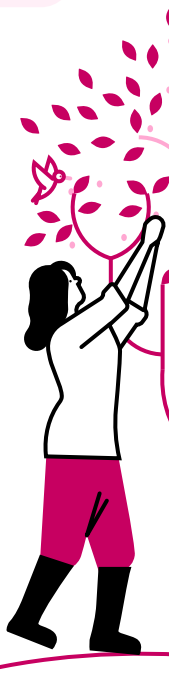
- **What are the MEAL standards and guidelines for Protection Case Management?**
  Getting to know MEAL standards, observing how you can: *Track progress, assess impact, remain accountable to service users, key stakeholders, and donors, and adjust and improve the Protection Case Management approach.*

Forms

Form 0: Intake and Response Criteria

Tools

Tool 2.1: Project Risk Matrix Template



Annexes

Annex 2.1: Protection Analysis Capacities

Annex 2.2: Key Questions for Protection Analysis

Annex 2.3: Protection Risk Identification

Annex 2.4: Workshop Agenda

Endnotes

1 Global CP WG, Inter-Agency Guidelines for Case Management and Child Protection, 2014, 33.

2 For more information on conflict sensitive approaches, see WeWorld (2022) Introduction to Conflict Sensitivity Toolkit. https://reliefweb.int/report/world/conflict-sensitivity-operational-toolkit?gad_source=1&gclid=CjwKCAjwufq2BhAmEiwAnZqw8qkFV1wWkkFtuFlvjWOLap9j-1qGuahxCzVDMSaYx-oiS2BjqktGahoCtZ0QAvD_BwE

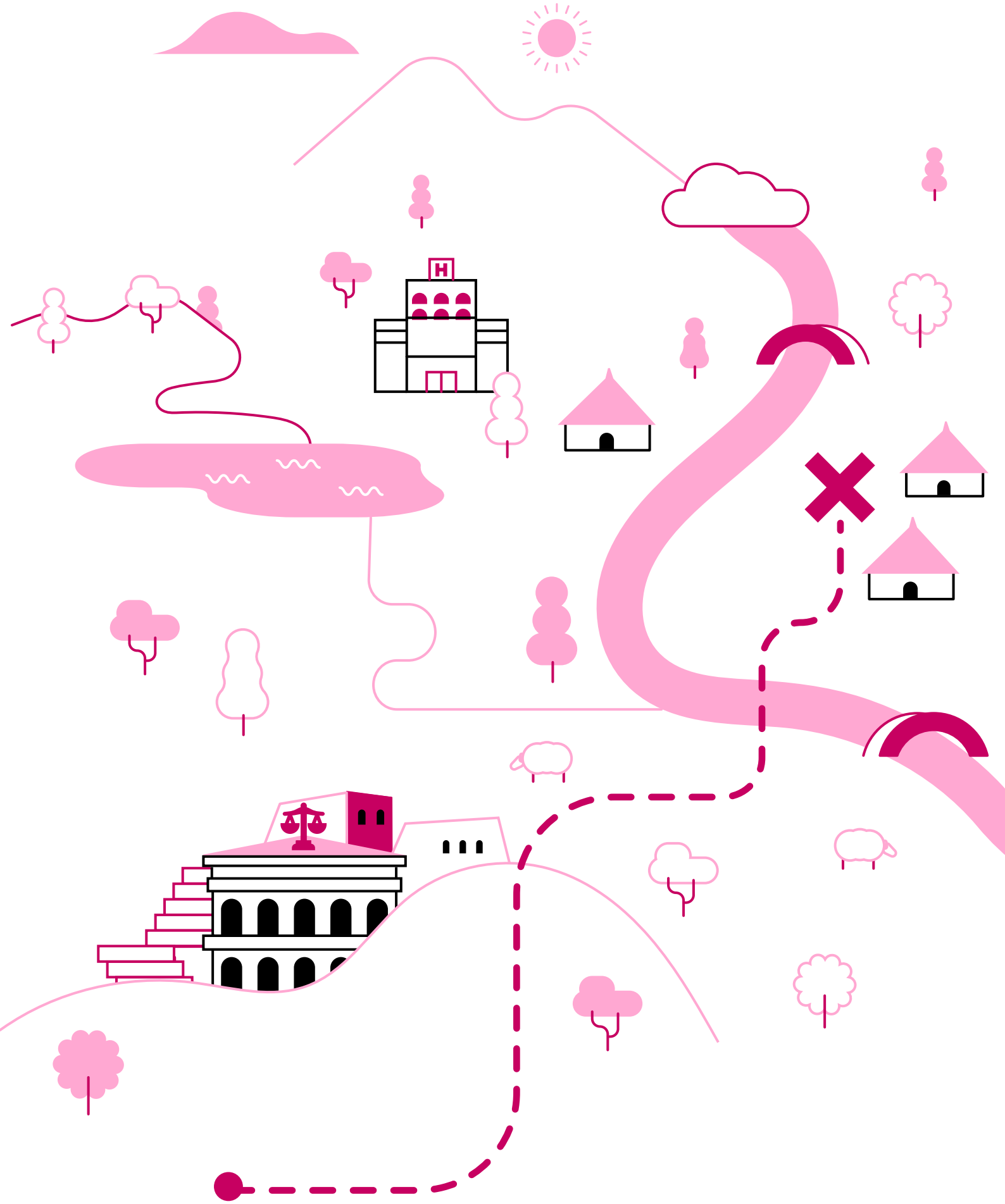
3 For more information on the 'do no harm' approach, please review the MHPSS MSP general principles and considerations. https://www.mhpssmsp.org/en/lesson/do-no-harm#page-1

4 In order for a service to be considered, Protection Case Management criteria should be central to one or more of these concepts

5 Intersectionality is an analytic framework that demonstrates how forms of oppression (such as racism, sexism, ableism) overlap, defining unique social groups (PAF).

6 The list provided in Module 1 and 2 has omitted concepts/risks associated with collective community level violence (because this case management service is for individuals), CP, GBV, and housing land and property violations.

7 The Socio Ecological Model is a theoretical framework that social workers can use to understand how the environment and individuals interact to shape who we are.



3

Designing and Maintaining Quality Protection Case Management Service: A Guide for Technical Staff

Welcome to Module 3. This module supports you and your team to design and maintain quality in your Protection Case Management service. At this stage, you have conducted protection analysis, coordination, and consultation to identify key aspects of your service, including who will be eligible for your service and how your service will interact with existing services and systems.

This module will help you consider aspects of setting up and maintaining a quality Protection Case Management service by helping you to answer the following questions:

- **What are the minimum standards of Protection Case Management?**
  Understanding the minimum required standards to offer Protection Case Management services and where to find further guidance on how to meet this standard throughout this guidance.
- **What are the main design decisions that I need to make with my team to establish a Protection Case Management service?**
  Addressing mode of delivery, understanding budget, and how to approach cash in Protection Case management, staffing and standard operating protocol development.
- **What are the MEAL standards and guidelines for Protection Case Management?**
  Getting to know MEAL standards, observing how you can: *Track progress, assess impact, remain accountable to service users, key stakeholders, and donors, and adjust and improve the Protection Case Management approach.*

What are the minimum standards of Protection Case Management?

To meet Protection Case Management criteria and approaches described throughout this guidance, your service should meet the following foundational, operational and resourcing standards.

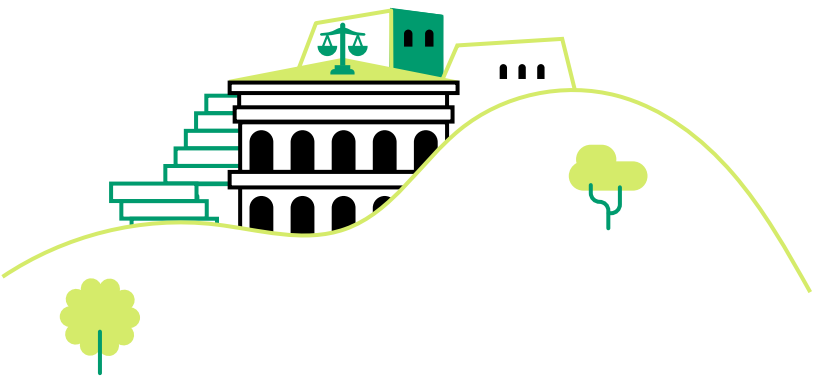
Table 1: A summary of minimum standards in Protection Case Management

Foundational standards	Where you can find guidance to support this standard
Protection Case Management is included in organisational strategy	All
Protection Case Management is designed based on protection and context analysis	Module 2
Localisation, partnership and exit strategies are developed and implemented	Module 2 and 3
Protection Case Management services have the staffing and budget to meet requirements	Module 3

Foundational standards	Where you can find guidance to support this standard
The service is guided by documented process and protocols, including a detailed risk-focused criteria, roles and responsibilities for internal and external actors, and information management and data protection protocols	Module 3
MEAL standards and processes are incorporated throughout the Protection Case Management approach	Module 3

Practice standards	Where you can find guidance to support this standard
Communities and caseworkers understand eligibility and response criteria	Module 2 and 3
Cases registered are consistent with eligibility criteria	Module 2 and 3
Casesworkers are observed taking assent/consent (at intake and whenever relevant)	Module 4 and 5
Caseworkers are observed providing reasonable accommodation where applicable	Module 4 and 5
Case file reviews demonstrate consistent care across risk levels/ caseloads	Module 2, 4 and 5
Caseworkers are observed developing/reviewing case plans collaboratively with service users	Module 4 and 5
Case plans utilise relevant multidiscipline services and respond to individual needs	Module 2, 4 and 5
Caseworkers call for documented case conferences as appropriate	Module 4 and 5

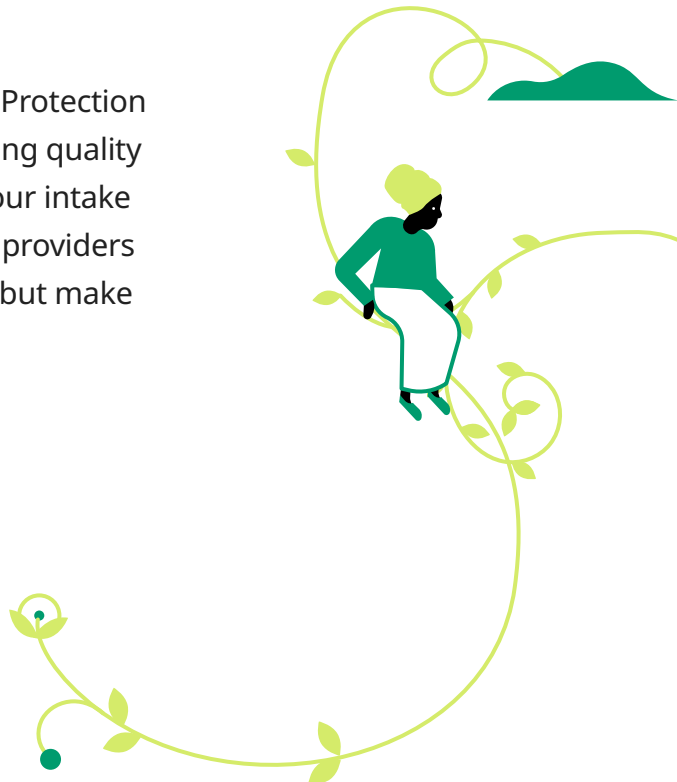
Practice standards	Where you can find guidance to support this standard
Referral systems are functional, incorporating an updated service mapping and ensuring service delays are proactively addressed appropriate to risk level	
Safety plans are developed and team implements as appropriate	Module 4
The Protection Case Management team implements agency documents and shares lessons learned and successful strategies	Module 5
Case plan implementation is conducted according to agreed deadlines	Module 2 and 4
Caseworkers are observed reviewing case plans with service user, as appropriate	Module 4 and 5
Barriers to case plan implementation are identified and addressed by supervisors	Module 5
Case file reviews are conducted regularly by supervisors	Module 5
Cases are closed as per standard operating procedure criteria	Module 3 and 4
Service user satisfaction surveys are conducted with consent, when possible, regularly addressing and discussing complaints and trends in feedback	Module 5



Staffing and staff support	Where you can find guidance to support this standard
Caseworker:service user ratio requirement is met (1:25)	Module 3
Team leader:caseworker ratio requirement is met (1:6)	Module 3
Staff have clear job descriptions	Module 3
Staff have required trainings for their roles	Module 5
Team or individual staff capacity building plans are in place	Module 5
Supervision conducted and actions/recommendations are addressed	Module 5
Staff and volunteers receive staff care and wellbeing support services and have access to MHPSS services	Module 5

Protection Case Management teams use this template as a checklist and planning tool in the development or realignment of similar programming to these standards.

Teams need to have clear written protocols regarding the Protection Case Management process in their programme, establishing quality benchmarks to hold teams accountable. If you have set your intake criteria and agreed on ways of working with other service providers (Module 2), you have completed a large part of this work, but make



sure it is documented and validated. To finalise your standard operating procedures, continue to reflect on the data that you collected in your protection analysis (Module 2), making several programmatic design decisions in consultation with the affected community and your team, including support services and other service providers. Protocol development is discussed below, but you will be developing it and making programmed decisions as you work through this chapter, including:

Assessing and mitigating risk to service users, caseworkers and organisations

Mode of delivery

Budgeting

Use of cash

Staffing, including community members supporting Protection Case Management

Information management and data protection

Part of your protocol development will include putting your documentation tools in place. Here are suggested Protection Case Management tools. This process involves reviewing them with your caseworkers and MEAL team, making any local adaptations as necessary. Do this prior to training your teams so they can become familiar with the documentation tools. For more information on how and when the tools are used, see Module 4.

What are the main design decisions that I need to make with my team to establish a Protection Case Management service?

Assessing and mitigating risk to service users, caseworkers and organisations

Many Protection Case Management service users are at-risk because of their inability to move freely without harm, they face threats in certain spaces, or they cannot approach services due to their circumstances. Likewise, caseworkers can be at risk due to associations with a service user group. As a humanitarian organisation, you may have some understanding of project risk analysis already. Protection Case Management can pose unique challenges associated with some service user groups and modes of service delivery. Work with your team to map potential risks whilst developing your intake criteria and programme design. Consider risks to service users and your organisation that may arise in your operating location. Collaborate with security teams and access working groups to develop safety measures that protect everyone involved in the programme. Connect with key protection actors to get information that informs your risk assessment, including any safety

audits conducted, GBV AoR secondary data reviews, and protection update analyses. Tool 2.1: Project Risk Matrix Template provides support.

Mode of delivery

Protection Case Management services can be delivered in various ways. When deciding *where* and *how* to provide your services, it is essential to consult with the community to ensure safe and confidential access for all who need them. One effective approach is to conduct safety and accessibility mapping with different community groups, asking them to identify spaces they consider safe and protective. Tool 3.1: Accessibility Checklist can guide you through this process.

Through your analysis, you may realise that a flexible approach governed by the needs of your service user is possible and appropriate. To assist in your decision making, consider the following pros and cons in your mode of delivery.

Mode of delivery - Centre-based Protection Case Management

Your centre for delivering Protection Case Management can be where a range of activities take place, such as within an existing national service, community centre, health centre, or elsewhere. Make sure to provide your services in a separate and confidential space or room within the centre. This does not include women's safe spaces.

Table 2: The pros and cons of centre-based services

Pros	Cons
As other services are offered in the centre, it becomes difficult to know who is receiving Protection Case Management support. Sessions can take place outside of influence from the community, in a confidential and anonymous manner.	In volatile security contexts, safety within a centre can be a concern. Authorities could request information about beneficiaries and enter the space.
It can be a visible and known space in the community.	Sustainability may be an issue, certain centres can be resource intensive and expensive to maintain.
Having a stable location can support community acceptance and allow time to build trust, as well as raise awareness of community-based interventions and the local services in the area.	Risk of attack if Protection Case Management is seen as a source of social tension or contrary to social norms.
Within a large centre, comfortable and private rooms for service users and staff can be easily prepared.	Centres may be located in unsafe spaces or far from people's homes, meaning people cannot physically reach the centre.
You can store confidential files and have access to computers and the internet.	Where there is increased population movement, people may not reside long enough in one location.

Pros	Cons
Allows access to a range of people who may choose to seek services.	
You can provide Protection Case Management to some service users for a longer period of time, building a support network within the centre.	
It can present opportunities for close coordination and effective referrals with other service providers e.g. in a health centre where there is also a psychologist they can refer to.	

Mode of delivery - Mobile-based Protection Case Management

Mobile-based Protection Case Management involves setting up a semi-permanent space identified in the community for a period, generally around three to six months. The space can be a room in an established local community centre, place of worship or school. It can also be a tent, a rented space or a container specifically built for this purpose. The IRC GBV Mobile and Remote Service Delivery Guidelines can provide further details on how to arrange mobile Protection Case Management.

Table 3: The pros and cons of mobile-based services

Pros	Cons
The space is often a visible and known space in the community.	Raising awareness of the mobile-based centre's location could be difficult.
If the mobile-based centre is big enough, it can offer other activities. As a result, it becomes difficult to know who is receiving Protection Case Management support as people outside the centre do not know who is receiving it. This ensures sessions can take place outside of influence from the community and in a confidential and anonymous manner.	It can be harder to establish a private and confidential space for Protection Case Management services depending on the building, tent or container. At a minimum, you need to make sure that there is a separate entrance and room for one-on-one sessions.
While not always as comfortable as more centre-based services, you can still make the space comfortable and private for service users and staff.	Mobile spaces might not be accessible far from people's homes, resulting in difficulty for some to physically reach the space. You should always consult with the community first.
Working with the community from the start to manage the space can be sustainable, particularly if you plan to transfer ownership to them for recreational activities when you leave. While this approach can help maintain community support networks, it requires ongoing resources and depends on the space remaining available long-term. Careful planning of your exit strategy is essential.	The temporary nature of the centre and potential lack of infrastructure can make it challenging to store confidential files and secure computers. One solution is to consider employing a security guard from the local community.
This approach can improve access for people in rural or remote areas who might struggle to reach centres in more populated locations.	It can be difficult to establish an internet connection, requiring the use of offline tools.

Pros	Cons
Less resource intensive and expensive to maintain than community centres and therefore more sustainable.	A lack of amenities can make it uncomfortable for staff. For example, without a functioning kitchen or a space to decompress.
	It may prove difficult to establish community acceptance and build trust in a short period of time.
	The temporary nature of the mobile-based centre may disrupt essential services to those that require support longer-term, or if the location is needed for its original purpose e.g. it is in a school and classes are starting. To avoid these situations, plan your exit strategy with the community from the beginning.

Mode of delivery - Outreach or home-based Protection Case Management

Outreach or home-based Protection Case Management normally involves providing services in someone's home or in another private space (if it is not safe to meet at home). In the past, service users and caseworkers have met in locations where there is some level of privacy that the service user determines is safe, such as a walk in a quiet space, the corner of a restaurant, or after hours at a school. In these cases, it is essential to ask the service user if it is safe to do so, where they prefer to meet you, and at what time and day.

Table 4: The pros and cons of outreach or home-based services

Pros	Cons
Services are accessible for those unable to go to centres and provided to people without additional cost (e.g. transportation).	Home visits may not be appropriate in certain contexts, as they could draw unwanted attention. If community members notice these visits, it might indicate someone is receiving special services, potentially compromising the service user's safety, confidentiality and anonymity.
Requires little to no resources (may require additional money on transportation).	Service users not visiting centres have less access to recreational activities or group psychosocial support sessions.
Service users can build relationships and/or draw on the support from community members (i.e. neighbour to visit weekly), leading to a more sustainable outcome.	It is harder to build a community support network for service users.
When requested by the service user, this approach allows appropriate engagement with their family. This engagement can identify additional support needs, such as when a female caregiver might benefit from complementary referral services.	Due to certain location issues, it can be difficult to find a private and confidential space for the service user.

Pros	Cons
Seeing a person's home can provide indications of risk for the caseworker, which can strengthen the safety plan.	Outreach efforts may need to be increased if people in need find it difficult to locate and contact your services.
	Those who are isolated at home have greater reliance on referrals through other service providers or community members. It will be more important to build referral capacities.
	It is unsafe to conduct home visits if the perpetrator of violence is within the home.

If your community consultations and private discussions with service users indicate a preference for home visits, work with them to develop harm mitigation strategies.

For all types of Protection Case Management services, you need to establish how individuals at risk will discover and access your support. This is particularly crucial for those identified as most vulnerable in your protection analysis and intake criteria. Your existing protection analysis may provide insights into these access pathways. You and your team could consider the following questions to understand a service user's access:

- How do people get information in this community? Who do they ask for help?
- Were any risks identified relevant to the spaces in which we meet our service users, their ability to access information and move freely? How can we plan to mitigate these risks? What resources will we need?
- Whilst Protection Case Management teams use technical terms, how should we safely describe our service to others? Do we need to develop different messages for different people?

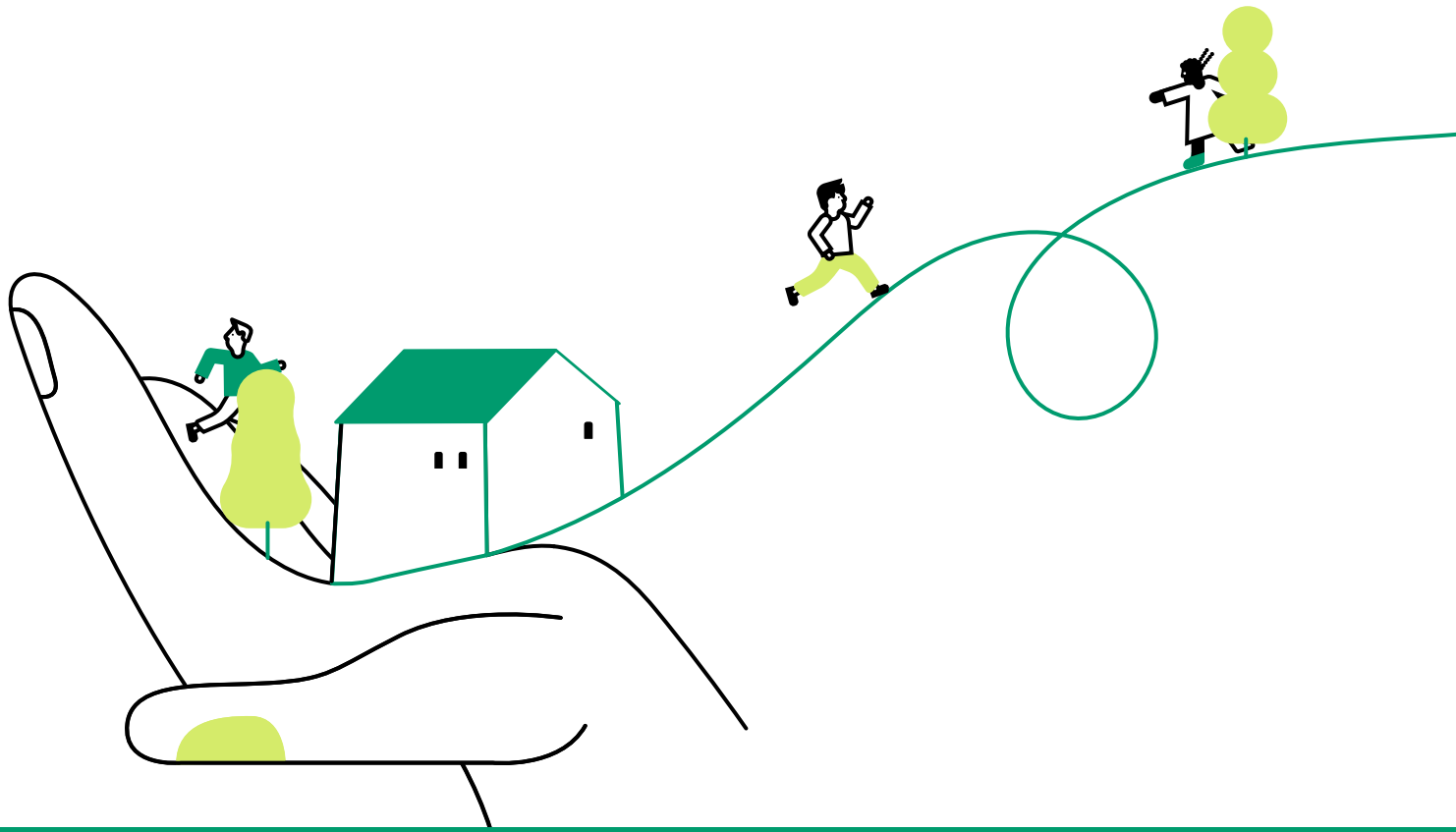
Throughout your project cycle, seek feedback from service users and community members about your approach (refer to the MEAL guidance in this module and Module 5). Use this feedback to adjust your service delivery model and design decisions as needed.

Remote and phone-based Protection Case Management services

During the pilot phase of this guidance, teams were directed to focus only on locations where face-to-face client contact was possible. As a result, remote or phone-only approaches have not been field-tested for Protection Case Management.

For guidance on remote service delivery, consult resources from other case management service providers, including:

- COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines
- Technical Note: Protection of Children during the Coronavirus Pandemic (v.2)



Budgeting for Protection Case Management

Quality Protection Case Management services must be adequately resourced. Your budget will be influenced by your mode of service-delivery and your operational context. Table 5 offers some key budget considerations.

Table 5: Protection Case Management budgeting

Line item	Description	Comments and justification
Staff salaries	Caseworkers, Protection Case Management officers (supervisor), capacity building officer, information management officer, community outreach focal points, volunteers, administration, and monitoring and evaluation staff – see below on staffing structure.	This will depend on the size of your team in line with your staffing structure. Do not add Protection Case Management as an activity onto the load of existing staff, establish a dedicated team.

Line item	Description	Comments and justification
Technical resources	Having assessed your organisational capacity to safely deliver Protection Case Management, you might have identified some technical gaps and decided to budget for the external resources you will need to establish and maintain a quality service. This might include an external supervisor who can provide experienced administrative, technical, and professional development advice to new or inexperienced Protection Case Management teams.	Some Protection Case Management implementers have benefitted from additional support for the 'lift' of setting up Protection Case Management systems; others have identified the need for focused, targeted or specialised training relevant to the intake criteria, such as inclusion and MHPSS support. If you do not have technical resources within your organisation or cohort to provide capacity building and ongoing supervision, consider budgeting for external supervision at least until your team develops their own technical expertise and confidence. You might recognise that the caseload has needs that require dedicated technical expertise in order to develop tailored responses and strategies.
Professional development	Training venues, training materials, trainers, funds to attend external training, see Module 5.	Capacity for on-going training, support and supervision is essential for providing quality services. This does not end with initial training of staff. Your staff will require refresher training(s), as well as training on skills and strategies relevant to the needs of the caseload and capacity gaps in the team throughout the programme period.

Line item	Description	Comments and justification
Staff support and wellbeing services	Staff support and wellbeing services must be provided to Protection Case Management staff. MHPSS for staff and volunteers must be available.	While supervisors play an important role in providing support to caseworkers, mandated staff support and wellbeing services should be made available, overseen by the organisation's human resources department or duty of care team. MHPSS services for all staff and volunteers must be made available.
Office supplies	Storage cabinets with locks for information management such as case files.	Data protection and self-referral purposes.
Comfortable, accessible and private spaces to meet individual needs	Ensure comfortable and private seating for one-on-one meetings that can be accessed by all individuals, including comfortable chairs, pillows, carpets, curtains, door locks and adequate lighting.	This will depend on your mode of service delivery and your entry point for intake. You may simply set up a room in a community centre or health centre, or set up the centre itself as part of your strategy. For community centres, consider having a waiting room with water, toilets and child space.
Accessibility and universal design	Permanent changes in infrastructures and information to ensure access for all. For example, ramps, handrails, wide entrances for buildings and latrines, adjusting height of door handles, and accessible information in several formats. See Tool 3.1: Accessibility Checklist to better understand the accessibility barriers service users might face.	Ensure no barriers are preventing anyone from fully participating in services. If you do not have technical resources within your organisation or cohort to think through these items, consider budgeting for technical support on inclusion.

Line item	Description	Comments and justification
Reasonable accommodations	Ensure accommodations for interpreters, support persons, and required adaption of infrastructure. For more information, see Annex 3.1: Accessibility and Reasonable Accommodation	Despite universal design, some individuals might face specific barriers and need reasonable support to participate in services.
Staff equipment	Equipment to support services e.g. computers, tablets, phones, phone costs, materials for service users to use in sessions like drawing items or fidget toys.	These needs will depend on your modality. Work phones will be needed for caseworkers to contact service users and to be contacted, as well as an additional emergency phone to be shared amongst staff for after hours contact. Caseworkers should not be expected to use their personal phones.
Transportation	Vehicle, fuel and maintenance.	For example, to support caseworkers conducting home visits or helping a service user access a service.
Communication with communities	Materials and leaflets on services, hotline cards, development of materials in different formats, holding community meetings, complaint boxes, creating a hotline.[1]	For two-way communication with service users, ensuring accessible channels for complaint and feedback. Types of will depend on consultation with the community.
Information Management System	Dependent on your Information Management System (IMS).	For organisations using tablets or smartphones to collect, store, organise, and protect service user data in a dedicated IMS.

Line item	Description	Comments and justification
Cash	Cash amount appropriate to context.	For instances where cash is required to achieve items in the case plan or meet urgent needs.

Cash in Protection Case Management[2]

Cash assistance is an available tool for caseworkers to support a service user to meet the goals set in their action plan. There is a growing body of evidence that cash assistance as part of Protection Case Management can contribute to protection outcomes.[3] Cash is recognised as an empowering tool, addressing a service user's protection risk(s) and supporting their recovery. It can enable immediate respite from violence or access to protection-related response services otherwise inaccessible due to prohibitive costs or limited financial resources. The objective of using cash within Protection Case Management is to facilitate and support a protection response, either by reducing an individual's exposure to immediate protection risks or by supporting their recovery from a protection incident that affects their physical safety, psychological well-being, or dignity. The primary aim of providing cash as a part of Protection Case Management should be to address a protection risk. The cash must be used to facilitate an action identified in their action plan, which adresses the protection risk the service user is facing. If a service user is unable to meet their basic needs, this should be addressed through unrestricted cash, multi-purpose cash or sectoral cash, and caseworkers can refer service users to these options.

Figure 1: Using cash in Protection Case Management

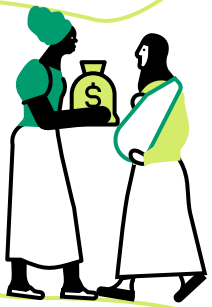
Step 1: Introduction and intake

Step 2: Protection risk assessment

In the initial assessment, the caseworker focuses on understanding the protection risks the client is facing, including their economic and social networks. Here is where the caseworker can identify risks that require cash assistance and analyse risks and barriers to accessing cash.

Step 3: Action planning and safety planning

Based on the identified needs, the caseworker should inform the client about the possibility of cash assistance and plan with the client how they would use the cash, how they will cope once cash assistance ends, as well as put in place enablers to address risks and barriers. Discuss the process of receiving cash and obtain the client's consent. Include cash assistance as an "action" in the action plan.



Step 4: Implementation of the action plan

The caseworker will ensure that they receive cash assistance and work with the client to remove any barriers to receiving the cash and accessing services. Caseworkers should work with the client to implement the action plan/ safety plan to mitigate any risk.

Step 5: Follow-up and monitoring

Caseworkers should assess a client's safety in the home and community, including any risks associated with the cash referral during each visit with the client. Post distribution monitoring should be completed.

Step 6: Case closure

Service users in coordination with caseworkers will define (within the action plan) if cash is an appropriate response to mitigate the protection risk. Caseworkers will analyse possible barriers for the individual to access cash, plan with the service user how cash will be used and the cash transfer value, include cash-based intervention in the action plan with the informed consent of the client, and ensure that the cash is received and the outcome assessed. The amount should be tailored and relevant to the specific protection needs and issues affecting this person/household and, whenever possible, cash should be unconditional and unrestricted to ensure maximum autonomy for service users.

In most circumstances, for cash assistance to be provided, it should satisfy the three S's:

Safe: The cash assistance will not increase risk to the service user.

Sustainability: Cash transfers will be used to meet a specific and non-recurring cost i.e. costs which arose recently that the person/household cannot meet at the time.

Suitability: Cash will effectively address the service user's most urgent needs for protection or when paired with other services within the service user's action plan.

Some examples for how protection cash can be used in Protection Case Management are:

- **Fear for a service user's immediate safety:** Costs for transportation and/or rent in cases of immediate eviction risks.
- **Removing barriers to service access or to community participation:** Based on the need, transportation, and service or equipment costs (e.g. legal assistance, access to assistive devices).

Cash can be used to purchase assistive devices. Assistive devices can improve a person's functioning in areas such as cognition, communication, hearing, mobility, self-care and vision. They can be physical products like wheelchairs, glasses, hearing aids, prostheses, orthoses, walking aids or pads; or digital products like software and apps that help with communication and time management. They can also be adaptations made to the physical environment, such as ramps or rails.[4] The provision of these items can have protection outcomes – especially for groups at risk of marginalisation, discrimination, and exclusion – by empowering them to navigate their environments, communicate effectively and access essential services.

Due to the potential for harm associated with the incorrect use or unsuitable prescription of such aids, ONLY health workers[5] and trained workers experienced in providing assistive technology can facilitate access to these products. Protection caseworkers with adequate training can provide referrals or use cash to support the purchase of assistive devices - only in coordination with specialised service providers. See Annex 3.2: Guidance Note on Provision of Assistive Devices.

Cash as a modality is not inherently riskier than other forms of assistance. However, it is essential that the caseworker and the service user understand if there are associated risks and how to mitigate them.[6] If you want to include cash as a tool within Protection Case Management services, be sure to develop a standard operating procedure for how to identify, assess, deliver, monitor, and evaluate the provision of cash safely and equitably, including identifying and addressing potential barriers that certain service users may face to access this type of support (e.g. digital literacy, accessibility of information, distribution points etc.). This should be developed in conjunction with your finance teams.

For more information on using cash as a part of protection programming, see this guidance on key considerations for cash in specialised and stand alone protection programmes.

Staffing for Protection Case Management

Your staffing structure

Your staffing is the most important resource in Protection Case Management. You can staff your services in different ways, depending on your resources and context. When planning out the size and shape of your team, remember:

- A caseworker should not have more than 25 cases at any given time. This needs to be monitored closely by supervisors who understand that some cases will require more support depending on the service user's needs or the stage of the process.

- Caseworkers should speak the same language as the service users they support whenever possible. If that is not possible, interpreters should be engaged.

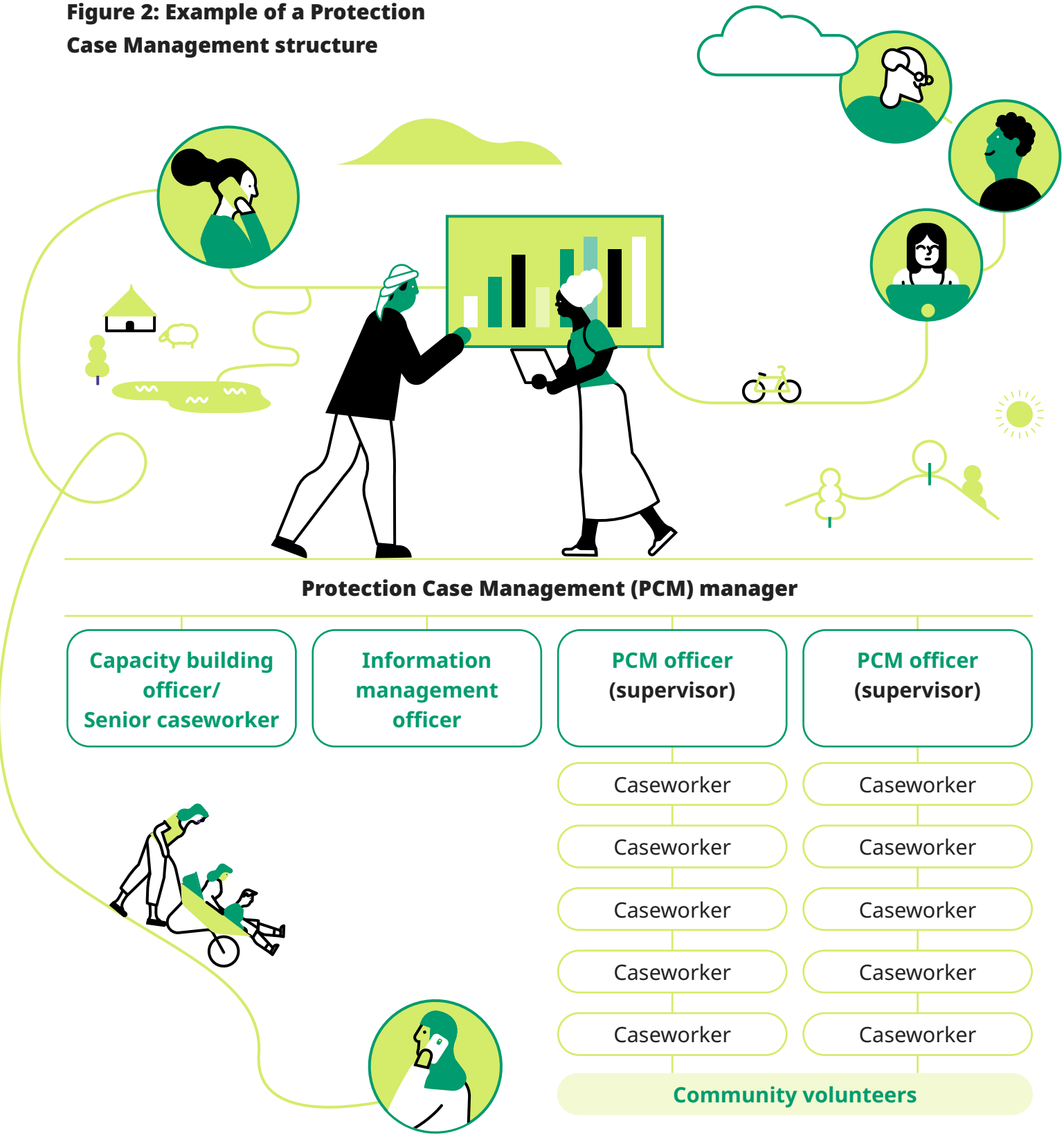
- The gender balance of your caseworkers should be relevant to your intake criteria. Service users might have a preference as to the gender of the caseworker they want to talk to. This should be established as early as possible.

- Supervisors should oversee no more than **six** caseworkers, allowing for proper support to caseworkers, mentorship and due diligence checks.[7]

- Information management and data protection will need to be supported by an information management assistant or officer.

- On-going training, learning and capacity building is necessary for staff. To support this, consider a capacity building officer to offer training and technical development in collaboration with the supervisor.

Figure 2: Example of a Protection Case Management structure



Community-based staff can support caseworkers when visiting service users who require daily or frequent visits until more sustainable care arrangements are put in place. Similarly, a *capacity building officer* who has the experience and technical skills can support the mentorship and training of caseworkers on an on-going basis. This staff member can also provide safe

identification and referral training to other organisations. Please see Annex 3.3: Staff Roles and Responsibilities.

Your staffing structure - community-based staff

Community mobilisers, volunteers, or other community-based staff are an integral part of preventing and responding to cases of violence in humanitarian settings. It is these staff who are often the first entry points into communities and help to identify [individuals] who are at risk of, or who are survivors of, violence.[8] The Alliance for Child Protection and Humanitarian Action has developed a Community Child Protection Volunteer Toolkit and Training Manual, based on a 2020 review of the evidence on the effectiveness of community volunteers. It documents current practices within Protection Case Management for children and other CP programming. Protection Case Management actors have adapted this toolkit for use in support of their adult protection caseloads. Do engage with this resource to ensure quality in your support of community-based personnel. Here is a summary of best practices promoted in this guidance, adapted[9] for Protection Case Management actors:

- **Get to know the community:** Seek out the community's 'natural helpers'[10]. Listen to them about how they are supporting at-risk members of the community.

- **Work with the community**: Invite community groups and leaders and marginalised community members into the process. When selecting community-based staff, be sure to prioritise trusted people who have communication and interpersonal skills.

- **Think carefully about how to work together**: Talk to different groups about the tasks they could take on and the time they have to give. Keep in mind that they may also be members of a vulnerable community and will need time for their families and economic activities. If a community member is doing full-time work and expected to take on responsibilities, they are no longer a "volunteer" and should be considered a caseworker. They must be trained, provided supportive supervision, and paid a fair wage.

- **Follow organisational policies on protection from sexual exploitation and abuse (PSEA) and data protection:** Community volunteers, when formally engaged, must adhere to the organisation's policies on PSEA and data protection. They should receive appropriate training on these commitments to ensure they understand the importance of safeguarding sensitive information and preventing exploitation and abuse. Volunteers should also sign relevant agreements or codes of conduct, ensuring accountability and compliance with organisational standards throughout their engagement.

- **Support ongoing learning with community-based team members:** According to the tasks agreed with volunteers, develop a learning plan together. If you are also utilising the skills and expertise of community members for your programming, do not limit regular support, supervision and coaching.

- **Link community-based staff to the protection team:** Consider ways to manage the power dynamics between staff and volunteers. Involve them in decision making and team discussions, incorporating the valuable insight and knowledge community volunteers bring to the team. If volunteers assist in identification or monitoring of cases, they must be continuously supported by a trained caseworker.

- **Ensure adequate resources for community-based staff to be successful:** Protection actors must have suitable funding for volunteer programming. This includes funds for ongoing training, coaching, and supervision (see Module 5). If sustained funding is not available, protection actors should carefully reconsider the recruitment of community members.

- **Prioritise volunteer safety and well-being:** Working in the community that you are a part of can be risky. Make sure community personnel are safe and protected. Set up regular dialogue groups to listen to volunteers and encourage support circles where personnel meet regularly to share knowledge and support each other. Hold regular 'appreciation' activities so they know they are valued by the protection organisation and the community.

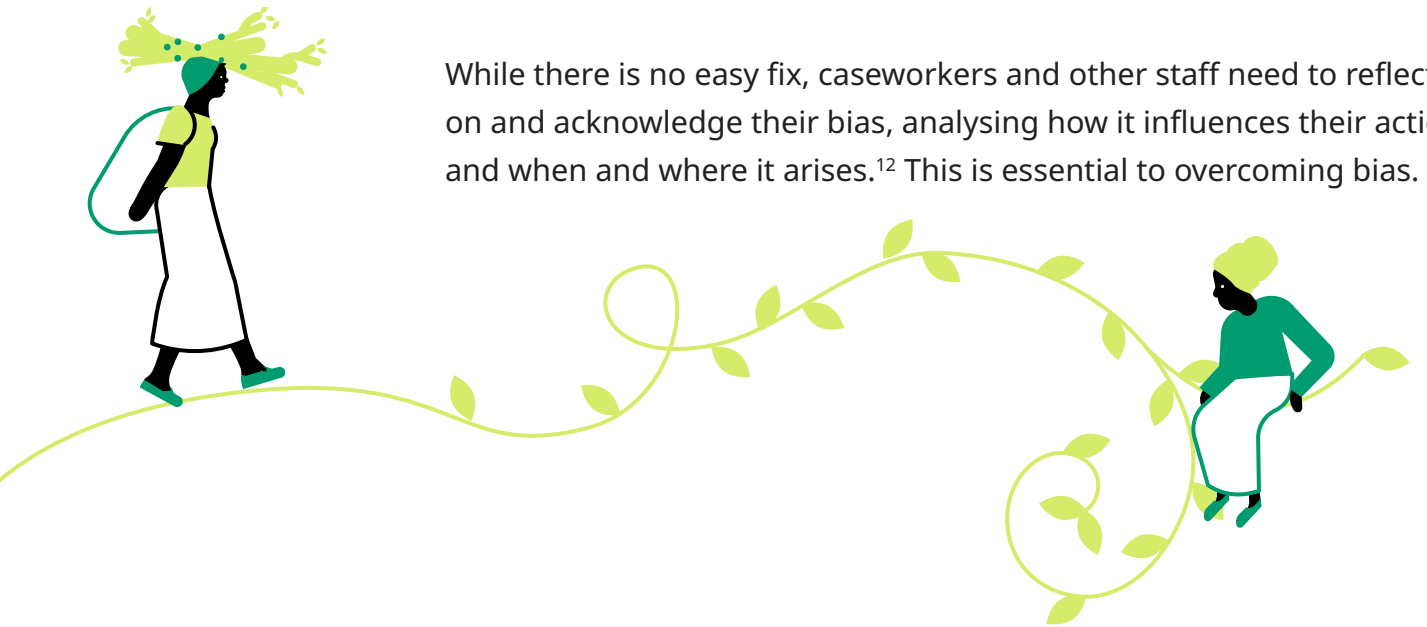
Attitudes, knowledge, skills

Some contexts have a professional social work structure and require certain qualifications in order to practise social work. In those instances, caseworkers need the required qualifications. However, this may not be possible in all contexts. When looking to recruit caseworkers in these contexts, qualifications or humanitarian experience should come second to having the right attitude.

People at risk may have intense emotional reactions, they may be indecisive or take sudden decisions, they may be distrustful, they may feel hopeless, and they may live in unhygienic or cramped conditions. Through these challenges, caseworkers will need to develop healing relationships with their service users. This has been well tested through the GBV case management practice, where the 'qualities of warmth, respect, genuineness, empathy and acceptance are key helping skills' - essential when working to build trust and induce hope.[11]

Attitudes

As mentioned, Protection Case Management relies on caseworkers building a positive and hopeful relationship with their service users. However, caseworkers have their own beliefs and values shaped by their culture, ethnicity, religion, gender, sexual orientation, socio-economic status, as well as their own personal experiences and history. Therefore, caseworkers must be aware of how these beliefs and values may lead to bias which affects their ability to use professional judgement, to actively listen and interpret information, to accurately document information, to develop positive relationships with their service users, and to avoid re-traumatization.



While there is no easy fix, caseworkers and other staff need to reflect on and acknowledge their bias, analysing how it influences their actions and when and where it arises.[12] This is essential to overcoming bias.

Addressing bias in your programme

1. **Interview stage:** During interviews, assess candidates' attitudes toward groups that face discrimination or stigma in your context (as identified in your protection analysis). Pay particular attention to their views regarding sexual orientation and gender identity, HIV/AIDS status, disability, and other locally relevant diversity factors. Candidates who demonstrate negative attitudes toward these groups should not be recruited as caseworkers.

2. **Orientation stage:** Train caseworkers and other staff on conscious and unconscious bias (e.g. patronising attitudes, lack of awareness of barriers faced by certain individuals). Provide them strategies for how to mitigate it in their work. Caseworkers can be asked to take an attitude scale to assess whether it is safe for them to work with service users (see Annex 3.4: Caseworker Capacity Assessment Form).

3. **Supervision:** Supervisors work with caseworkers to address bias through their work and to review progress by re-using the attitude scale.

Knowledge

Caseworkers' knowledge will grow over time through training, supervision and coaching (see Module 5). At a minimum, caseworkers should have knowledge of:

- Potential risks facing the prioritised communities, their capacities, and vulnerabilities
- Basic helping skills and psychological first aid
- Information about common mental health conditions (i.e. depression, anxiety, stress), as well as an ability to identify key signs of stress and psychological distress

- Available services, how to access those services, and the quality of those services, including the accessibility and attitudes of services providers towards diversity
- Data protection protocols and the information management database
- Complaint and feedback mechanisms for service users
- Self-care and well-being approaches

Skills

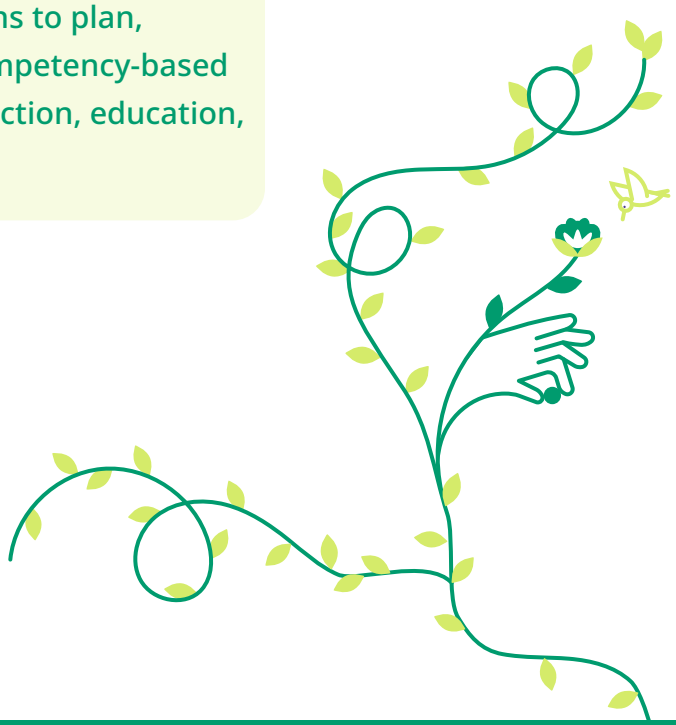
Caseworkers must be able to put their knowledge and attitudes to practise through their skills. This takes practice and comes with experience. They will need time to develop these skills through training, supervision, and peer support.

Caseworkers should be able to:

- Recognise whether a person is at risk, including what type of risk and determine the case's risk-level accurately
- Respond to immediate life-saving needs and develop safety plans
- Collect disaggregated data on disability accurately
- Assess mental health and psychosocial wellbeing and the needs of service providers
- Ask for informed consent/assent
- Identify potential barriers (e.g. accessing the physical environment and information), offering reasonable accommodations to support the service user's participation, if needed
- Build trusting relationships and maintain confidentiality principles throughout the duration of service provision
- Communicate without judgement and demonstrate empathy

- Inform the service user about available services and assistance options
- Conduct a safe, accountable, and timely referral for services
- Support the service user in recognising key issues and developing an action plan
- Use IMS, safely documenting and storing service user data
- Report any incidence of violence or sexual exploitation according to organisation procedures
- Use basic psychosocial support and psychological first aid skills, including active listening, identifying key signs of stress, and responding appropriately

MHPSS Protection Case Management caseworkers should be adequately trained, supervised and supported based on the requirements of the activity or activities that they are involved in. Observing, assessing and supporting the development of competencies (knowledge, skills, and attitudes) helps to ensure high-quality programmes. Assessing and monitoring competencies can also help in tailoring training, support and supervision. The Ensuring Quality in Psychosocial and Mental Health Care (EQUIP) platform and tools support teams and organisations to plan, design, adapt and implement existing and new competency-based MHPSS training for various sectors (e.g. child protection, education, health, etc.).



Protection Case Management protocol

Your Protection Case Management protocol should be reviewed and updated every six to 12 months. To ensure protocol adherence, your standard operating procedure should be developed in cooperation with the national protection sector, avoiding duplication or inconsistency with local social welfare procedures and practices. If this isn't relevant in your context, you will need to develop your own.

A protocol should include the following:

- **Guiding principles:** Create standard operating procedures in line with your guiding principles to ensure services are rights-based and centred on service users.

- **Case prioritisation:** This should be based on your contextual protection analysis, detailing the risk factors and protective factors that can help caseworkers prioritise cases. Programs may have to come up with a system to ensure that they see high-risk cases more regularly. Case prioritisation procedures should be outlined regularly.

- **Case management procedure:** An outline of the case management steps in the country to make them as practical and specific to your context as possible.

- **Caseload limit:** The best-practice guidance is a maximum 20-25 cases per week. However, this may vary from location to location and should be reviewed. The maximum number of caseworkers to be overseen by a supervisor should be not more than six.

- **How 'high-risk' cases will be handled:** A high-risk case is usually one in which there is an immediate threat to the service user's physical or psychological safety. Supervisors should define with their staff what they define as a "high-risk" case and what the procedure will be for handling such cases. For example, to whom and when does the caseworker bring such a case to a supervisor's attention? Should they phone the needed service provider directly rather than sending an email? When does the supervisor bring it to their manager for support?

- **Mandatory reporting:** The protocol should include mandatory reporting procedures and provide detailed guidance on how caseworkers handle such situations, including when they report to the supervisor and when the supervisor must report this to their manager.

- **Case coordination and conferencing:** Clearly mapped areas of responsibility for agencies to support referral between Protection Case Management streams. To assist this, established procedures for triggering case conferences for complex cases should be developed.

- **Referrals systems:** Updated version of the service maps, referral minimum standards and referral pathways.

- **Risk mitigation matrix:** Detailed advice on how to deal with potential risks, including what can be done to mitigate unintended harm and maintain service user safety and security.

- **List of forms:** The protocol should include a checklist of the Protection Case Management forms that a caseworker needs, correctly documenting the process.

- **Data management & protection protocol:** The protocol should outline steps to be taken to collect, store, and share information so that it remains safe and confidential (see Annex 3.5: Standard Operating Procedure Data Management and Protection). An additional agreement should be developed to share data safely between relevant organisations (see: Annex 3.6: Staff Data Protection Agreement).

- **Complaint and feedback, including PSEA protocols:** Contacts, advice and additional information that can be used to inform service users how to report complaints and provide feedback.

Information management

Documenting service user data

Protection Case Management forms document ongoing critical services. It is a standard practice in the field of social work, essential to making data-driven decisions. Standardised forms have been created by protection actors to use in various settings. They have gone through a review process and are the suggested starting point for developing and/or harmonising Protection Case Management forms.

If your programme uses digital documentation, you will need to determine what data platform best suits your needs and context. A data platform should aid in managing your caseload and facilitating documentation. You can explore existing databases within your organisation or context, or conduct a technical software requirements assessment. This process can be as simple as identifying the features and functionality needed in a system, and comparing them to existing or custom options to determine the best way forward. Note that any IMS used should follow Protection Case Management Software Requirements (see Annex 3.7: Software Requirements Specifications). Whether you decide to use a database with electronic forms or a spreadsheet with paper forms, you will need to ensure it is properly maintained by information management staff. These staff should be integrated into the team and trained on data protection and confidentiality. Staff should sign a data protection agreement to be clear that their work is in line with data protection standards (see Annex 3.6: Staff Data Protection Agreement).

Service users should have control over their data and, where possible, caseworkers must facilitate the service user's access to any documentation upon request. Therefore, caseworkers should try to use the same words as the service users when documenting meetings and discussions; this can be a helpful method for caseworkers to monitor the progress made by their service user and recognise new problems. Case notes should be based on facts and professionally substantiated judgement, avoiding bias. Caseworkers should refrain from using dismissive or offensive language.[13]

Protecting service user data

Data protection is the act of protecting personal or sensitive information in terms of how it is documented, stored and shared. During Protection Case Management, a substantial amount of information is gathered about service users. Caseworkers must document service users' personal protection data, details of their discussions, and actions taken on behalf of the service user. This ensures accountability in managing their cases.

Policies, protocols and practices for data protection are essential to our work, as unauthorised access or sharing of data can endanger service users and jeopardise your programme. You will need to establish data protection protocols and have staff sign a data protection agreement if you are to carry out Protection Case Management services (see Annex 3.6: Staff Data Protection Agreement),

For further protection of service user data, you can follow a data protection checklist (see Annex 3.8: Data Protection Checklist). Study a sample data protection protocol that includes the handling of data in emergency situations such as evacuations.

Information sharing

In many contexts, there are several organisations working together to provide services to persons with heightened protection risks. As a result, sharing information about cases and using referral forms becomes necessary. As discussed, actors involved in a referral pathway need to agree on what service user information should be shared, when, and with whom. They must agree how this information will be shared and followed up on - verbally, electronically or by paper - and on appropriate procedures to ensure the confidentiality and protection of persons at heightened risk. This can be documented in an information sharing protocol (see Annex 3.9: Data Sharing Agreement Template)[14].

While the IMS you use is primarily for supporting the Protection Case Management process with your service user, aggregated data analysis from this system can also inform other' advocacy and prevention work or help to prioritise interventions and resources.[15] Bear in mind that sharing this data should only be done after a risk assessment and when

agreed with other case management service providers on how to share it without causing harm. You should never share identifying information e.g. service user bio-data.

For more detailed information on the development of IMS protection, check out the Protection Information Management website.

What are the MEAL standards and guidelines for Protection Case Management?

Humanitarian and development organisations adopt MEAL activities to track progress of their interventions, assess their impact, adjust and improve approaches, as well as remaining accountable to service users, key stakeholders and donors.

Figure 3: Defining MEAL components

Monitoring: The continual and systematic collection of data to provide information on project progress. Monitoring involves the ongoing collection and review of data to provide program managers and other stakeholders with indications of progress against program targets.

Evaluation: User-focused, systematic assessment of the design, implementation and results of an ongoing or completed project. In contrast to ongoing monitoring, evaluations are periodic reflections at specific points of time.

Accountability: A commitment to balance and respond to the needs of all stakeholders (including project participants, donors, partners, and the organization itself) in the activities of the project.

Learning: Having a culture and processes in place that enable intentional reflection. Through learning, teams can make smarter decisions that lead to the best outcomes for service users.

For more information, see Annex 3.10: Common MEAL Terms and Definitions.

MEAL activities for Protection Case Management are specifically designed to consider the sensitive nature of interventions, drawing from the information service users share with their caseworkers. By following MEAL guidance, Protection Case Management teams are ready to:

- **Understand Protection Case Management process, quality and impact:** MEAL activities help to identify and demonstrate the effectiveness, relevance, appropriateness and quality of Protection Case Management interventions, and their impact on service users.

- **Implement evidence-based decision making:** MEAL generates actionable information that caseworkers, supervisors, managers and organisations can use to make evidence-based decisions related to programme design, implementation and resource allocation.

- **Strengthen accountability and transparency:** Systematised MEAL practices help build a culture of accountability and transparency among key stakeholders, including service users, communities, donors and partners. MEAL ensures that organisations are accountable, efficient and responsive to the needs of their service users.

- **Responsible data management and use:** MEAL guidelines and principles help teams to record, process and use information generated as part of the Protection Case Management process in a safe and responsible manner.

The following Protection Case Management **MEAL guidelines** detail:

- **Roles and staffing requirements** for Protection Case Management MEAL activities and processes

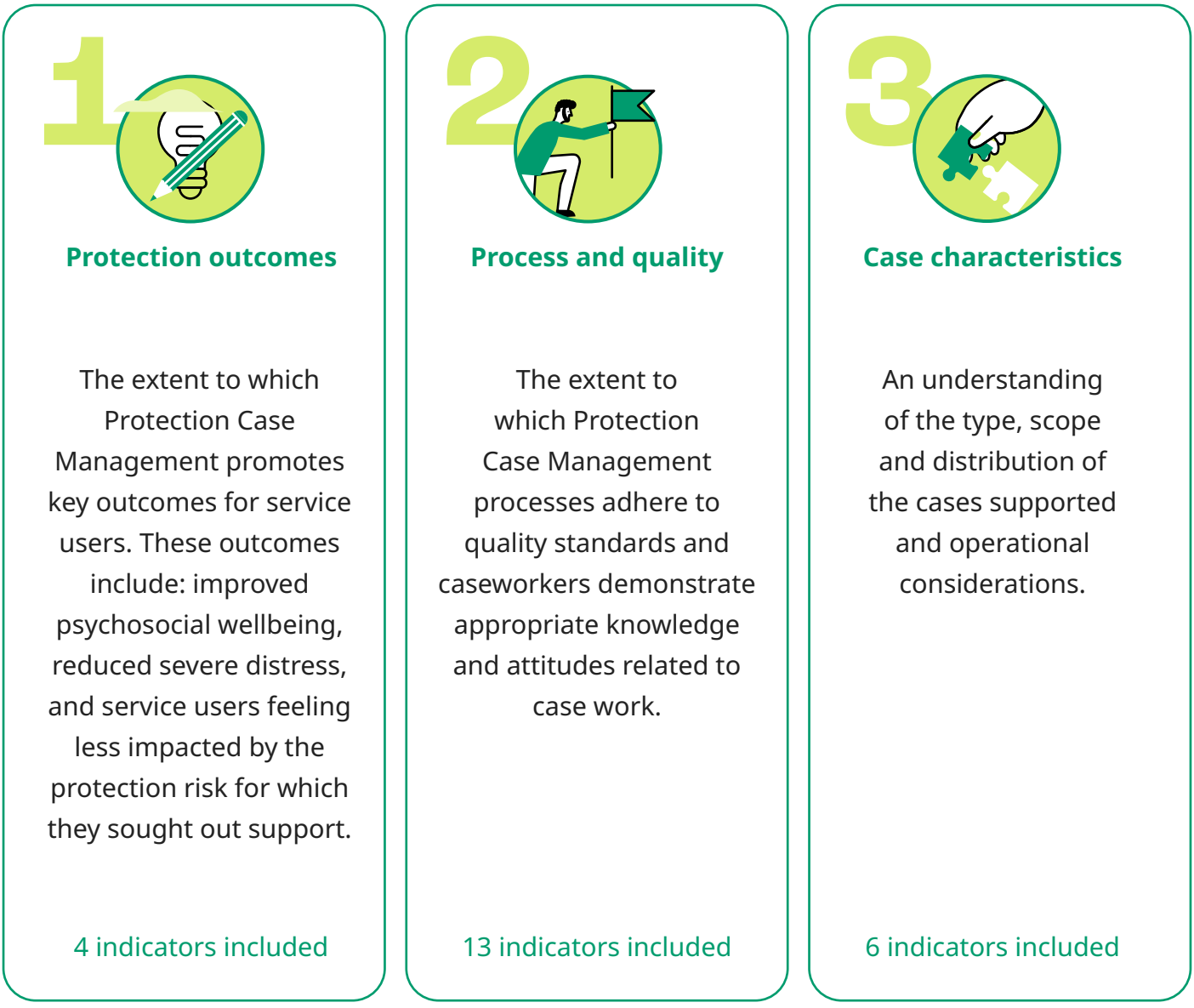
- Suggested Protection Case Management **outcome and output indicators** (with guidance on interpretation and use)

- **Data collection and management flow**, including different stages of the data life cycle (e.g. from planning to end of project archiving and destruction)

- **MEAL templates, tools, and databases** which can be contextualised where possible to fit the purpose and context (e.g. for teams with limited access to technology or those using a digitalised case management)

These guidelines will be structured around three **key categories of Protection Case Management data** (see below), which align with sections found in the Protection Case Management ToC (see Annex 3.11: Measuring the Protection Case Management Theory of Change):

Figure 4: Key categories of Protection Case Management data

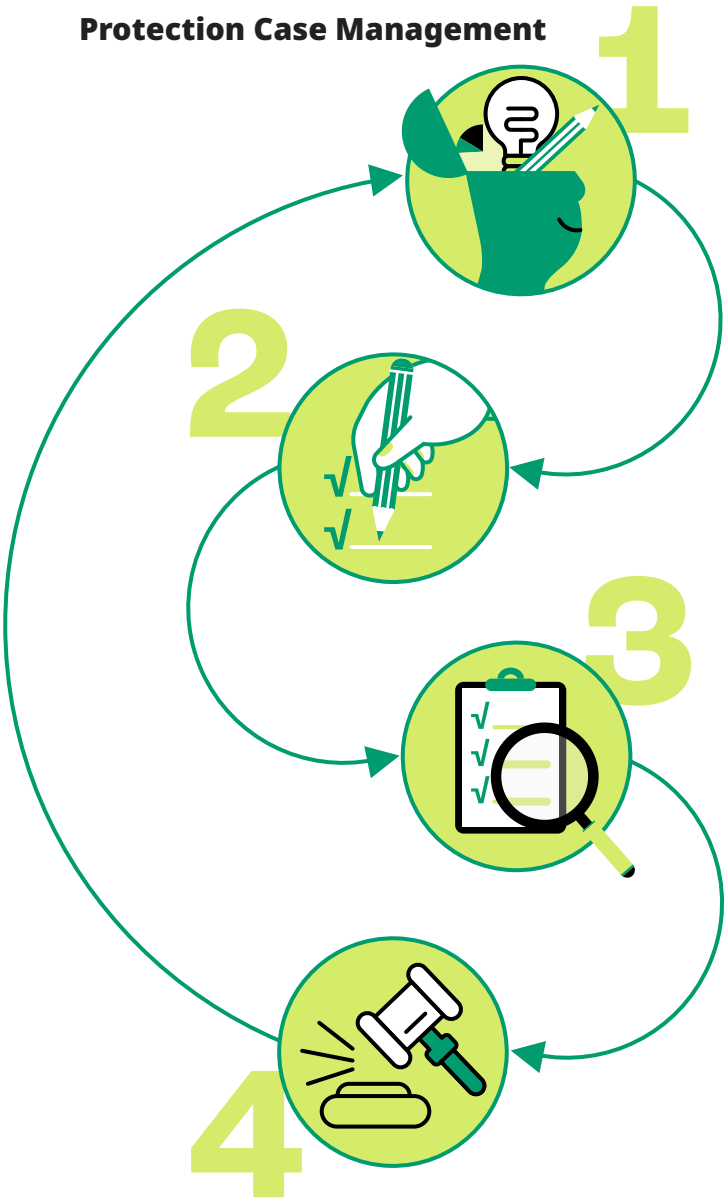


Planning for Protection Case Management MEAL

The Protection Case Management flow

Much of the information collected for Protection Case Management MEAL is captured through existing case management forms and as part of programming processes, rather than standalone data collection activities. Understanding the overall flow of Protection Case Management (see Figure 5) can therefore be very helpful for understanding how MEAL integrates into programming.

Figure 5: MEAL life cycle for Protection Case Management



1. Caseworker capacity strengthening

Capacity assessment form

2. Case intake

(1) Intake form
(1a) Interpreter non-disclosure agreement
(2) Informed consent and registration
(3) Protection risk assessment
(4) Psychosocial wellbeing assessment (baseline)
(5) Basic MHPSS assessment
(6) Case action plan
(5) Basic MHPSS assessment
(7) Referral form
(8) Safety plan

3. Ongoing case monitoring

(9) Follow-up form
(10) Case file checklist
(6) Case action plan
(8) Safety plan
(5) Basic MHPSS assessment

4. Case closure

(11) Case closure form
(4) Psychosocial wellbeing assessment (endline)
(5) Basic MHPSS assessment (endline)
(12) Service user feedback survey

Number in brackets represents form number.
Indicators come from forms in bold. You can find all forms listed, here.

Roles and responsibilities in the MEAL process

Effective MEAL Protection Case Management requires strong collaboration and coordination among different team members. The main responsibilities for each function include:

Case work	Collect data as part of the Protection Case Management process	Contribute to the analysis and trends
Case supervision	Aggregate and validate data	Conduct case reviews and debriefings to improve data quality
	Facilitate service user feedback mechanism	Analyse and use data for action and reporting
MEAL	Design context-specific MEAL systems	Support the selection of indicators
	Analyse and use data for action and reporting	Ensure MEAL standards are met throughout the process
	Train staff on MEAL practices, including service user feedback mechanisms	

Information management	Customise and maintain Protection Case Management IMS, including data processing	Ensure data responsibility standards are implemented throughout the Protection Case Management process
	Analyse and use data for action and reporting	

Project management	Ensure MEAL standards are met throughout the Protection Case Management process	Analyse, use and disseminate data for action and reporting
	Support the selection of indicators	

List of customisable Protection Case Management MEAL indicators

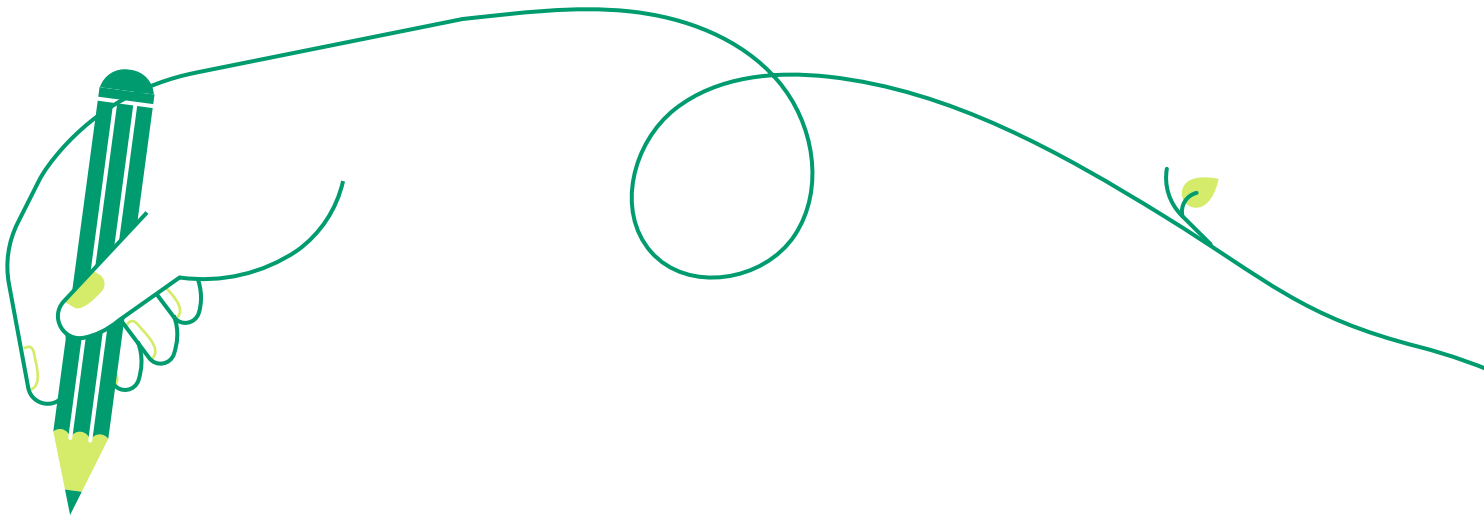
During the initial planning process, Protection Case Management teams select and customise a list of indicators, based on MEAL standards. Table 6 displays a non-exhaustive list of indicators that consider protection outcomes, process/quality standards, case characteristics to understand the population served, donor specifications, specific learning objectives, the change or outcomes that teams aim to contribute to through their Protection Case Management programmes, and context-specific limitations and goals.

Remember, you are not expected to use all indicators. For more details, see Tool 3.2: Protection Case Management Indicator Matrix and Annex 3.11: Measuring the Protection Case Management Theory of Change

Table 6: Protection Case Management MEAL indicators

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Protection outcomes				
PO-01	Percentage of service users who demonstrate improved psychosocial wellbeing after receiving Protection Case Management support	Form 4: Psychosocial Wellbeing Assessment	At risk assessment and case closure	**Numerator:** Number of service users surveyed whose psychosocial wellbeing scores improved by at least 3 points **Denominator**: Number of service users who participated in both stages of the psychosocial wellbeing survey

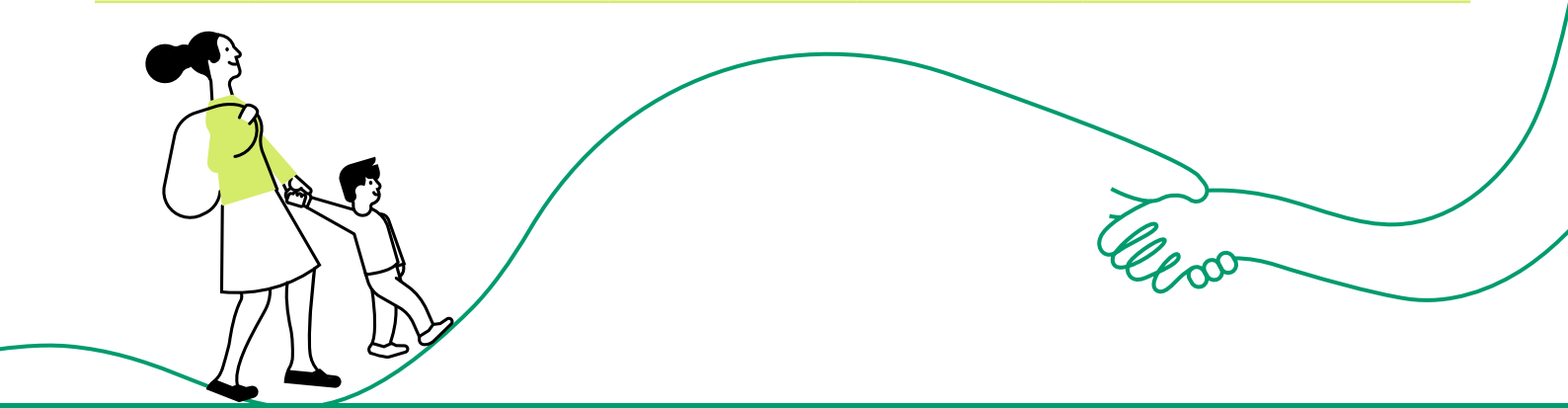
Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Protection outcomes				
PO-02	Percentage of service users who report being less impacted by protection risks after receiving Protection Case Management support	Form 3: Protection Risk Assessment Form 11: Case Closure	At risk assessment and case closure	**Numerator:** Number of service users reporting less impact from the protection risk at case closure compared to the risk assessment stage **Denominator**: Number of service users who shared how much a protection risk is impacting their life at both the risk assessment and case closure stage



Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Protection outcomes				
PO-03	Percentage of service users with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving Protection Case Management support	Form 5: Basic MHPSS Assessment	At risk assessment and case closure	**Numerator:** Number of service users with an initial score of 15 or higher whose final score was 5 or more points lower than the initial score **Denominator**: Number of service users who completed the assessment at least twice and scored 15 or higher at intake
PO-O4	Percentage of service users who report that they are better equipped to reduce or mitigate the protection risk after receiving Protection Case Management support	Form 3: Protection Risk Assessment Form 11: Case Closure	At risk assessment and case closure	**Numerator:** Number of service users who report they are better equipped to reduce or mitigate the risk at case closure than they did at the risk assessment stage **Denominator**: Number of service users who shared their ability to cope at both the risk assessment and case closure stage

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-01	Percentage of intakes eligible for Protection Case Management	Form 1: Intake	Quarterly	**Numerator:** Number of cases meeting the eligibility criteria **Denominator**: Number of intakes
PQ-02	Number of total service users	Form 1: Intake	Monthly	**Numerator:** Number of service users with open and closed cases **Denominator**: N/A
PQ-03	Number of new cases registered for Protection Case Management	Form 1: Intake	Monthly	**Numerator:** Number of cases opened **Denominator**: N/A
PQ-04	Percentage of cases closed due to meeting objectives of the action plan	Form 11: Case Closure	Quarterly	**Numerator:** Number of cases that have been closed because the objectives of those case action plans have been met **Denominator**: Number of closed cases

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-05	Percentage of service users who received cash assistance to address their protection risks through Protection Case Management	Form 6: Case Action Plan Form 9: Follow-up and Monitoring	Monthly	**Numerator:** Number of service users who received cash assistance **Denominator**: Number of service users
PQ-06	Average number of cases per caseworker per month	Form 1: Intake	Quarterly	**Numerator:** Number of open cases **Denominator**: Number of caseworkers
PQ-07	Percentage of caseworkers whose knowledge assessment score is at least 70 per cent	Supervision Form 1: Caseworker Capacity Assessment	Quarterly	**Numerator:** Number of caseworkers who score 70 per cent or higher on the knowledge assessment score **Denominator**: Number of caseworkers who finalised the caseworker capacity assessment



Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-08	Percentage of caseworkers whose attitudes score is at least 80 per cent	Supervision Form 1: Caseworker Capacity Assessment	Quarterly	**Numerator:** Number of caseworkers whose attitudes score is at least 80 per cent **Denominator**: Number of caseworkers who finalised the caseworker capacity assessment
PQ-09	Percentage of case files reviewed that meet 80 per cent of criteria of a case file checklist	Supervision Form 4: Case File Checklist Tool	Quarterly	**Numerator:** Number of case files that meet 80 per cent of criteria within a case file checklist **Denominator**: Number of case files reviewed
PQ-10	Number of caseworkers trained in Protection Case Management	Project records	Quarterly	**Numerator:** Number of caseworkers trained in Protection Case Management **Denominator**: N/A

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-11	Percentage of service users that felt they were involved in decisions during their case management	Form 12: Service User Feedback Survey	Quarterly	**Numerator:** Number of service users who indicated they felt they were included in decisions **Denominator**: Number of service users who agreed to participate in the established feedback mechanism
PQ-12	Percentage of service users that are satisfied with the case management services	Form 12: Service User Feedback Survey	Quarterly	**Numerator:** Number of service users who report being satisfied with the case management services **Denominator**: Number of service users who agreed to participate in the established feedback mechanism

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-13	Percentage of successful referrals	Form 6: Case Action Plan Form 9: Follow-up and Monitoring	Quarterly	**Numerator:** Number of successful referrals - a referral is considered successful when the client has successfully accessed the service. This information is usually shared by the client during a follow-up visit. **Denominator**: Number of referrals
Case characteristics				
CC-01	Percentage of cases by protection risk	Form 3: Protection Risk Assessment	Monthly	**Numerator:** Number of cases per protection risk **Denominator**: Number of cases
CC-02	Percentage of cases by risk level	Form 3: Protection Risk Assessment	Monthly	**Numerator:** Number of cases per risk level **Denominator**: Number of cases

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Case characteristics				
CC-03	Percentage of cases by duration	Form 1: Intake Form Form 11: Case Closure	Quarterly	**Numerator:** Number of cases per duration **Denominator**: Number of cases
CC-04	Percentage of service users that have a disability	Form 3: Protection Risk Assessment	Monthly	**Numerator:** Number of service users that have a disability **Denominator**: Number of service users
CC-05	Percentage of cases with a finalised safety plan	Form 8: Safety Plan	Monthly	**Numerator:** Number of cases with a finalised safety plan **Denominator**: Number of cases
CC-06	Percentage of service users reporting symptoms of moderate to severe distress in the 14 days prior to survey completion	Form 5: Basic MHPSS Assessment	Quarterly	**Numerator:** Number of service users reporting symptoms of moderate to severe distress in the past 14 days prior to survey completion **Denominator**: Number of service users

A note on outcome monitoring

Outcome monitoring is a process by which the impact of Protection Case Management is measured. Annex 3.13: Outcome Monitoring Guidance provides guidance on how to measure impact on service users psychological wellbeing, reduced severe distress, and the impact of protection risks on service users' day-to-day lives. Country teams can select one or more of these three potential outcomes to measure as part of their service delivery.

Protection Case Management data flow

Different Protection Case Management data collection and data management tools must be implemented throughout the case management process, as well as at predefined moments during the project cycle. **Figure 6 outlines the different tools across the three categories of Protection Case Management learning**.

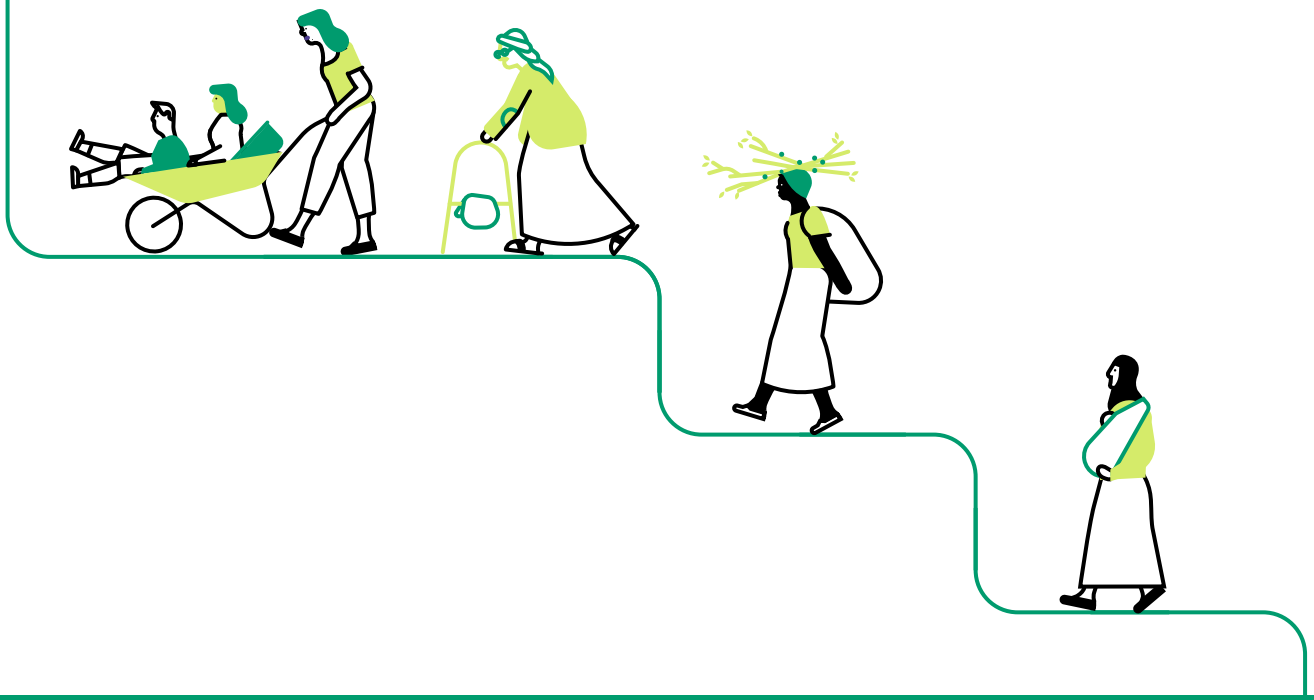
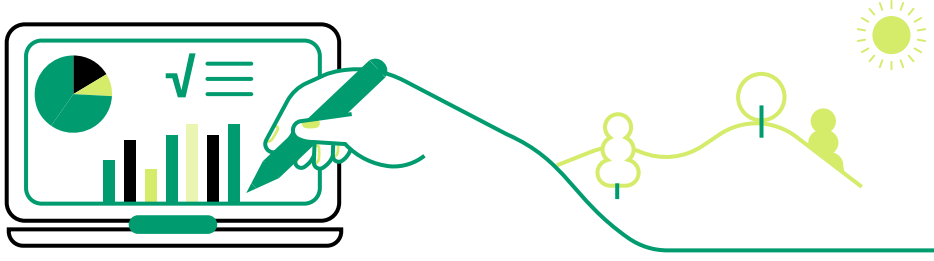


Figure 6: Data flow for Protection Case Management MEAL tools and dashboards

	Protection Case Management process and quality	Case profile	Protection outcomes
Step 1 Contextualise indicators / forms and train staff on use			
Step 2 Administer forms as part of the Protection Case Management and supervision process	• Capacity assessment • Case file checklist	• Intake and registration • Protection assessment • Safety assessment • Action plan • Follow-up • Case closure • PHQ9	• Interim client feedback • Reactive channels • Protection outcome survey • End line client feedback
Step 3 Process, analysis and interpretation	Analysis dashboard	Analysis dashboard	Output TBC
Step 4 Implement measures to improve data quality			



Centering service user MEAL approaches: Service user-centred Protection Case Management MEAL activities and programming rely on responsible data management and analysis. An important component of this is informed consent of the service. For each component of the service delivered, gather informed consent, including participation in the Protection Case Management process, participation in any monitoring and feedback activity, and sharing of data for other purposes. Always make it clear that they can refuse participation in any monitoring activities, which does not affect their ability to receive Protection Case Management services. See Module 4 for further guidance on how to obtain consent that is meaningful and informed. MEAL components should strengthen delivery of quality services for service users, helping programmes be responsive to service user needs and feedback. Service user feedback is seen as a core part of routine monitoring. Service users are encouraged to provide feedback at any point during the case management service, by using reactive feedback channels such as hotlines or during conversations with their case managers. To collect structured feedback on the service provided, all service users should be invited to participate in the service user feedback survey. See Annex 3.12: Client Feedback Modalities for more information on the modalities that can be used to administer this survey.

Caseworkers should ensure that service users are aware of these feedback mechanisms, and that programme staff receive actionable updates generated by feedback data collected.

All feedback received by service users requires tailored follow-up by teams.

Table 7: Feedback follow-up by teams

Type	Examples	Follow-up
General feedback/ other	Positive feedback and other issues raised that do not require follow-up, such as thanking the caseworker for their support	If required, direct follow-up with the Protection Case Management team, within one month

Type	Examples	Follow-up
Programmatic complaint – minor dissatisfaction	Most complaints related to the relevance, quality or impact of interventions; access related issues such as the timing or location of services; issues related to a lack of voice and empowerment	Direct follow-up with the Protection Case Management team, within 14 calendar days
Programmatic complaint – major dissatisfaction	Complaints about safe access to services, unfair treatment, lack of respectful and dignified treatment by staff, attitude, exclusion of a minority/ vulnerable group	Direct follow-up with the Protection Case Management team, within 7 calendar days
Breach law or safeguarding misconduct by Protection Case Management staff or external service providers	• Exploitation and abuse (sexual, economic, other) • GBV • Bribery, corruption, and kickbacks • Child safeguarding • Fraud • (Sexual) Harassment or discrimination • Physical safety risks • Procurement fraud • Retaliation • Threat	**Critical**: Immediate follow-up required, in line with the response specific referral process. Aid workers must report any known or suspected allegations of sexual exploitation and abuse in line with the survivor-centred approach and be aware of their organisational policy. For detailed guidance on how to handle complaints, refer to the Guidance Note: INTER-AGENCY SEXUAL EXPLOITATION AND ABUSE REFERRAL PROCEDURES

For further detail, see Form 12: Client Feedback Survey.

MEAL data collection tools and guidance

This section includes an overview of all key data collection tools, as listed in Figure 6: Data flow for Protection Case Management MEAL tools and dashboards.

Protection Case Management process and quality forms

Annex 3.4: Caseworker Capacity Assessment (knowledge and attitude)

- **Purpose of tool:** To understand and monitor caseworker's attitude, knowledge and skills. It contains minimum competency standards for all caseworkers offering user-centred Protection Case Management services. It tests caseworkers' internal biases and attitude as it pertains to the cases they support. Once the assessment is complete, the supervisor and caseworker agree on the suggested priorities in each area for technical capacity building and development.
- **Key MEAL indicator(s)**:
  - Percentage of caseworkers whose knowledge assessment score is at least 70 per cent (PQ-07)
  - Percentage of caseworkers whose attitudes score is at least 80 per cent (PQ-08)

Supervision Form 4: Case File Checklist Tool

- **Purpose of tool:** A guide for supervisors to review a single protection case by reviewing all of the different core Protection Case Management tools (identification and intake, protection risk assessment, action plan, safety plan, follow-up and case closure). This tool is part of regular coaching, and feedback should be provided in individual supervision sessions. It can also be used to review multiple case files independently. Where common trends are observed (i.e. mistakes or challenges), these can be addressed in group sessions together.

- **Key MEAL indicator(s)**:
  - Percentage of case files reviewed that meet 80 per cent of criteria of a case file checklist (PQ-09)

Case profile forms

Form 1: Intake Form

- **Purpose of tool:** To gather essential information about individuals seeking assistance or support to receive Protection Case Management services. The form serves as a foundational document that enables caseworkers and service providers to understand if the service user is eligible for Protection Case Management services, basic bio-data information, and any barriers the service user might face with access case management.
- **Key MEAL indicator(s)**:
  - Percentage of intakes eligible for Protection Case Management (PQ-01)
  - Number of total service users (PQ-02)
  - Number of new cases registered for Protection Case Management (PQ-03)
  - Average number of cases per caseworker (PQ-06)
  - Percentage of cases by duration (CC-03)

Form 3: Protection Risk Assessment

- **Purpose of tool:** To understand the circumstance of the service user and their protection risks. The assessment will include detailed bio data information, as well as information about the service user and their protection risks, including any vulnerabilities and strengths the service user will have. This process involves gathering comprehensive information to determine the most appropriate course of action for each service user.
- **Key MEAL indicator(s)**:
  - Percentage of service users who report being less impacted by protection risks after receiving Protection Case Management support (PO-02)
  - Percentage of service users who report that they are better equipped to reduce or mitigate the protection risk after receiving Protection Case Management support (PO-04)
  - Percentage of cases by protection risk (CC-01)
  - Percentage of cases by risk level (CC-02)
  - Percentage of service users that have a disability (CC-04)

Form 6: Case Action Plan

- **Purpose of tool:** To record and plan agreed interventions needed to address the service user's risks.
- **Key MEAL indicator(s)**:
  - Percentage of service users who received cash assistance through Protection Case Management (PQ-05)
  - Percentage of successful referrals (PQ-13)

Form 8: Safety Plan

- **Purpose of tool:** To record and plan for how to mitigate risk of harm for service users whose safety is at risk.
- **Key MEAL indicator(s)**:
  - Percentage of cases with a finalised safety plan (CC-05)

Form 9: Follow-up and Monitoring

- **Purpose of tool:** To re-assesses service user needs, including safety, mental health and referral tracking.
- **Key MEAL indicator(s)**:
  - Percentage of service users who received cash assistance through Protection Case Management (PQ-05)
  - Percentage of successful referrals (PQ-13)

Form 11: Case Closure

- **Purpose of tool:** To record information on why the case is closed, and ensures the caseworker, supervisor and service user agree on the next steps.
- **Key MEAL indicator(s)**:
  - Percentage of service users who report being less impacted by protection risks after receiving Protection Case Management support (PO-02)
  - Percentage of service users who report that they are better equipped to reduce or mitigate the protection risk after receiving Protection Case Management support (PO-04)
  - Percentage of cases closed due to meeting objectives of the action plan (PQ-04)
  - Percentage of cases by duration (CC-03)

Protection outcomes forms

Form 4: Psychosocial Wellbeing Assessment

- **Purpose of the tool:** Designed to gather information from the service user about different aspects of service users wellbeing. It is a questionnaire with 14 statements about feelings and thoughts, covering a number of areas relevant to Protection Case Management, including:
  - Positive functioning and competence
  - Autonomy and empowerment
  - Coping, resilience and hope
  - Positive affect and emotions
  - Relationships and social support

To measure change for a specific service user, the tool is administered at two points in the process: At the start and end of the service delivery. The aggregate results can be shared with donors and other stakeholders to prove the value of Protection Case Management.

- **Key MEAL indicator(s):**
  - Percentage of service users who demonstrate improved psychosocial wellbeing after receiving Protection Case Management support (PO-01)

Form 5: Basic MHPSS Assessment

- **Purpose of the tool:** To identify signs and symptoms of distress in individuals, through nine questions. It helps case managers understand how these problems are impacting the service users life and ability to take care of themselves. It assists decisions regarding immediate referral and tailored MHPSS support. To use the tool as a way to measure the impact of case management, the tool can be administered at the start of case management and at case closure. This is especially relevant when working with service users who report severe distress at the start of the Protection Case Management process.
- **Key MEAL indicator(s):**
  - Percentage of service users with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving Protection Case Management support (PO-03)
  - Percentage of service users reporting symptoms of moderate to severe distress in the 14 days prior to survey completion (CC-06)

Form 12: Service User Feedback Survey

- **Purpose of the tool:** To enable the service user to provide feedback on the services provided in a confidential manner - the service user feedback survey is administered during or after the process. The tool measures the service user´s perspectives on access and safety of the services, whether they received respectful and dignified treatment, their sense of empowerment throughout the process (and its relevance), and satisfaction with the services.
- **Key MEAL indicator(s):**
  - Percentage of service users that felt they were involved in decisions during their case management (PQ-11)
  - Percentage of service users that are satisfied with the case management services (PQ-12)

Note: The third protection monitoring outcome (indicators PO-02 and PO-04) is measured at the protection risk assessment and case closure stages.

Data sharing considerations

Before sharing data with anyone outside the Protection Case Management process, consider certain characteristics of your collected information. See Table 8 for more information.

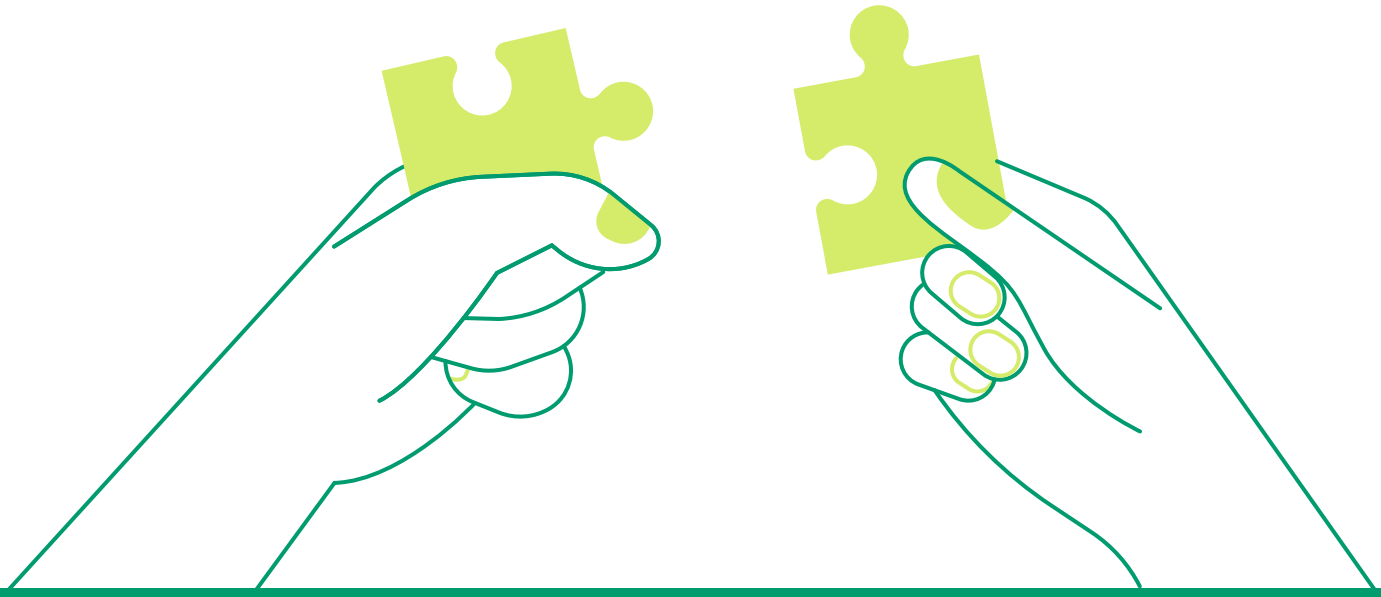


Table 8: Data considerations before sharing

	Strictly confidential	Restricted
Definition	Information or data that, if disclosed or accessed without proper authorisation, **are likely to cause severe harm or negatively impact** service users, caseworkers, supervisors or the organisation. Highly limited, bilateral disclosure only. Determined and approved on a case-by-case basis, with assurance of upholding the highest standards of data protection.	Information or data that, if disclosed or accessed without proper authorisation, **are likely to cause minor harm or negative impacts and/or be disadvantageous** to caseworkers, supervisors or the organisation. Can be shared - based on a clearly specified purpose and related standards for data protection.
Forms	Form 1: Intake Form Form 3: Protection Risk Assessment Form 6: Case Action Plan Form 8: Safety Plan Form 11: Case Closure	Supervision Form 1: Caseworker Capacity Assessment Supervision Form 4: Case File Checklist Tool
Groups who have access to individual level data	Service user, supervisor, case manager, and data processor (MEAL or information management focal point)	Supervisor and data processor (MEAL or information management focal point)

Data management and analysis

To report on the key MEAL indicators selected (see Table 3: Protection Case Management MEAL indicators), case managers, supervisors and coordinators report on key characteristics for each case and the overall process. If the Protection Case Management team uses hard copy forms to capture service user-specific data, this reporting can be systematised using the Tool 3.3: Protection Case Management Dashboard. This information is updated as the case progresses. For instance, when its status changes from open to closed. The information is cleaned and consolidated by the information management focal point, who uses the Protection Case Management Excel dashboard to share these insights with the Protection Case Management team, and other stakeholders (see Annex 3.7: Software Requirements Specifications).

The Protection Case Management dashboard interface

Using a digital platform to populate and store Protection Case Management forms facilitates this type of reporting. It enables the monitoring of case and service user characteristics in real time, without additional reporting requirements for case managers, supervisors and coordinators. For more information on the requirements for such a platform, see Annex 3.7: Software Requirements Specifications.

Overall interpretation guidance

In general, all interpretation is guided by the following questions:

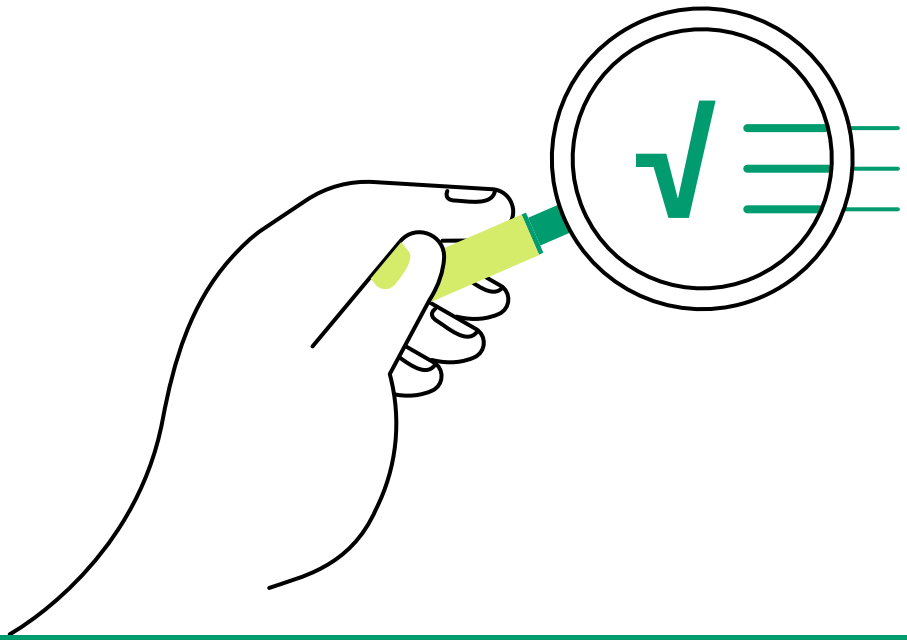
- What does this data mean? What trends can be seen? Which cases are outliers and why so?
- What could the data possibly be telling us about our (programme, services, outreach, etc.)? What doesn't it tell us?
- How does this data compare to last month, last year? How is this quarter different from last quarter?
- How can this information be used? For our programme design? For our prevention programming? For our information dissemination/ awareness raising? For our advocacy efforts?
- Who else needs to know about this? How do we safely share our findings?

Detailed interpretation guidance by indicator is available in Annex 3.14: Indicator Interpretation.

Table 9 offers questions that can generate actionable insights for each outcome (based on indicators).

Table 9: Reflection questions to support outcomes

	Reflection questions by recommended disaggregation	Use
Protection outcomes *Indicators PO-01 to PO-04*	• Does the outcome of the Protection Case Management service differ when looking at **gender, age, disability status, displacement status, risk level,** and/or **type of protection** risk exposed to? • To what extent do outcomes differ between **geographic areas?** • How does service user feedback on the service provided differ between **caseworkers** and between **geographic locations**?	• Supervision and caseworker skills development • Donor engagement • Case management planning, strategies, and service adaptation • Coordination with other actors and advocacy



	Reflection questions by recommended disaggregation	Use

Process and quality
 	
Indicators PQ-01 to PQ-13
	• Have **referrals been successful**? For all types of services required, in all geographic areas? If not, what are the main barriers?
	• Have all service users who report safety and security concerns **finalised a safety plan** with their caseworkers? If not, why not?
	• How do Protection Case Management processes and quality indicators, including case to caseworker ratio, differ between **caseworkers** and **geographic areas**?
	• When looking at a summary of the case file checklist, what is the **percentage of cases that meet the following criteria:**
	  ◦ Was informed consent/assent to collect, store and share information obtained?
	  ◦ Was the risk assessment carried out within one week of the identification?
	  ◦ Was the case plan developed with the service user?
	• How do they differ between **age, gender, risk level, and type of protection risk** the service user has been exposed to? *(include reference to indicator(s))*
	• How has this changed as compared to the **previous review period?** *(include reference to indicator(s))*
	• What can the capacity scores for different **caseworkers** tell us about current strengths and capacity limitations? *(include reference to indicator(s))*
		• Supervision and caseworker skills development
		• Staffing and budget programmatic decision making
		• Donor engagement

	Reflection questions by recommended disaggregation	Use
Case characteristics *Indicators CC-01 to CC-06*	• What can the number of intakes by service user **age, gender, place of residence, and disability status** tell us about the key characteristics of our service users? *(include reference to indicator(s))* • Do these findings indicate **specific barriers** to accessing services for potential service users with certain characteristics (e.g. of a certain age, with a disability, those living in a specific geographic area)? *(include reference to indicator(s))* • What are the most common **types of protection risks** reported by service users and what can this tell us about the resources and referral mechanisms required? Are service users facing certain types of violations more likely to reach out to Protection Case Management? *(include reference to indicator(s))*	• Staffing and budget programmatic decision making • Donor engagement • Advocacy

Use of Protection Case Management data for strategic programming

Protection Case Management data serves multiple purposes:

1. Supporting operational staff (case managers, supervisors and coordinators)
2. Meeting donor reporting requirements through aggregated data
3. Enabling broader contextual analysis for advocacy and strategic planning

Before using data for these purposes, ensure proper informed consent procedures are followed (see Module 4).

Donor relationships

At the project design phase, promote the use of standard indicators to monitor progress towards goals set out in the Protection Case Management grant agreements, including:

- **Outputs:** The number of caseworkers trained, the number of new cases registered, the percentage of service users who received cash assistance.

- **Quality and outcome:** The percentage of service users that are satisfied with Protection Case Management services, the percentage of service users who demonstrate improved psychosocial wellbeing after receiving support, the percentage of service users with mental health needs who demonstrate a reduction in symptoms of severe distress over the course of the process, the percentage of service users who report to be less impacted by protection risks after receiving support.

Negotiate data-sharing restrictions at grant inception

Protection Case Management services handle highly sensitive information, requiring careful consideration when sharing data with external actors, including donors. The most critical restriction concerns numerical targets: neither the total number of service users nor specific violations should be predetermined. Setting quotas - such as specifying a minimum number of torture survivors to receive support - must be avoided in project documentation.

This restriction stems from the complex nature of Protection Case Management. A quota-driven approach inevitably compromises service quality, as caseworkers may feel pressured to prioritise specific profiles or, more worryingly, turn away those who fail to meet target criteria. There's also the risk of caseworkers feeling compelled to force disclosure simply to meet donor requirements. Moreover, service users typically present multiple, interconnected concerns, making it impractical and potentially harmful to predict specific case numbers or types during the proposal stage.

Data that reflects the quality and coverage of the service can be provided instead:

- **Outcome indicators**: For example, the percentage of service users who demonstrate improved psychosocial wellbeing after receiving support, the percentage of service users with mental health needs who demonstrate a reduction in symptoms of severe distress over the course of the process, or the percentage of service users who report being less impacted by protection risks after receiving support.

- **Output indicators**: For example, the number of cases opened and closed, the number of caseworkers trained in Protection Case Management, or the number of service users per caseworker.

One of the guiding principles of Protection Case Management is the right to confidentiality (see Module 1). Such confidentiality is based on strict data sharing agreements and only based on explicit service users permission. As such, personally identifiable data cannot be shared with donors, unless these criteria are met. Alternatively, aggregated data can be shared. For instance, on service users and case profiles reached.

Data for advocacy and analysis

Aggregated Protection Case Management data provides further insights into the protection risks service users are facing, existing barriers to services, rights, and their preferred solutions. As it does not require additional primary data collection, reviewing Protection Case Management data can be a cost-effective method to inform context analysis and strategic planning. It can help answer questions such as:

- What are examples of barriers that people face when trying to access services and/or rights?
- Which services are requested by service users but not available?
- What are some of the key drivers of violence against the population in areas of service?
- Who is included among the perpetrators of these threats?
- What are common coping mechanisms and solutions service users prioritise to address the issues?

However, as Protection Case Management only includes the experiences of those able to access the services, there are several considerations when using Protection Case Management data for context analysis:

- Do consider the **context** of the data and who have provided their consent to share their data as part of wider statistical analysis. It does not include the experiences of survivors unable to reach one of the service providers who use the Protection Case Management IMS. As such, Protection Case Management data **can never provide insights on prevalence of protection incidents** in a certain geographic area.

- In light of these limitations, **do not share the number** of incidents reported. Instead, use percentages. With percentages, round up or down rather than using decimal points. Numbers should not get too specific to avoid a recalculation into absolute numbers. Instead, report any important proportional increase or decrease.

- **Be careful with trend analysis.** Protection Case Management data reflects the level of access to Protection Case Management services. As such, an increase in *reported* violations does not necessarily mean an increase in the *occurrence* of such violations. It could reflect an increased trust in programming or service providers, or an expansion of services provided.

- Information should **always be interpreted by the team directly involved in Protection Case Management**. Sharing descriptive data without interpretation to those unfamiliar with Protection Case Management is likely to lead to misinterpretation of trends and issues.

- Do **triangulate** data with other available information sources, including protection monitoring and analysis initiatives.

Evaluations

Learning from evaluations supplements routine monitoring. It allows for key reflection questions to be asked at specific points in the Protection Case Management programming cycle, test underlying assumptions, and bring in voices beyond service users. It is recommended after the closure of any Protection Case Management process. If budget allows, conduct the evaluation process externally. Key programme components that are covered within evaluations include the relevancy and adequacy of an intervention, coherence with other interventions, efficiency, effectiveness, impact, and sustainability.

Summary of key points

This Module builds on the protection analysis that was conducted and foundational decisions that were taken during the steps outlined in Module 2. Work through Module 2 before proceeding with the design steps outlined in this chapter.

In order for your service to be a Protection Case Management service aligned with this guidance, it must meet or be actively working to meet the minimum standards outlined in this module. There is guidance for how to do this in this module and in others.

Develop your service delivery design and related protocols before training your teams and delivering the service. It will take time to consider which mode of delivery is appropriate, what resources you need, and how they will be used. This is important for the safety of your service users and staff, as well as the quality of the service.

Learning from your service through monitoring and service user feedback is important to improving your protocols, identifying the professional development needs of your staff, as well as your accountability to donors, service users, and other stakeholders. Plan to do this by using this guidance to finalise your own MEAL standards and guidelines.

Up next

Module 4: Delivering Protection Case Management: A Guide for Supervisors and Caseworkers

This module will guide supervisors and caseworkers in creating a comprehensive, user-centred approach to Protection Case Management, answering the following questions:

- **How do I establish a trusting and supportive service user relationship?**
  Taking a more considered look at how to build a safe and secure environment for service users throughout the entire Protection Case Management process.

- **What is the step-by-step process of Protection Case Management?**
  Preparing for Protection Case Management sessions with service users by providing a more in-depth look at the steps of Protection Case Management:
  - Step 1: Introduction and intake
    - Introductions
    - Urgent needs
    - Explaining service user rights
    - Explaining confidentiality
    - Determining initial risk level
  - Step 2: Protection risk assessment
    - Risk and vulnerabilities
    - Protective strengths and capacity
    - Strengths-based approach
  - Step 3: Case action planning
    - Goal setting with service users
    - Safety planning
    - Accompaniment
  - Step 4: Implementation of case action plan
    - Direct service provision
    - Referral
    - Lead case coordination
  - Step 5: Follow-up and monitoring
  - Step 6: Case closure and case transfer

Forms

Form 1: Intake Form

Form 1A: Interpreter Non-Disclosure Agreement

Form 2: Informed Consent and Registration

Form 3: Protection Risk Assessment

Form 4: Psychosocial Wellbeing Assessment

Form 5: Basic MHPSS Assessment

Form 6: Case Action Plan

Form 7: Referral Form

Form 8: Safety Plan

Form 9: Follow-up and Monitoring

Form 10: Case File Note

Form 11: Case Closure

Form 12: Service User Feedback Survey

Tools

Tool 3.1: Accessibility Checklist

Tool 3.2: Protection Case Management Indicator Matrix

Tool 3.3: Protection Case Management Dashboard

Annexes

Annex 3.1: Accessibility and Reasonable Accommodation

Annex 3.2: Guidance Note on Provision of Assistive Devices

Annex 3.3: Staff Roles and Responsibilities

Annex 3.4: Caseworker Capacity Assessment

Annex 3.5: Standard Operating Procedure Data Management and Protection

Annex 3.6: Staff Data Protection Agreement

Annex 3.7: Software Requirements Specifications

Annex 3.8: Data Protection Checklist

Annex 3.9: Data Sharing Agreement Template

Annex 3.10: Common MEAL Terms and Definitions

Annex 3.11: Measuring the Protection Case Management Theory of Change

Annex 3.12: Client Feedback Modalities

Annex 3.13: Outcome Monitoring Guidance

Annex 3.14: Indicator Interpretation

Endnotes

1 Best practice is to coordinate with other agencies which already have a hotline. This avoids setting up multiple hotline numbers for the same service in the same area, which can be confusing for people..

2 Thanks to the GPC C4PTT for reviewing this section of the guidance as part of this revision.

3 GPC, *Cash and Voucher Assistance for Protection*. https://globalprotectioncluster.org/publications/1886/policy-and-guidance/policy/cash-protection-stocktaking-paper-march-2024-updated

4 WHO, Global Report on Assistive Technology: Summary. https://cdn.who.int/media/docs/default-source/assistive-technology-2/3128-emp-summary-landscape-local-print-081222.pdf?sfvrsn=37f41429_5

5 For example, WHO's online Training in Assistive Products is designed to prepare primary health and other personnel to fulfil an assistive technology role. This may include identifying people who may benefit from assistive technology, providing simple assistive products such as magnifiers and dressing aids, or referral for more complex products and other services.

6 Overseas Development Institute, Risk and Humanitarian Cash Transfer Programming, 2015. https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9727.pdf

7 As recognised by established sources for supervision ratio standards: the *Child Welfare League of America, the Council on Accreditation, and the Child Protection Supervision and Coaching Package.*

8 The Alliance for Child Protection in Humanitarian Action, Community volunteers and their role in case management processes in humanitarian contexts: A comparative study of research and practice, 2021. https://alliancecpha.org/sites/default/files/technical/attachments/cp_community_volunteers_-_low_res.pdf

9 The Alliance for Child Protection in Humanitarian Action, 7 Best Practices to Support Community Volunteers. https://alliancecpha.org/sites/default/files/technical/attachments/7_best_practices_poster.pdf

10 Natural helping refers to the informal style of the untrained lay helper. Natural helpers rely on intuition, familiarity, natural responsiveness, and personal opinions.

11 Chang, V., Scott, S., Decker, C. (2009). *Developing Helping Skills: A Step-by-Step Approach to Competency*. Brooks/Cole Cengage Learning: California. 93.

12 ACAPS, *Cognitive Bias*, 2016, 7. https://www.acaps.org/fileadmin/Technical_notes/acaps_technical_brief_cognitive_biases_march_2016.pdf

13 Global CP WG, *Inter-Agency Guidelines for Case Management and Child Protection*, 2014, 44. https://alliancecpha.org/sites/default/files/technical/attachments/cm_guidelines_eng_.pdf

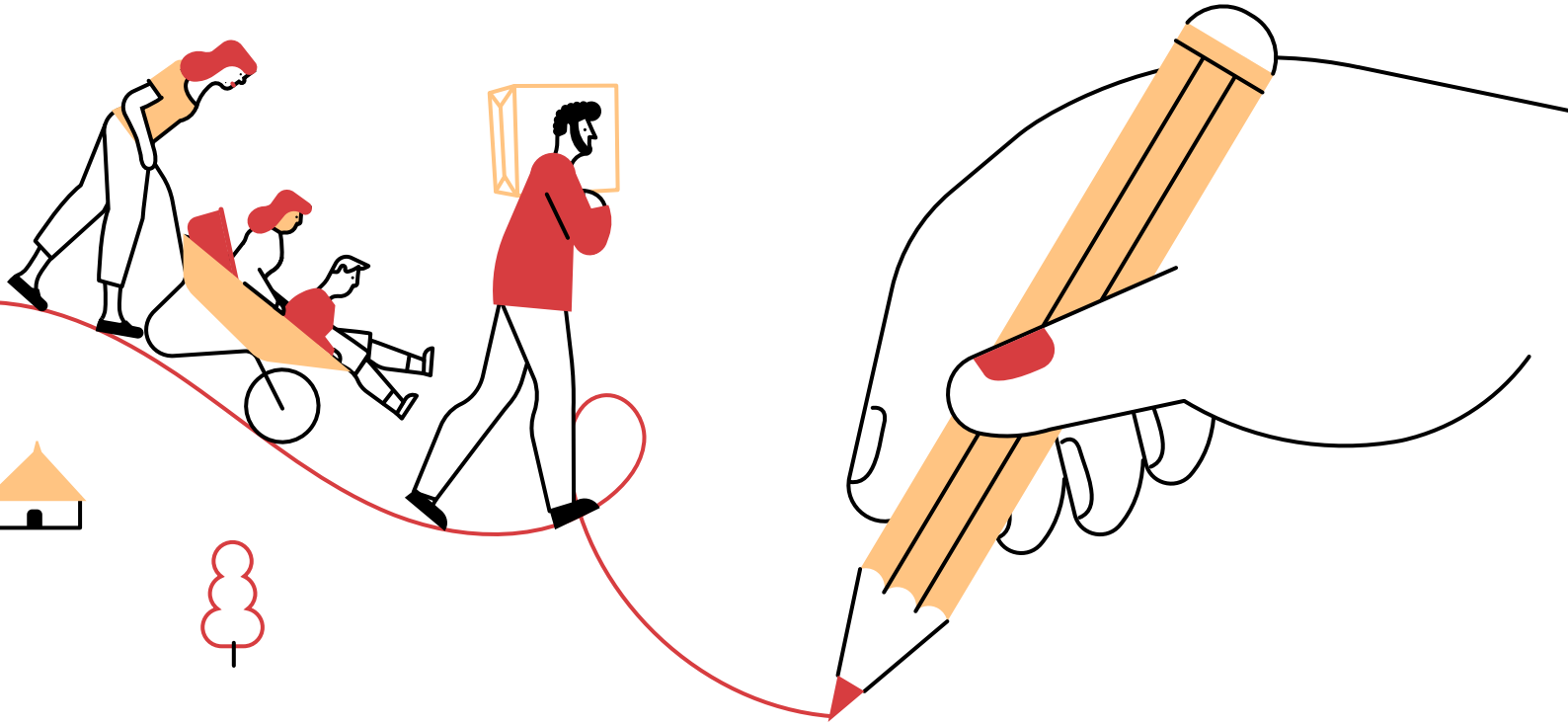
14 Ibid. 34.

15 GPC PIM Guidance, 2018, available at: http://pim.guide/

4

Delivering Protection Case Management:

A Guide for Supervisors and Caseworkers



Welcome to Module 4. This module will guide supervisors and caseworkers in creating a comprehensive, user-centred approach to Protection Case Management. If you have your own local protocols, please defer to them. If these are not yet established, read Module 3 and talk to your team about establishing correct protocols before delivering Protection Case Management services.

This chapter will help you answer the following questions:

- **How do I establish a trusting and supportive service user relationship?**
  Taking a more considered look at how to build a safe and secure environment for service users throughout the entire Protection Case Management process.
- **What is the step-by-step process of Protection Case Management?**
  Preparing for Protection Case Management sessions with service users by providing a more in-depth look at the steps of Protection Case Management, including:
  - **Step 1: Introduction and intake**
    - Introductions
    - Urgent needs
    - Explaining service user rights
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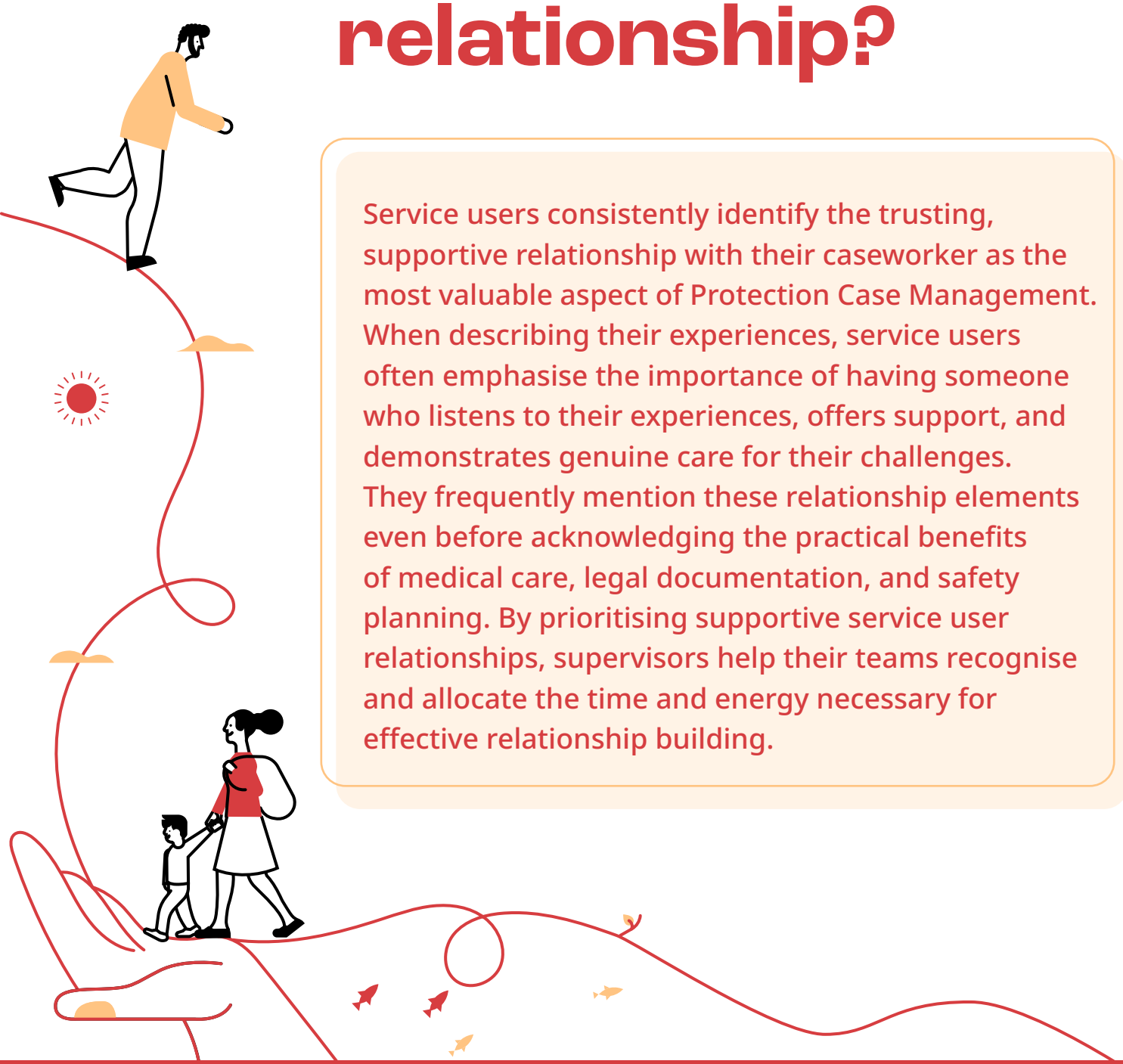
    - Direct service provision
    - Referral
    - Lead case coordination
  - **Step 5: Follow-up and monitoring**
  - **Step 6: Case closure and case transfer**

How do I establish a trusting and supportive service user relationship?



Service users consistently identify the trusting, supportive relationship with their caseworker as the most valuable aspect of Protection Case Management. When describing their experiences, service users often emphasise the importance of having someone who listens to their experiences, offers support, and demonstrates genuine care for their challenges. They frequently mention these relationship elements even before acknowledging the practical benefits of medical care, legal documentation, and safety planning. By prioritising supportive service user relationships, supervisors help their teams recognise and allocate the time and energy necessary for effective relationship building.

Key elements of building effective service user relationships include:

- Obtaining informed consent and clearly explaining confidentiality throughout the process, not only during step one. Always secure consent before sharing any service user information with others.

- Prioritising active listening and support during sessions rather than focusing solely on completing forms. Take time to understand the service user's situation and needs fully.

- Maintaining a strong working relationship by accepting the service user's narrative, even when you suspect there may be additional information. Focus on building trust to encourage open communication over time.

- Feeling like you can be yourself in a session with a service user.[1] This involves striking a balance between what is appropriate, safe and constructive - a skill that develops over time through experience and the support of your supervisor.

Caseworkers require basic psychosocial support skills to establish a trusting and supportive relationship with service users. These skills extend beyond Protection Case Management, benefitting all frontline workers across sectors, including volunteers and trusted community members. Through these essential skills, frontline workers build trusting and supportive relationships and respond appropriately to service users in acute distress or with urgent needs. Caseworkers should integrate basic psychosocial support skills across every step.

It is important to note that basic psychosocial support differs from psychological intervention. Instead, it represents a fundamental, humane and supportive approach to assisting people in distress and serves as an entry point to further support and referrals, as needed.

Basic psychosocial support for frontline workers, including protection actors, is a key activity in the MHPSS Minimum Service Package (Activity 3.2). Protection Case Management teams should refer to the MHPSS MSP for relevant guidelines, standards, tools, and recommended training topics.

How should I prepare for a Protection Case Management session?

For every meeting with a service user, acknowledge that you may not know their current situation context. Understand that they may be affected by various situations, including:

- a stressful, distressing or emergency incident
- a lack of safety and trust
- moderate to severe distress
- physical, communication or attitudinal barriers that limit discussion of any distressing experiences[2]

Prepare before you meet with an individual. This will put you in a better position to establish a rapport. Manage your expectations during the meeting and be ready to address any difficulties which might arise. It will also help you to manage your own stress levels and reactions.

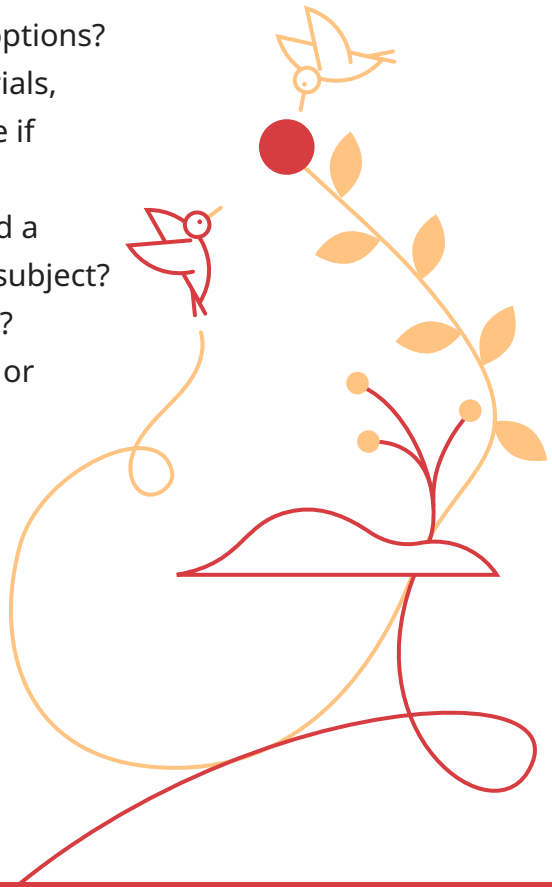
Before every meeting, take into account the following:

Meeting checklist

- **Logistic updates**
  - Have I agreed on a preferred date, time and location with the service user?
  - Have I allocated enough time for the meeting to avoid rushing the service user?
  - Do I have all necessary stationery for the meeting?
  - Have I arranged and prepared all relevant case file documentation, including any documents that need to be signed (e.g. referral forms or interpreter disclosure forms)?
  - Have I taken my phone for security purposes? Have I ensured I will not use it during the meeting, unless necessary?
  - Have I considered any safety or security implications of the meeting space?
  - Am I visibly wearing my staff ID card, unless it is unsafe to do so?

- **Reasonable accommodation**
  - Have I checked with the service user about any adjustments needed for their participation (e.g. communication style adjustments, interpreter services, accessible meeting space)?
  - Have I considered whether the service user has acquired a new disability since our last meeting?

- **Planning and support**
  - What is the purpose of today's meeting, and am I prepared for the activities I plan to complete with the service user?
  - Have I refreshed my memory on psychosocial support skills such as active listening and supportive communication?
  - How was the service user's mental health and psychosocial wellbeing during our last meeting, and could that have changed since then?
  - Are there any requests or actions from the service user (e.g. referrals, gender preference for caseworker) that I need to follow up on before the meeting?
  - Have I identified the service user's capacities, and how can I support them in building on these?
  - Is there specific information I need to share with the service user based on our previous meeting?
  - Do I have an up-to-date service mapping, including safety and accessibility details, to provide full information on service options?
  - Have I brought any useful information or awareness materials, such as hotline cards or other contact information, to share if needed?
  - If a challenging conversation is anticipated, have I prepared a flexible plan and considered the best way to approach the subject?
  - Is the service user's case file up to date before the meeting?
  - Have I followed up on the service user's request for a male or female caseworker, if applicable?



Service user preferences in caseworker selection

Establish service users' preferences regarding their caseworker's gender at the earliest possible stage. If a caseworker of the preferred gender is unavailable, take the following steps:

1. Consult with your supervisor about available options

2. Consider collaborating with other Protection Case Management agencies that can provide gender-appropriate care

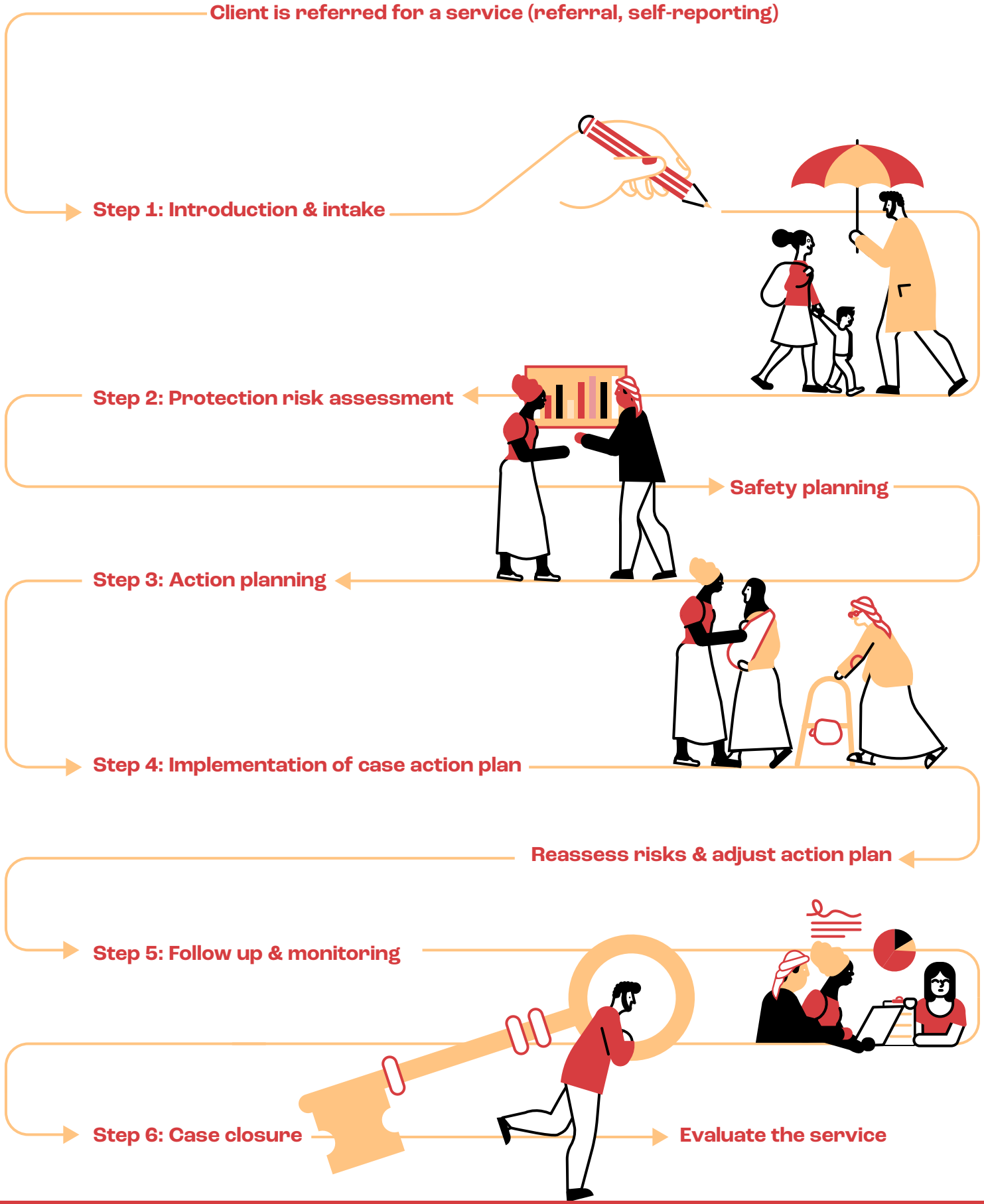
3. If no suitable caseworker is available and it is safe to do so:
   - Complete an immediate safety and security assessment.
   - Determine if the service user faces heightened risk.
   - Postpone the comprehensive risk assessment.
   - Clearly explain to the service user that their case will transfer to a caseworker of their preferred gender for future assessment and follow-up.
   - Remember that gender is not the only important factor in caseworker selection. Consider additional preferences related to language abilities, cultural background, the specific nature of risks faced by the service user, and/or other aspects of the caseworker's profile that may affect service delivery.

These factors can significantly influence the service user's comfort level and willingness to engage with Protection Case Management services.

What is the step-by-step process of Protection Case Management?

Protection Case Management may not always feel so clear cut when you are supporting a service user. The following steps will guide the structure of your process and priorities.

Figure1: The steps of Protection Case Management



Protection Case Management steps align with specific documentation tools for recording your work with service users. These tools help you identify and utilise relevant information to support your service user's journey.

Table 1: Overview of the Protection Case Management steps

The Protection Case Management process is not linear. It is flexible depending on your service user's needs.

Protection Case Management steps	Key tasks
Introduction and intake	**1.** Introduction **2.** Identify immediate safety risks (carry out safety planning if required) **3.** Address barriers to participation in the meeting **4.** Begin the process of informed consent/assent **5.** Determine whether to open a case file **6.** Determine the risk level **7.** Ask for permission to proceed
Protection risk assessment	**1.** Repeat introduction and intake tasks 1-4 **2.** Assess risks and needs **3.** Assess capacities and vulnerabilities **4.** Re-assess the risk level

Protection Case Management steps	Key tasks
Case planning	**1.** Repeat introduction and intake steps 1-4 **2.** Summarise the assessment and check in **3.** Define risks together **4.** Agree on goals together **5.** Agree on actions together **6.** Carry out safety planning (if required) **7.** Get informed consent for referrals **8.** Make accompaniment plans (if required) **9.** Document your case plan **10.** Agree when/where to have a follow-up visit **11.** Discuss any concerns with your supervisor
Implementing the case plan	Carry out service provision as per the individual case plan. This might include: • Direct service provision • Referral • Lead case coordination or advocacy on behalf of the service user
Follow-up and monitoring	**1.** Repeat introduction and intake steps 1-4 **2.** Follow up with the service user and monitor progress **3.** Reassess risks and revise your case plan, if required **4.** Ask for informed consent for further referrals *During the follow-up stage, you may need to develop a safety plan*
Case closure	**1.** Identify if the case meets case closure criteria in agreement with the service user **2.** Close case as per protocols

Main objectives, tasks and recommendations for each Protection Case Management step

Step 1: Introduction and intake

Objective

To establish a rapport with the individual and to determine whether to open a case file for Protection Case Management services. Caseworkers will need to recognise whether someone is at heightened risk and be familiar with their organisation's prioritisation criteria - determining whether Protection Case Management is the most appropriate intervention for them.

Tasks

- Introduction
- Begin the process of informed consent/assent
- Collect basic bio data
- Assess protection risks, including immediate safety risks
- Understand barriers to participation in the meeting
- Determine whether to open a case file
- Determine the risk level
- Ask for permission to proceed

Documentation

- Form 0: Intake and Response Criteria
- Form 1: Intake
- Form 2: Informed Consent and Registration

The introduction and intake step allows an initial discussion with a potential service user. This lets you to determine whether they face a specific risk and their risk level without asking questions, which the person may be worried or embarrassed to answer before they know you better. A person's ability and willingness to recount experiences and to trust you can depend on various factors, including age, sexual orientation, gender identities, culture, health condition, disabilities, mental health and psychosocial well-being, past experiences and expectations of the future, amongst other capacities. Some may open up, others may find it more difficult.[3] Do not pressure the person to answer any questions or provide more detailed answers than they want to. This initial discussion allows you to respect the person's need to have a sense of control during the process.

However, there may be situations where the conversation naturally moves into more specific or detailed information. At this point, two situations could occur:

1. You determine the person to be at heightened risk and they are comfortable and forthcoming with providing information.

2. You are unsure whether someone faces a specific risk and you find it useful to draw on some of the questions in the protection risk assessment form that are more prescriptive (see Form 3: Protection Risk Assessment).

In these situations, you may find that you complete all or part of the introduction, intake, and protection risk assessment in the same meeting.

Introduction script

'My name is _____ [insert name]. I am a caseworker for the_____ _____[insert name of organisation]. I am glad that you have contacted us. I received your referral from_____ [insert name of organisation].

As agreed, I am with _____ [insert name]. They are the interpreter to help us to communicate. This is the only role of the interpreter. S/he is both impartial and neutral. If you have any questions throughout the interview today, please direct them to me and not to the interpreter.

May I ask how you prefer me to call you? Thank you _____ [insert their name]. I am here to listen to you and to see whether we might be able to support you. Before we start, do you feel safe and comfortable talking to me here or do you prefer we go to another place?'

Create a comfortable, safe and private space

Make sure the physical space you are in is private, accessible and comfortable. Ensure that the service user can understand and communicate with you. Try to build rapport from the beginning, retain these communication skills through every stage. Remember to use basic psychosocial support skills during introductions and every interaction. This can help create a comfortable and safe space for the service user.

Here are some tips:[4]

- **Communicate concern** to your service user. Use empathy and active listening[5,6] as if the service user's feelings are your own. Examples include:
  - *That sounds like it was very challenging/upsetting/frightening for you.*
  - *You have been through a lot.*
  - *That must have been a painful experience.*

- **Verbal and non-verbal skills** also communicate to the service user that you are listening to them.
  - Keep your body posture open, avoid crossing your arms or sitting away from the person, face the person but remain respectful of local customs.

- Where culturally appropriate, keep eye contact and mirror the service user's language. For example, using any local idioms of distress they might use to convey a sense of understanding and respect for the service user's experience.
- Express similar emotions to theirs by your facial expressions.
- Use brief verbal indications that you are listening such as '*okay*', '*I see*'.

- **Praise openness** to help your service user feel comfortable talking about personal, difficult, or embarrassing topics. Examples include:
  - *Thank you for telling me that.*
  - *I understand it isn't easy to talk to me, but I think it can be helpful for your recovery.*
  - *You were very courageous sharing those intimate feelings with me.*

- **Validating** their problems means letting them know that their reactions are understandable and normal. However, do not tell the service user you know what they are going through. It can have the opposite effect of validating their experience. Examples include:
  - *You have been through a very difficult experience and it isn't surprising you are feeling this way.*
  - *Many people I have worked with are also feeling this way.*
  - *This is a common reaction to a situation like this.*

- **Respect** your service user's beliefs and values. This means listening to your service user without sharing an opinion or judgement based on your own values.

- **Speak in a calm, not loud voice**. Avoid changes in mood and attitude at any time toward the person.

- **Avoid giving advice and/or** telling your service user what to do and not to do. This will undermine your service user's ability to manage their own problems.

For tips on how to communicate with persons with disabilities including persons with visual impairments, speech difficulties, deaf or hard of hearing, physical impairment, intellectual disability, or psychosocial disabilities, refer here: Annex 4.1: Inclusive Communication Tip Sheet.

Remember, do not focus on your notes or forms. While documentation can be useful to record information, you should set it aside and try not to fill any forms or be on your tablet or laptop. You should focus on the person and provide help. You can complete your forms once back in the office. If you wish to take notes, you should always ask.

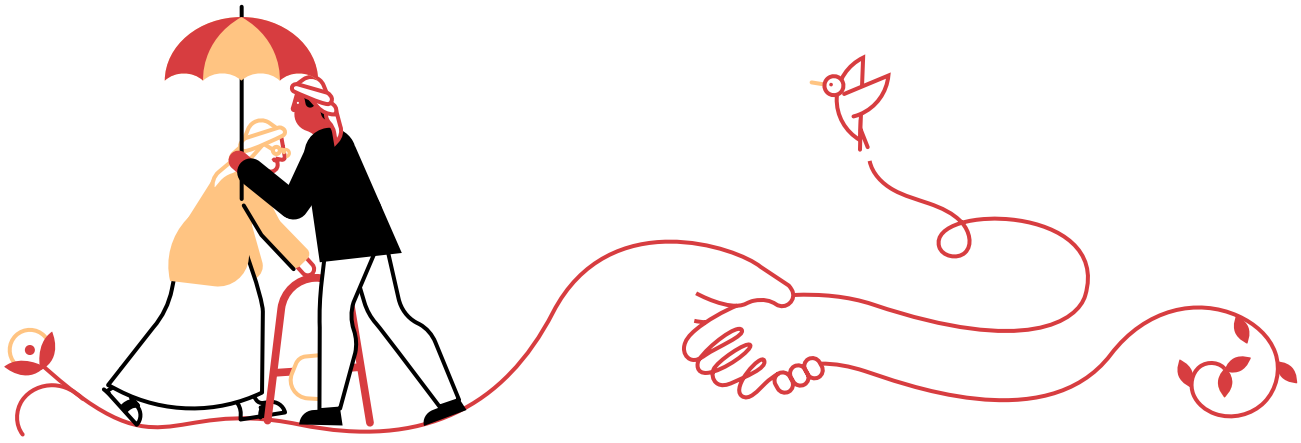
Assess immediate safety risks

If a service user appears very upset or with active suicidal thoughts, exhibits out of control behaviour, or appears to be in danger, follow these steps:

1. **Maintain professional composure and validate the service user's trust:** Express gratitude for their willingness to share this crisis and affirm your commitment to support them. Employ active listening techniques and maintain a measured response without displaying heightened emotional reactions.

2. **Inform and engage supervision:** Clearly communicate to the service user your need to consult with your supervisor immediately. Maintain contact with the service user while speaking with your supervisor. Develop and agree upon a clear safety plan with all parties before concluding the session.

3. **Ensure immediate safety measures:** If supervisor contact proves unsuccessful and the service user lacks continuous support, facilitate an immediate referral to appropriate health services or a secure, supervised environment. The caseworker must maintain presence with the service user if no alternative supervision options exist.



Grounding techniques to calm and reassure the service user

- You can say: 'You seem very scared or worried, let's try to stay in the present, take a slow deep breath, relax your shoulders.'

- Ask the service user to inhale through the nose and exhale through the mouth. Have the service user place their hand on their abdomen and then watch their hands go up and down while the belly expands and contracts.[7]

This guidance includes MHPSS interventions for caseworkers, including emotional regulation activities such as grounding techniques. To find the grounding techniques for caseworkers, see Annex 4.4.5: Emotional Regulation in Annex 4.4: MHPSS Activities and Resources. Caseworkers should work with their supervisor and peers to identify appropriate grounding exercises, adapt them and practise prior to implementing them with service users.

For additional grounding techniques and information on grounding, see Doing What Matters in Times of Stress: An illustrated Guide (WHO), an easy to read illustrated guide with information and skills to help manage stress. Techniques can be easily applied in a few minutes each day.

For immediate urgent medical needs, such as severe bleeding, or extreme pain, take action to get medical help with the individual's verbal consent. This may mean linking the service user directly to a health clinic or hospital. For life-saving medical services involving financial cost, collect receipts and invoices for future payment. Make sure you have the national ambulance service or the Red Cross or Red Crescent number at all times.

In case of imminent risk of harm to self or others, make an emergency referral to the appropriate services. For risk of suicide or self-harm, refer to the relevant Mental Health services or specialised MHPSS services. If these are unavailable, consider referrals to local health facilities or other relevant protection services. Before making external referrals to local health facilities, assess potential risks to the service user, particularly in contexts where attempted suicide is criminalised or where health facilities may cause harm.

Address barriers to participation in the meeting

When advance preparation has not been possible, access potential barriers to your service user's participation in the session. Consider:

- **Physical barriers:** accessing, entering, moving within and using the meeting location
- **Communication barriers**: understanding and exchanging information needed for informed consent
- **Social and attitudinal barriers:** including potential biases or prejudices that could affect the caseworker-service user relationship

You must address these barriers as soon as possible with the service user. Work with the service user to identify and implement reasonable accommodations that support their full participation. Establish clear communication methods for the informed consent process. While some service users may only need minor adjustments to communication style, others may require additional accommodations before proceeding with the session and consent process.[8]

Understand informed consent/assent

Follow these steps when seeking informed consent:

1. Address barriers to providing informed consent by supporting decision-making
2. Explain the Protection Case Management process and their rights
3. Explain confidentiality and its limitations
4. Explain risks and potential benefits
5. Ask whether there are any questions
6. Ask for permission to continue

1. Address barriers to informed consent by supporting decision-making

You need to involve your service user in this discussion. In situations where communication is challenging, a person cannot lose their right to provide informed consent simply because they face barriers to accessing information and communicating. You must adjust your way of communicating for your service user so they can fully participate and provide consent or refuse Protection Case Management services.[9]

Script to support decision-making for informed consent:[10]

'I will do my best to support your participation in this process, particularly so that you feel you can understand and communicate with me well, but also so that you easily reach and use the spaces that we meet in.

In terms of our communication, please feel free to stop me and let me know at any time during our session or following sessions if you need any form of support to understand or communicate with me, and what support you need. For example, I can show you a consent form that is easier to read, arrange for a sign language interpreter, or, if you would like, you can also ask a trusted individual to support you to understand or communicate through our conversations and the informed consent process.

Depending on what support you need, it may take me a few days to arrange it, but I will try my best. If I am unable to arrange it for any reason, I will let you know and we can try to arrange another source of support.'

Present information in a format accessible to the service user – either in their preferred format or one that ensures clear understanding. This may include their preferred language, sign language or easy-to-read consent forms.

Addressing communication barriers

If you are working with a person with whom you are having difficulty communicating, ask yourself the following key questions:

- *Did you try more than one method of communicating the information? Have you given them time to process this information and ask questions?*
- *Did you allow the service user to express her/his preferred way of communicating, and arrange for any reasonable accommodation? For example, involving simultaneous or sign language interpretation.*
- *Are you able to determine whether the service user understands the information provided and the consequences of decisions they may make? How did you determine this? For example, through questions, discussions, gestures, writing, pictograms, or other forms.*
- *Have you been able to ensure that the service user's decisions are voluntary and not forced or coerced by others? How did you determine this?*
- *Is a caregiver or family member already involved? If so, how? Are they answering the questions you ask without consulting the service user?*

After reflecting on these questions, consult your supervisor if the service user needs additional communication support or you have concerns about their capacity to provide independent consent. Your supervisor will help determine what further support is needed. Together, review the following processes:[11]

- Where safe, involve a trusted support person or interpreter to facilitate understanding and communication with your potential service user. If safe to do so, ask your service user for their permission to include someone they trust or an interpreter to facilitate their communication and to enhance their ability to provide or refuse informed consent. You will need to carefully check that the support person does not act on behalf of the service user but *only supports* the process.[12] Let the service user independently identify who they would like to involve, and watch for any signs that they agree or disagree with the suggestions being made.

- It is good practice for service users to sign a consent form (see Form 2: Informed Consent and Registration) to confirm they agree to the presence of an interpreter in the meeting. Interpreters will need to sign a non-disclosure agreement (see Form 1A: Interpreter Non-Disclosure Agreement), to promise they will not breach confidentiality. This agreement must be signed by the service user and the interpreter.

Interpreters must have the attitudes, knowledge and skills needed to follow codes of conduct, handle sensitive disclosures appropriately, and accurately convey what service users communicate to caseworkers. They should be trained in addition to signing the non-disclosure agreement accordingly.

- When all options are exhausted, evaluate whether the proposed decision aligns with the service user's vital interests and well being.[13] This means taking a decision based on the best interpretation of the will and preferences of the service user only where it is *'necessary in order to protect the essential interest for the person's life, integrity, health, dignity or security.'*[14] Consider the following:
  - **Safety:** Does the decision or action protect the service user from potential abuse (physical, emotional, psychological, sexual, etc.)?
  - **Assuming capacity:** Is the decision or action in line with the best interpretation of the will and preferences of the service user?
  - **Cost-benefit analysis:** Do the potential benefits of the decision or action outweigh the potential risks?
  - **Healing:** Does the decision or action promote the service user's overall healing, growth and recovery?

Considerations for obtaining and documenting service user's consent

In instances where capacity to consent by the service user has been confirmed, ensure that consent is given voluntarily. Allow sufficient time for the service user to understand, consider the information, and ask questions. If the service user requests additional information, provide a timely response. Consider the following:

- Consent must be related to a specific proposed Protection Case Management process and be documented.
- The person obtaining consent should be knowledgeable and well informed about the conditions and proposed services available when entering the specific Protection Case Management process.
- Caseworkers should continue to share information, listen to service user ideas and opinions, and explain how and why decisions have been made. This interaction will also assist in monitoring changes in capacity over time and with different types of decisions.

Once you have established your service user's participation in the session, you can continue with the informed consent process.

2. Explain the Protection Case Management process and their rights

Explain the Protection Case Management process, what usually happens at this stage of the process, and what their rights are through the process.

Script to support the explanation of the process and service user's rights

'It is important that you have a clear understanding of what this Protection Case Management service is. Protection Case Management just means that we will talk together about what support you need, how I will support you to put in place goals to address these challenges, and how I will connect you to the right services.

For us to be able to work together, I will need to ask you about your background and your current situation. In the session today, it would be useful for me to understand a bit more about your situation so that we can see whether our services would benefit you, and whether we have the right expertise to support you.

***It is important that you know your rights during this process**. At any time during the session and the process please feel free to:*

- *Not answer my question if you don't want to, and you can always ask me to stop, take a break, or slow down*
- *Ask me to repeat any questions or explain information in more detail*
- *Request to adjust the way I am communicating to support your understanding or communication with me*
- *Request any other adjustments to allow you to participate fully*
- *Request to talk to someone else, including a different gender or for another reason, or work with another organisation - this would have no negative consequences*
- *Request for your information not to be documented*
- *Request to see your case files or other case notes*
- *Refuse referrals to services if you don't want them*
- *Stop the Protection Case Management process at any time'*

3. Explain confidentiality and its limitations

Emphasise your commitment to confidentiality and that all information shared will be kept strictly confidential. A service user's data will be stored safely. Only the most essential and minimum information will be shared after their consent for any services needed. Exceptions where confidentiality must be broken, which are intended to protect them and others, must be clearly explained. Reassure the service user that breaking confidentiality does not automatically mean authorities will be involved.

Script to explain confidentiality and its limits

'Whatever you tell me during this meeting and the whole process will be confidential. This information will stay between us, including any notes I write down during our meeting(s). Any forms or information I collect during our meeting will be stored safely and I am the only person who will be able to access this information. This means that, without your permission, I will not tell anyone what you tell me and only share limited information with service providers for you to receive services only after your consent. We will make sure as far as possible that your participation in this process is not known by anyone.

However, there are a few situations where I may have to speak to someone without asking your permission. If you tell me that you want to hurt yourself, I may need to inform my supervisor or others who can help keep you safe. Similarly, if you want to hurt someone else, I may have to notify the relevant authorities to prevent harm. Lastly, if a UN or humanitarian worker has hurt you, I would need to report this to my supervisor to ensure that action is taken to stop them from harming anyone else.

Sharing information at these times is meant to keep you safe and get the best help for you. Other than these times, none of your information will be shared without your permission.'

4. Explain risks and potential benefits

Explain risks and benefits of Protection Case Management services at two key stages:

1. Before initial intake and before hearing the service user's story

2. After discussion but before proceeding with Protection Case Management services or referrals

While some general risks and benefits can be explained initially, the full assessment must be tailored to your specific context, the service user's individual situation, and information learned during their story

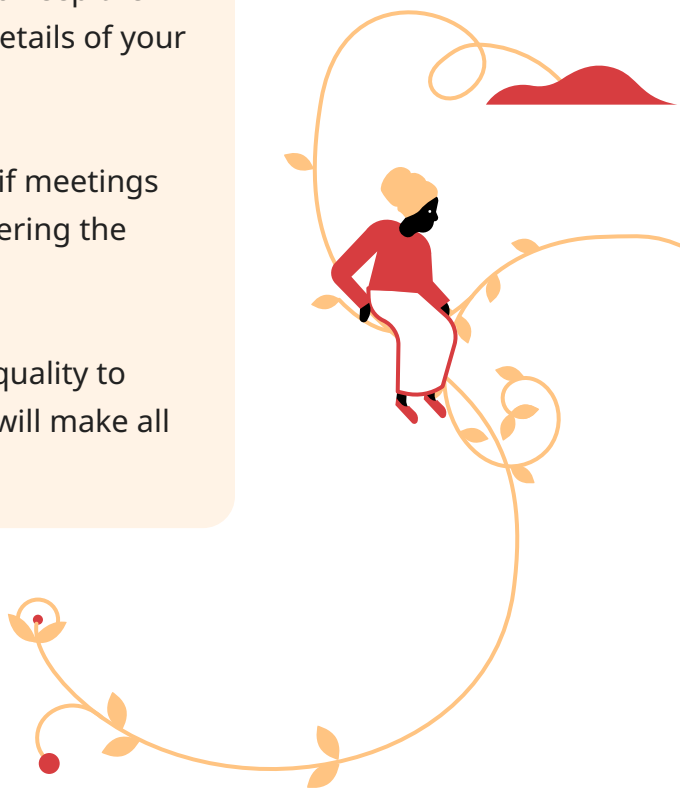
Provide a detailed risk-benefit assessment before seeking consent for Protection Case Management services or making referrals.

Potential risks

- Loss of confidentiality, meaning that someone outside of this session could find out what was discussed and confidential information could be accessed. This may happen if there was loss, misplacement or unauthorised access to a file.
  Explain that you will take all possible precautions to keep their engagement in this process confidential. Provide details of your data protection protocols.

- A service user's anonymity could be compromised if meetings don't take place in a safe and private place. Considering the safety concerns of a meeting is essential.

- There may not be the services available to a good quality to manage your service user's risks. Explain that you will make all efforts to connect them to services that exist.



5. Ask whether there are any questions

Allow time for questions about the information provided, including details about Protection Case Management services, referral options, and their rights. Service users often need time to:

- Process the information shared
- Consider safety implications
- Formulate questions
- Make informed decisions
- Ensure they have adequate time to respond, and avoid rushing this crucial dialogue

6. Ask for permission to continue

Once the service user confirms their understanding of the service and their rights, seek permission to:

- Gather information about their situation to determine how best to provide support
- Take notes during the session

If a service user has already informed another organisation of their situation, ask whether they want to tell their story again or gain consent to receive details from the other organisation.

Example:

Do you agree to participate in the meeting? ☐ Yes ☐ No

Do I have your consent to document your responses on a tablet and/or paper ☐ Yes ☐ No

Do I have your consent to receive your information from the another organisation? ☐ Yes ☐ No

If yes: Proceed to ask more questions to determine whether to open a case file.

If no: Provide information about available services to the person verbally, as well as any relevant materials and/or hotline numbers to receive services in the future. If they require a one-off service or advocacy action, then conduct a quality referral.

Determine whether to open a case file

Caseworkers need to determine if the person has experienced, is experiencing, or is at immediate risk of experiencing a protection risk. See the questions Form 1: Intake. Remember, these questions should be used as guidance only.

Collect basic bio-data

Caseworkers need to collect demographic data on the person's age, gender and disability. To determine whether someone has a disability, the introduction and intake form has integrated the **Washington Group Short-Set of Questions (WG-SS)** on disability (see Form 1: Intake). This information does not help with referrals, nor with understanding the type of disability a service user has. It indicates whether or not they have a disability.

Collecting data on disability: What is the Washington Group short-set of questions and why use it?

Caseworkers must facilitate the full and effective participation of persons with disability in our services.

'Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others'. [15]

The WG-SS questions help identify disability by understanding who has difficulty doing basic universal activities (e.g. walking, seeing, hearing, cognition, self-care, and communication), and who may be at greater risk of facing barriers and/or not participating in home and community life. The WC-SS six questions are non-stigmatising, do not require medical knowledge, and use simple and natural language to refer to disability without using the word 'disability' - as using the word 'disability' can affect the way people respond. These questions have been used and tested extensively in many countries and contexts.[16] You must ask these directly to each person who is over 18 years old.

There are additional WG data sets if you have additional information needs:

- **Person with mental health and psychosocial disabilities:** For a better determination of people with mental health and psychosocial disabilities, the enhanced set can be integrated into Protection Case Management forms.
- **Extended set:** A set of questions that ask about more functional domains (e.g. affect, communication, upper body functioning, pain and fatigue), and more questions within each domain. It could be used as a special module for a more detailed analysis of disability.

For more information please see: Annex 4.2: Guidance on Washington Group Short Set Use.

Assess whether the person faces a specific risk

Caseworkers should use broad, open-ended questions that prompt the service user to start telling their story in general terms. You can always go back for details if appropriate and needed. Let the person take breaks and tolerate silences. Give them time to manage emotions and organise thoughts.

Tips for asking questions[17]

Using **TED questions** can help encourage the person to think about their situation, reflect, and provide a better overview of their situation. This gives the service user a feeling of control to avoid triggering or difficult memories:

- **T**ell me more...
- **E**xplain for me...
- **D**escribe what happened...

If you are unable to recognise whether the person is at heightened risk and need specific details, you can use **probing questions** to understand more: *who, where, when, where*, and *how*. Only ask such questions if the person is forthcoming with information. Make sure to be non-judgmental and neutral when you ask.

Who:

- *"Who else is involved or aware of the situation?"*

What:

- *"Can you describe what concerns you have right now?"*

When:

- *"When did this first start happening?"*

Where:

- *Is there a specific place where you feel more or less safe?"*

How:

- *"Can you explain how this situation is affecting you?*

Remember: You may naturally move into the protection risk assessment stage to gain a more comprehensive understanding of your service user's risk(s), resources and resilience. At this point, remind yourself that you still need to determine the specific protection risk type and case risk level and ask for informed consent to proceed.

Form 0: Intake and Response Criteria provides a detailed assessment framework for protection risks in your context, including descriptions of high, medium and low risk levels. The caseworker must determine both:

- The most relevant protection risk
- The appropriate risk level for the service user

As Form 0 cannot capture every possible scenario, consult your supervisor when uncertain about risk classification.

A helpful technique to close the discussion can be to summarise the person's story in your own words to check you have understood them and ask for any corrections.

Determine the risk level

Determine the case risk level and flag any case that might require immediate attention. Medium and high-risk cases should be prioritised for Protection Case Management Services.

Determining the risk level of each service user's situation will help caseworkers to prioritise a case appropriately within their broader caseload. It helps to determine the timeframe for intervention, indicates the frequency of visits needed, and how frequently the service user should require a follow-up. Risk level determination is an ongoing process as someone's level of risk will change over time. Risk levels should be reassessed at all stages of the process - from introduction and intake to assessment, as well as each follow-up visit.

Whenever possible, individuals and households at risk should be empowered and supported to independently access services and support. Those in this position are considered low-risk cases and do not require Protection Case Management services. These service users should still be provided with information on access to available services and assistance, and be supported to decide how to address their problem. This may be through conducting a one-off quality referral or advocacy action or by informing how to access a service themselves.

Ask for permission to proceed

After completing the session and assessing risk level, inform the service user about appropriate next services.

If the service user meets the prioritisation threshold for intake into Protection Case Management services and has fully understood the informed consent process, you must seek their permission to proceed for the next stage, intake. Consider the following:

- Before asking for consent to proceed, explain the process again, including the person's rights, confidentiality and its limits, and the risks and benefits of the process.

- You should use Form 3: Informed Consent and Registration which the service user can sign/thumbprint. Where possible, keep this form separate from the rest of the service user's case file. This ensures adequate separation between the service users identifying information and details about their protection situation. Important when storing data offline.

- Explain the next steps of the process. Agree on another date, time and location to meet. Provide the service user with the relevant hotline/work number and remind them of your name and organisation so you can be contacted if needed.

Note:
If the service user does meet the protection threshold for Protection Case Management services or chooses not to receive them, provide information about available services in their area, along with relevant information/ awareness materials and hotline numbers for future access. If they can benefit from a one-off quality referral or advocacy action, seek their consent to conduct the referral. Remember that situations change over time, and service users may return for reassessment of their eligibility.

Step 2: Protection risk assessment

Objective

A protection risk assessment is necessary to gain a comprehensive understanding of the service user's risks and resulting needs, resources and resilience, including their family composition, current living situation etc. A protection risk assessment also gathers relevant information to be passed to other service providers to facilitate referrals, if needed. It is designed to ensure that every service user receiving Protection Case Management services benefits from a consistent approach to evaluating their situation.

A risk assessment should be carried out within two weeks of a service user's intake. In some cases, a risk assessment may be carried out during Step 1.

Tasks

- Continue to explain the process as you did in Step 1 e.g. introduction, assess immediate safety risks, address barriers to participation in the meeting, start the process for informed consent/ assent to proceed
- Assess risks and resulting needs
- Assess protective strengths, capacity, resources and positive influences
- Reassess the risk level

Documentation

- Form 3: Protection Risk Assessment

The protection risk assessment builds on information gathered during the introduction and intake. To avoid repetition during this stage, fill in any information you have already gathered during the intake step into the protection risk assessment. The protection risk assessment sets the stage for the entire journey of the Protection Case Management process. This journey can vary widely depending on the outcome of the assessment and the type of risks and protective factors identified.

This process should help you and your service user agree on goals and actions for their case plan. This process should be done through a semi-structured interview, asking questions that invite the service user to participate. Remember, the protection risk assessment form is there to facilitate the documentation of this information but does not require you to ask every question with the service user. Only ask relevant questions based on the service user's needs.

Assess risks and resulting needs

During each discussion with the service user, caseworkers must assess their immediate safety and to ensure the appropriate on-going prioritisation of the case. As a caseworkers you should focus on:

- Understanding the service user's environment and their place within it
- Who the service user is, their potential needs for support and their urgency
- Recognising positive and protective influences and strengths

To do this, the following key areas should be considered:

- **The nature of violence**
  - Assess whether the service user faces an immediate risk of physical or psychological violence.
  - Determine if immediate medical care is needed while ensuring the safety of the service user.
  - Evaluate whether neglect is intentional or due to caregiver limitations (e.g. lack of time or resources).
  - If the service user expresses fear of violence, consider whether this fear is well-founded, giving them the benefit of the doubt when in doubt about potential harm.

- **The relationship of the (alleged) perpetrator to the service user**
  - Understand the closeness of the relationship between the (alleged) perpetrator and the service user.
  - Identify if the (alleged) perpetrator is a partner, caregiver, state or non-state actor, or plays a role in the household or community.

- Assess the (alleged) perpetrator's influence over and access to the service user to inform safety and case planning.
- Note any actions taken by the (alleged) perpetrator, such as legal measures.

- **Frequency**
  - If there is a history of recurring violence, coercion or deliberate deprivation, focus on understanding the most recent incident to assess current needs.
  - Avoid requiring the service user to recount every incident during the initial interview.
  - Allow the service user to share a full history of abuse if they choose to do so.

Where your service user is at-risk of danger (e.g. killing, kidnapping, abduction, enforced disappearance, or physical, emotional or psychological abuse or assault), the caseworker should complete a safety plan with the service user. This supports the caseworker to analyse the risk of harm in their lives and think about how to reduce those risks. Service users with other safety concerns may also be supported using this process. Some service users like to keep a copy for themselves so they can refer to it (see Form 8: Safety Planning).

- **Housing**
  - Assess the service user's living situation, noting risks such as safety concerns, exploitation, or isolation (if violence occurs in the home).

- **Economic situation**
  - Understand the service user's economic conditions, including their ability to participate in financial decisions and control resources.
  - Address these questions confidentially, prioritising the service user's perspective rather than that of the income earner or family decision-maker.
  - Recognise that lack of control over resources can increase protection risks like neglect and exploitation.

- **Physical health status**
  - Evaluate the service user's physical and mental health, including any disabilities, as these may influence their experiences of harm, family relationships, and unique protection risks.
  - Consider the interconnection between physical and mental health (e.g. poor physical health can worsen mental health and vice versa).
  - Develop a comprehensive understanding of health needs to inform referrals and recommendations.

- **Mental health and psychosocial status.**
  - Conduct a basic MHPSS assessment to evaluate mental health and psychosocial well-being. A list of options for assessment tools are listed in Table 2. Included in the form is the Patient Health Questionnaire-9 (PHQ-9) with minor adaptations (see Form 5: Basic MHPSS Assessment).
  - Determine if referrals to additional or specialised MHPSS service providers are required.
  - Before conducting assessments, review potential tools with a supervisor and choose an appropriate tool based on the population, context, and goals.
  - Adapt the tool as needed and complete training prior to use.

Table 2: MHPSS assessment tools

MHPSS assessment tool	Description
PSYCHLOPS	PSYCHLOPS is a short one page mental health outcome measure and can be used during the course of any psychotherapeutic intervention
***Patient Health Questionnaire-9 (PHQ-9)**	The PHQ-9 is a multi-purpose instrument for screening, diagnosing, monitoring and measuring the severity of depression

MHPSS assessment tool	Description
WHO Disability Assessment Schedule 2.0	WHO Disability Assessment Schedule 2.0 was developed through a collaborative international approach with the aim of developing a single generic instrument for assessing health status and disability across different cultures and settings
WHO Well-being Index (WHO-5)	The WHO-5 Well-Being Index is a questionnaire that measures current mental well-being (the previous two weeks). Originally developed to assess both positive and negative well-being, this five question version uses only positively-phrased questions to avoid symptom-related language

- **Access to services**
  - Identify barriers preventing the service user from accessing services and understand their root causes, such as non-inclusive service design, safety concerns or disabilities, lack of available services or information, stigmatisation or discrimination.
  - Use this understanding to inform the Protection Case Management plan.

- **Need for legal assistance**
  - Assess gaps in the service user's knowledge of their rights, which can increase vulnerability to rights violations and protection risks.
  - Recognise that access to justice aids recovery, reduces risks, and supports healing.
  - Determine if the service user faces barriers in accessing documentation or legal assistance and their willingness to receive help.
  - Facilitate access to civil status documentation (e.g. birth or marriage certificates) when needed to help the service user claim their rights.
  - Ensure that all individuals, including alleged perpetrators, can access legal advice and representation.

Assess protective strengths and capacity, resources, and positive influence

All service users, their families, and communities possess resources and skills to help themselves and contribute positively towards finding solutions to their own problems. Caseworkers and supervisors must work to engage service users and families to play an active role in the Protection Case Management process. Gathering information on a service user's family, social, and spiritual life and strengths can help to determine a service user's protective and resilience factors, which may support their healing and recovery. Do they have positive coping mechanisms? Are family relationships supportive? Are they members of a religious or community group? Is it safe and desirable for the service user to rely on these contacts for support in this instance? Are there community members supportive of the service user? A list of capacities is provided in Annex 2.1: Protection Analysis Capacities.

Take a strength-based approach

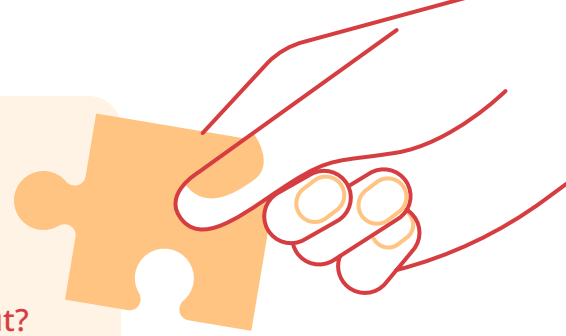
A focused discussion with a service user about their strengths and capacities can lead to opportunities to develop and share skills and strengthen connections. To start this conversation, it has been helpful for caseworkers to focus on three key areas:

1. What has worked for the service user before?
2. What doesn't work for them?
3. What might work in the present situation?

Areas you can explore[18]

Service user's situation, skills, interests

- What are you doing / managing well?
- Tell me something you are proud of?
- What interests you?
- When people say good things about you, what are they likely to say?



Support networks, community connections, resources

- Who are the special people you can count on?
- What connections do you have in the community?
- What role do you play in the lives of people you care about?
- Who supports you in your day-to-day life? In what way?
- What resources do you have around you to make this easier?
- How have you managed to survive this far given all the challenges you have faced?

Values, strategies

- What are the things in your life that you really value?
- What are your ideas about the current situation?
- What has worked for you in the past/what have you tried?
- How have you adapted?
- What have you learned which could be helpful moving forward?
- What's one thing that you could do to move forward?
- What would you like to get out of our work together?

Caseworkers can list the strengths (see Table 3) that are mentioned by their service user.[19]

Table 3: Examples of service users' strengths

Individual/inter-personal	Community
• Personal qualities, knowledge and skills, relationships, passions and interests • Health, finances, transport, housing	• Links with neighbours, supportive community groups, shared interest groups, community leaders • Health and social care services, community buildings, religious buildings, schools

This can help the caseworker and the service user to consider:

- How can these strengths (knowledge, experience, expertise) be used to the advantage of the service user?

- What other skills, knowledge, experience or expertise do people directly or indirectly involved in the person's life already have or need to acquire?

Caseworkers should try to have an objective understanding of the service user's views so that strengths are not underestimated. For example, someone who has been living with a severely reduced level of mobility for a long time may have become accustomed to the limitations in their day-to-day life. An objective understanding can help to reveal the true impact on the service user's wellbeing.

Documenting information

Whenever possible, caseworkers should use the service user's exact words when documenting meetings and discussions. This can be an essential method for monitoring progress and recognising potential problems. Caseworkers and their supervisors are responsible for ensuring that all case documents are complete and factual. Caseworkers should be careful to distinguish between facts and professional judgement, ensuring that all professional decisions and recommendations are substantiated and non-judgemental.

Reassessing the risk level

Refer to Step 1 (introduction and intake) for explanation on how to determine a service user's level of risk. For further support, refer to your localised Form 0: Intake and Response Criteria.

Step 3: Case action planning

Objectives

To detail the service user's assessed risks and develop specific, time-bound goals with the service user to address these risks. This can be through actions or services provided.

If a safety plan is necessary, it should be completed immediately with the service user.

Note: A case plan should be developed usually within two weeks after the protection risk assessment has been completed. This can take a number of sessions with your service user. However, case planning is done according to the urgency and complexity of the case.

Key tasks

- Repeat introduction, assess immediate safety risks, address barriers to participation in the meeting, start the process for informed consent/assent (see Step 1)
- Summarise the assessment and check in
- Define risks together
- Agree on goals together
- Agree on actions together
- Carry out safety planning
- Get informed consent for referrals
- Make accompaniment plans
- Document your case plan
- Agree when/where to have a follow-up visit
- Discuss any concerns with your supervisor

Documentation

- Form 2: Informed Consent and Registration
- Form 6: Case Action Plan
- Form 7: Referral
- Form 8: Safety Plan

The case plan

A case plan should be based on the comprehensive risk assessment and be consistent with the findings of the assessment, including the service user's available strengths and resources. The case plan should identify the agreed upon actions and items to address identified risks. It should be documented and regularly reviewed during the follow-up and updated accordingly.

Case plans and safety plans are different. A safety plan can be developed at any point when service users have specific safety concerns and need support in planning their response. For example, a service user receiving threats of violence from a neighbour due to their political affiliation might need to plan escape routes and essential items to take if the situation escalates. While safety plans address specific threats, case plans are broader documents that address all priority concerns and needs. Both types of plans are tailored to the service user's individual situation.

The service user is the actual owner of the case plan and developing the case plan must involve the service user. If the service user requests or the case's complexity increases, meetings can include the participation of supportive family members/carers and/or the supervisor, as long as it is safe and appropriate to do so. However, you must make sure that the service user makes the decisions and is not pressured to take actions in any way. Where a service user requires a multi-sectoral approach to address their problems, you can also consider calling for a case conference.

As a caseworker, you should generally avoid giving advice to service users even though it is a very normal reaction. For example, when working with a service user, showing signs of depression and expressing difficulty in making decisions, avoid giving direct advice – this could create dependency and limit their ability to manage future situations independently. Instead, provide clear information about available options, including the benefits, risks, and likely outcomes of each choice. This upholds the empowering nature of Protection Case Management while ensuring service users remain central to their own decision-making process.

Developing a case plan

Summarise the findings shared by your service user during the risk assessment. Include the service user's specific risks, resulting needs, and their protective capacities. Always check whether the summary is correct with your service user and whether there are additional points to add. Together, agree on the key risks the service user needs to manage.

Define the risks together

Although defining risks together can be challenging, it is an important process for the service user and helps to establish clear goals. These are two possible options to support this:

1. **Understand which risks are solvable, unsolvable or unimportant**[20]

   You can focus your discussion with the service user on those risks which are important but also solvable (i.e. you can influence).[21] Focus on risks which are important and solvable in your case plan. Record these with your service user, ensuring they are specific and practical. For example, instead of writing problems such as 'feeling worthless' or 'I need to leave the country', you should write problems such as 'the absence of my father's death certificate has prevented me from claiming my property'.

   - **Solvable risks** are those which together you can have influence over and reduce. For example, reducing your threat of eviction by seeking a written housing contract with your landlord.

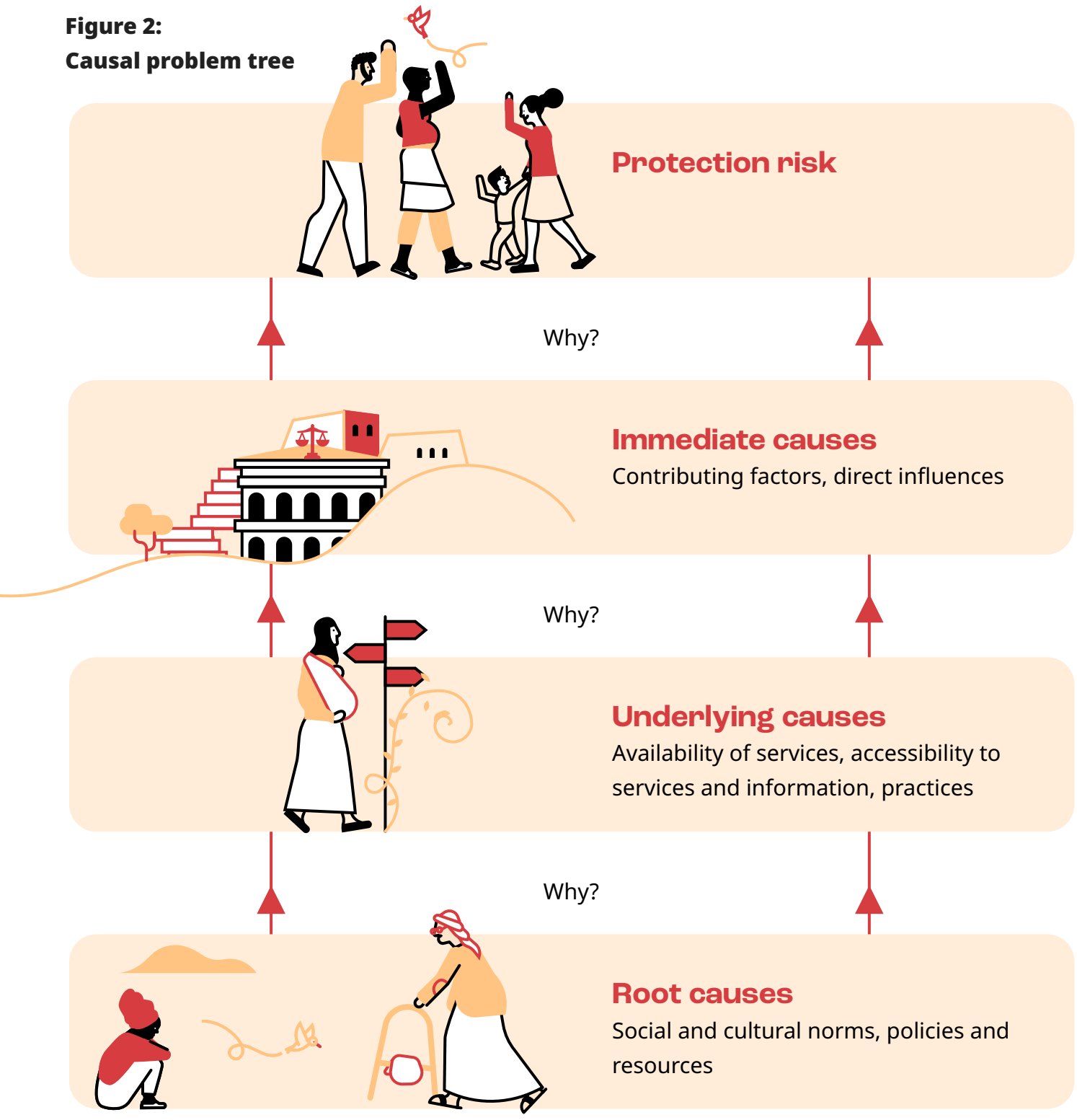
   - **Unimportant risks** are those which the service user doesn't think are important.

   - **Unsolvable risks** are similar to problems which you and the service user have little control over. For example, an internally displaced Sudanese person may be at risk when returning to his home and may want the crisis there to end.

2. The problem tree

Discuss with your service user the root causes, the underlying causes, and the immediate causes of their problem. This can help the service user to see how challenges are related, process them, and focus on what they can change. The main way to do this is to keep asking why (see Figure 2).[22]

Figure 2:
Causal problem tree



Agree on goals together

The caseworker has the responsibility to present all possible options and consequences to the service user, and the service user is the primary decision maker to identify their goals with the support of the caseworker.

1. Asking these questions can help service users define their goal: *How would your life (e.g. daily living) be different if you did not experience this risk/problem? What change do you want to see?*

2. Consider how you and the service user could incorporate their MHPSS needs into their goals. For support, please refer to Annex 4.4.2: Client Coping Plan. This resource, found under MHPSS interventions for caseworkers, is designed to assist caseworkers in developing coping plans with service users. The caseworker does have an important role in ensuring that goals identified by the service user are realistic and helpful in the short and long-term. For example, it would be inappropriate to list 'resettlement' as a desired outcome. Identified goals must be measurable and achievable. To do this you can provide them with information on available options, such as services and actions, and the benefits and risks of those options (draw on an up-to-date and accurate service mapping).

Agree on actions together

This is what needs to be done to accomplish the goal. This may take several sessions to complete, but continue to support your service user to make the decisions themselves. A combination of different actions may be needed, and each should be listed separately:

- **You can break down the overall goal into manageable tasks**. For example, a man who has a physical disability and wants to find work may need to get information about what work is available, learn about what is needed for different jobs, and register on a vocational training course.

- **Ensure that actions are feasible, and do not expose the service user to further risk**. For example, if an action requires the service user to travel to another location, discuss risks related to the travel – including barriers, checkpoints and costs – to ensure that the action is feasible.

- **Look to build on and enhance the service user's strengths and resources at the individual, household and community level**. You can draw on their protective factors to help reduce their risk. For example, service users who feel socially isolated could be supported to volunteer in their local community centre, or, where safe to do so, a service user can ask a family member to remind them to exercise or to walk with them to reduce stress.

- **Name who is responsible for the actions**. There may be more than one responsible person/organisation, but aim to separate responsibilities according to specific tasks when possible. The caseworker should always be responsible for a minimum of one action per goal (such as monitoring the case plan). If multiple actors share responsibility for tasks under one goal, or if several interrelated goals involve various actors, consider organising a case conference with all relevant participants.

- **Agree on a timeframe for actions**. This is the date the action is intended to be completed. It should not be binding, but it can give the service user an understanding of when they can expect the action to be completed, while also making sure to manage their expectations. For example, when making a referral, note the receiving organisation's expected response times and explain to the service user that these are estimates. Keep the service user informed of any feedback received or potential delays.

Safety planning

A caseworker must develop a safety plan with any service user who indicates immediate or ongoing risk of violence or harm. Based on a thorough safety and security assessment, this plan enables the service user to follow pre-determined actions when their safety is compromised. Through collaborative planning, service users identify potentially dangerous situations and develop strategies to react and reduce harm.

Using either the integrated protection risk assessment or a separate safety planning form, develop the safety plan with your service user. This can be incorporated into Form 8: Safety Plan or maintained as a separate document as needed. When conducting safety planning, clearly

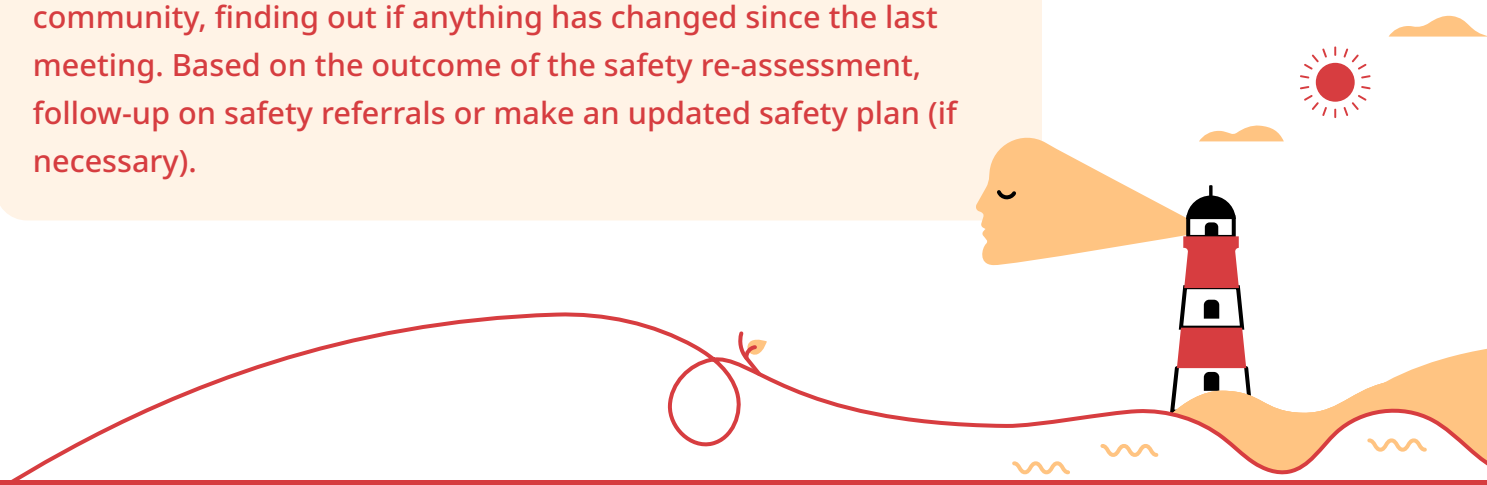
communicate to service users that the goal is to help reduce potential harm – not to suggest they are responsible for controlling when or where they might experience violence.

The key tasks of safety planning are to:

- Help the service user identify patterns in the abuse or harm. For example, does it happen in certain places or at certain times?
- Identify strategies for avoiding situations in which they may be at-risk.
- Identify safe people and places that the service user can go to in an emergency. Identify any potential risk and barriers.
- Consider other barriers that a service user could face while trying to escape and seek support.

Safety planning requires a very individualised approach and will look different depending on the type of violation (i.e. risk of abuse, risk of enforced disappearance, suicidal ideations, imminent risk of eviction etc.) and what options and resources are available to the service user. Usually, there are some coping mechanisms already in place. The key is to find out what is already working for the service user and build upon it. As the service user begins to identify potential responses and resources, help them to plan exactly what they would do in potentially threatening situations.

Caseworkers should assess a service user's safety during every visit. During follow-up visits, caseworkers should ask specific questions about the service user's safety in their home and community, finding out if anything has changed since the last meeting. Based on the outcome of the safety re-assessment, follow-up on safety referrals or make an updated safety plan (if necessary).



Annex 4.3

Suicide Safety Plan

Introduce this plan for those at risk of suicide. You can use this optional script: *"A safety plan[23] helps us to understand the warning signs that you may not be safe, and helps us to come up with a plan to help you to feel safe when needed. You will bring a copy of this home with you and you can look at it and use the tools anytime you feel the warning signs."*

1. What are thoughts that make me feel like hurting myself and/or ending my own life?

   _____

   Feelings?_____

   Situations?_____
2. What activities can I do to help myself feel calm? What has worked in the past?

   _____
3. What are my reasons for living?

   _____ _____ _____ _____
4. Who can I talk to when I am upset and feeling like hurting myself or ending my own life? (include more than one person)

   _____ Phone number_____

   _____ Phone number_____

   _____ Phone number_____
5. Is there anything I can remove from my environment to make me safer? (e.g., lethal means)_____
6. Things I can do when I am not feeling safe:

   Places I can go:_____

   Professional I can call:_____

   Hotline number:_____

   If I am in danger of hurting myself or fear for my safety, I must call emergency response or go to nearest hospital.

   Emergency number:_____

   Closest hospital (address and phone number): _____

   _____

   _____

Get informed consent for referrals

Remember, when needing to refer a case, seek a service user's permission to share information. This can be done using Form 7: Referral. If referring by phone, do not share confidential information in a public space. Only share information that the other party needs to know to support the provision of services to the service user.

To obtain informed consent, caseworkers should explain and discuss with the service user:

- The referral process, and what potentially will happen as a result
- The risks and benefits of the intervention (e.g. medical treatment, shelter assistance, etc.)
- Their rights to decline or refuse any part of an intervention provided by the caseworker or the receiving organisation at any time, their right to request the deletion and removal of this information at any time
- Explain what information will be shared with the receiving organisation and how it will be protected - according to your data protection protocols

Reminder: If informed consent is not given, do not proceed with the referral. Instead, provide them with the relevant information should they change their mind.

Make accompaniment plans

For referrals, caseworkers should develop accompaniment plans when service users want someone to go with them to other agencies or service providers. Discuss this carefully with service users, as in some settings, caseworkers are known in the community. Even the simple act of a caseworker walking a service user to a facility or police station may raise community curiosity and inadvertently break confidentiality. Always use strategies that safeguard service users' confidentiality throughout the referral process.

How to document your case plan

Once you and your service user have discussed and developed your case plan, it may be helpful to conduct a review with your supervisor. Once finalised, go over it with the service user one final time.

Once reviewed, you and your service user can sign the case plan. Remember to review and update your case plan during follow-up visits. When actions are completed or no longer relevant or feasible, mark the completion in the 'date completed' column. You should then make sure you note the justification for this in Form 9: Follow-up and Monitoring.

Agree when/where to have a follow-up visit

The caseworker should discuss with the service user options for a follow-up visit and be very specific about where it will take place and when. When arranging follow-up visits, it is important to discuss with the service user what barriers could prevent or get in the way of them being able to make a follow-up appointment.

Refer to Step 1 to address barriers to participation. Possible options include:

- Make appointments for the service user to come to your centre/ facilities
- Make sure the facility is accessible for the service user
- Meet the service user inside another service provider's office if that protects their privacy better
- Visit them at home if this does not compromise safety or confidentiality and is preferred by them

Discuss any concerns with your supervisor

If issues arise during your case planning regarding urgent safety concerns, discuss them with your supervisor before you close the session with the service user.

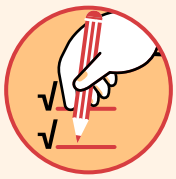
Step 4: Implementation of case action plan

Objectives

To work with the service user, the family, and the community and service providers (when possible and appropriate) to ensure the service user receives appropriate actions as part of the goals in their case plan.

Consent for referrals can be taken during case planning. Service provision timeframes are set in the case plan and followed up by the caseworkers and their supervisor.

Implement this step directly after the case plan is completed and endorsed.



Key tasks

- Repeat introduction, assess immediate safety risks, address barriers to participation in the meeting, start the process of informed consent/assent (see Step 1)
- Direct service provision
- Referral
- Lead case coordination

These steps are not in order.

Documentation

- Form 7: Referral
- Where appropriate, repeat Form 5: Basic MHPSS Assessment regularly

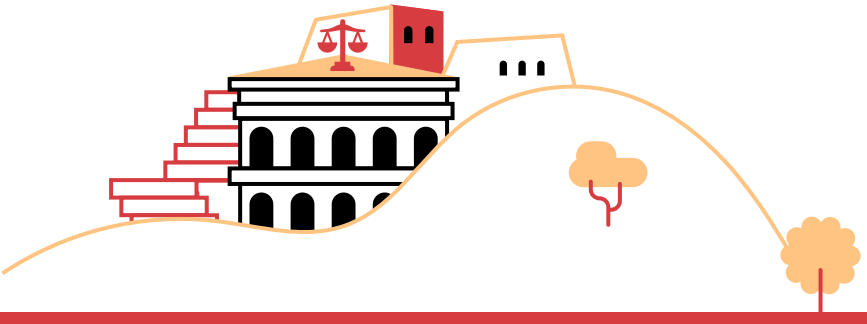
Direct service provision

Caseworker support depends on the skills, circumstances and programme goals and objectives. Direct support may include MHPSS support and counselling, direct cash support (to reduce protection risks), working with family members, and/or a carer with service user consent.

During the Protection Case Management process, you can provide psychological first aid through non-intrusive care and support. This includes:

- Assessing needs and concerns
- Helping service users address basic needs (such as food, water and information)
- Listening to service users without pressure to talk
- Offering comfort and creating a calming environment

Caseworkers help service users connect to information, services and social support networks to protect them from further harm. In contexts with limited referral options, MHPSS from the caseworker becomes crucial and should continue throughout the process. You can support service users in following their agreed accompaniment plan for referrals, including accompanying them to service providers, and, with appropriate training, provide referrals or facilitate cash support for assistive devices, but only in coordination with specialised service providers. Due to the potential for harm associated with the incorrect use or unsuitable prescription of such aids, ONLY health workers and trained/qualified workers can facilitate access to these products. See Annex 3.2: Guidance Note on Provision of Assistive Devices for more details.



Provision of mental health and psychosocial support

Protection Case Management is an empowering and service user-centred process, which is a mental health and psychosocial intervention in itself, in parallel with on-going care and support provided. Caseworkers can provide emotional support through their non-judgmental, caring manner with the service user. This can be nurtured through healing statements, active listening and calming techniques. Helping a service user to restore their coping strategies and reconnect with friends and community can provide a great source of strength and comfort. Caseworkers can also be trained in specific sessions to better support service users in various ways.

Individuals respond to stress, distress and difficult life events in a variety of ways that are informed by their age, race, ethnicity, sexual orientation, gender identity, nationality, religion, development, experiences, temperament, culture, faith, community, and support. Some may need basic support while others may require focused support or specialised care. As an individual evolves through experiences and their needs change, the types of support and services that are beneficial to them also change. Equally important to recognise, the response to stress and mental health concerns by individuals, groups, and communities is greatly impacted by the social experience of discrimination, structural racism, and oppression. Additionally, some individuals, groups and communities will benefit from coordinated suicide prevention, safety planning, and crisis response services. Therefore, service providers must recognise that essential services may only be beneficial if they are also perceived as safe by the individual, group or community.

For more detailed information on providing MHPSS through Protection Case Management see Annex 4.4: MHPSS Resources and Activities. For service users in severe distress, see Annex 4.5: Working with Clients in Severe Distress, Self-harm and Suicidal Ideation.

Referrals

When service users cannot access services, a caseworker must contact the relevant service provider - either directly or through a supervisor. Ensure the relevant service is provided in a safe and accountable manner to the service user through a quality referral.

Referrals (with consent) can be made to formal specialised services and non-formal community-based groups. These may include internal organisational services or external providers offering legal support, CP, sexual and gender-based violence, health, MHPSS, shelter, and other support., CP, check this health, MHPSS, shelter, and other support. Assess the quality of all referred services and identify any barriers before making referrals

Referrals often work best when caseworkers are familiar with the services offered and the staff providing them. You should continually educate service users about relevant services and service providers. Develop strong working relationships with referral agencies.

Service mapping

Caseworkers should have access to a regularly updated and accurate mapping of services when meeting with a service user. If this is not available through your local coordination systems, your team may have to develop one by consulting with referral receiving agencies. It's crucial to have information about the accessibility of service providers. When referring to a person with a disability, the caseworker should conduct an accessibility audit of the service provider to identify any barriers. These barriers should then be communicated to the service user. This way, actions to remove the barriers can be established before the service is accessed.

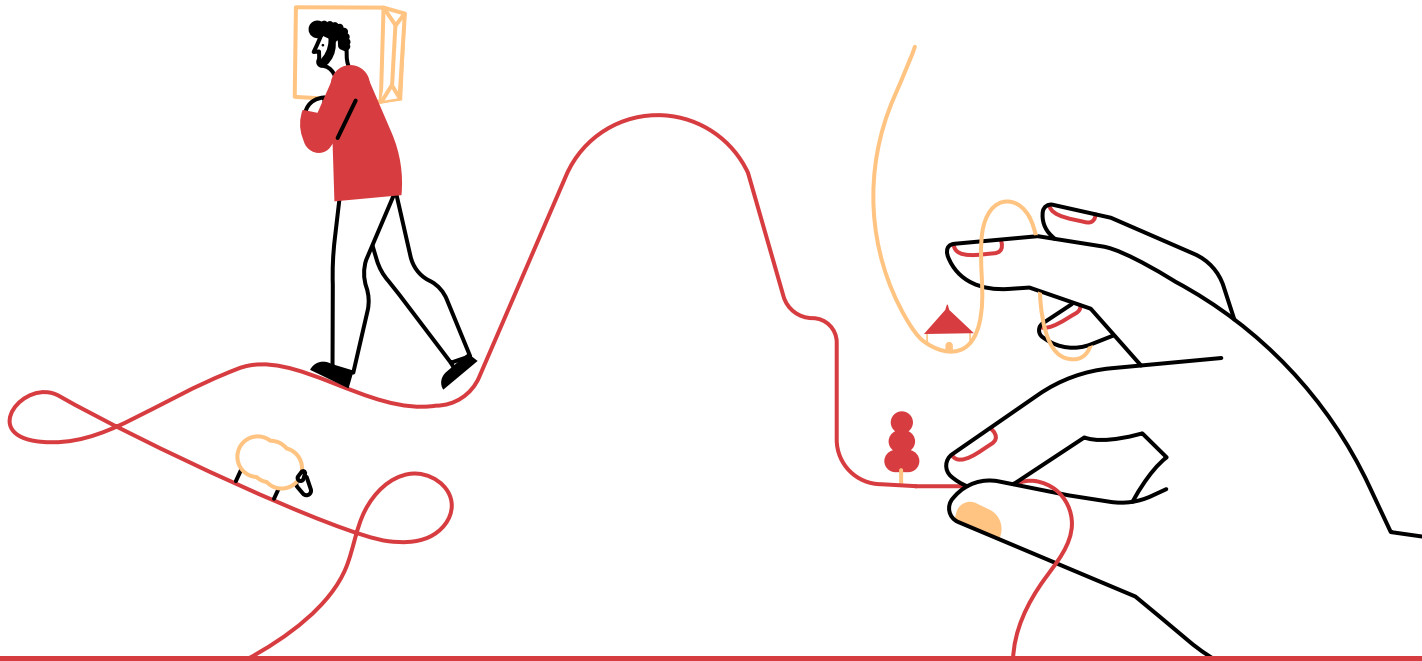
While various organisations involved are responsible for providing their specific services, Protection Case Management agencies maintain overall responsibility. This includes following up with both service user and service provider to ensure quality assistance is provided and risks are mitigated.

Caseworkers must seek permission to share information for each new referral conducted using Form 7: Referral.

Lead case conferencing

A key role of a caseworker is to coordinate any care and services received by the service user, acting as a liaison between the service user and service providers, advocating for timely and quality care, and working with service providers to reduce barriers for the service user's access.

Therefore, you are responsible for following-up referrals to make sure services are provided in a timely manner. When necessary and appropriate, organise a meeting with the main actors and service providers involved in the case plan. Discuss the case plan and find short-term and/or long-term solutions. This procedure is best reserved for complex cases and when a service user's needs are not being met in a timely or appropriate way. Note that the service user (and their family members) do not usually attend. These meetings provide opportunities to review activities, establish progress and barriers, map roles and responsibilities, look for solutions, and adjust current service plans as needed.



Step 5: Follow-up and monitoring

Objective

To assess progress on case plan goals and ensure the plan remains relevant.

Follow-up and monitoring is undertaken from the time the case plan is agreed until the case closure or transfer. The frequency of follow-up visits depend on the risk level/urgency of the case.

Case review meetings with supervisors and other relevant meetings should also be documented in this phase. Every significant interaction with the service user should be documented in the case follow-up form.

Key tasks

- Repeat introduction, assess immediate safety risks, address barriers to participation in the meeting, start the process of informed consent/assent (see Step 1)
- Follow-up with your service user and monitor progress
- Reassess risks and revise your case plan
- Ask for informed consent for further referrals
- If necessary, you may need to develop a safety plan

Documentation

- Form 9: Follow-up and Monitoring

Follow up with your service user and monitor progress

Throughout Protection Case Management, caseworkers and their supervisors are responsible for following up with their service users and monitoring progress made toward the case plan - agreed with the service user, the service user's family/carer, and other relevant service providers.

You should follow up with service users regularly, based on the case's risk level. Supervisors and caseworkers should agree on the appropriate steps for follow-up and case monitoring.

During these follow-up sessions, provide updates on the implementation of assigned actions in the case plan, discuss any challenges or difficulties, and/or collect information on changes or outcomes which have occurred since the initial risk assessment.

Adjust the case plan in agreement with the service user in response to these new developments. Here is a summary:

- Meet with or contact the service user as agreed.
- Reassess the service user's risk/safety.
- Reassess the service user's mental health and psychosocial wellbeing. Use the Form 5: Basic MHPSS Assessment to determine any changes. You can do this after a sudden event or on a regular basis.
- If you observe significant changes, consult your supervisor about developing a safety plan or completing the suicidal ideation assessment in Form 5: Basic MHPSS Assessment. This can be done at any point, with the service user's agreement.
- Review and update the case plan with the service user each visit.
- Revise the case plan with the service user, making sure to document outcomes of referrals, emerging risks and schedule a follow-up visit.
- Implement the revised case plan, making sure to obtain informed consent for new referrals.

Remember: Often, a service user's situation can change. New information emerges or a plan is not effective. Protection Case Management is not a linear process. You need to be prepared to circle back to the assessment and planning phase and revise your case plan. Don't worry, this is a usual occurrence.

Step 6: Case closure or transfer

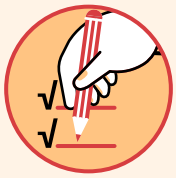
Objectives

To ensure the safe, responsible and appropriate termination of services for the service user. This process should be done in consultation with the service user and when the case plan goals are achieved or services are discontinued for other legitimate reasons (e.g. death, relocation, request of service user, etc.).

A case transfer is a last resort in specific situations. This is usually due to greater technical proficiency or geographical proximity, ensuring the best possible service provision for the service user.

Documentation related to case transfer should:

- Explain the reason for the transfer
- Outline discussions with the service user regarding the transfer
- Include proof of the service user's consent for the transfer
- List the information provided to the new organisation as part of the transfer process



Key tasks

- Deciding when to close a case
- How to document a closed case
- Case transfer, if applicable

Documentation

- Form 11 Case closure

The conclusion of Protection Case Management services may depend on multiple factors. While initial risk assessment and case planning might indicate a time-limited intervention for specific issues, new concerns may emerge that question whether ending the relationship is appropriate.

Deciding when to close a case

Service users, caseworkers and supervisors review the case and discuss closure together. With the service user, identify any issues or matters of concern that may require ongoing support or assistance. Always reassure the service user that they can return if they have new issues or challenges. Cases can be reopened.

Reasons for case closure

- When it is agreed that the goals set in the case plan have been met, there are no additional protection risks, and the service user and their family (if relevant) will no longer benefit from continued Protection Case Management services.

- If the service user cannot be found or contacted for a minimum of 60 days, despite repeated attempts, the case can be considered closed. All attempts to contact the service user must be recorded in the service user file. The case file can be reopened in the event the service user returns.

- The service user wants to close the case for any reason. Our goal is to respect their wishes.

- If a service user is deceased, the case will be closed. However, support for the family must be considered. When providing services alongside government partners, ensure any death is reported to the relevant government department.

- When the service user's primary needs cannot be met, and/or the service user does not wish to receive direct support or be visited on a regular basis, the case can be closed.

Future planning approach

For service users with complex, long-term needs, they or their family may request ongoing Protection Case Management support. This requires planning for anticipated changes and agreeing on points of future contact. Some service users may need recurring support until they reach a durable solution. Even when current involvement ends, you can agree with the service user to resume contact at specific future points, such as during significant transitions.

How to document a closed case

Caseworkers are charged with completing the case closure form and reviewing the case with their supervisor to obtain approval. Review all the forms in the service user's file and ensure the case file is complete. Ensure that the service user's file is appropriately archived according to your organisation's policies.

Closed case files should be stored in a secure and private place for a specific period of time. Check your organisation's data protection protocol or national legislation.

Case transfer

Avoid transferring cases unless absolutely necessary, such as when service users relocate to another area or country, the organisation implements an exit strategy, or technical quality requires transfer to ensure better services. When better services are not guaranteed, consider case conferences or joint support instead. Good coordination between Protection Case Management streams (CP and GBV, and other technical teams) from the start can prevent unnecessary transfers.

Case transfer shifts the full responsibility for case plan coordination, follow-up, and monitoring of the service user to another organisation or department. Develop a hand-over plan with the receiving organisation - communicating this to the service user and family/carer when relevant. Best practice includes the current caseworker introducing the service user to their new caseworker.

In situations where whole caseloads are transferred to another organisation or government department, review all case files to confirm transfer safety and verify the service user's consent to share information.

Summary of key points

The establishment of a supportive relationship with a service user is key to successful Protection Case Management.

Prepare for your Protection Case Management sessions using this guidance, review your documentation, seek advice if you need it, and reflect the objectives of each step of the process to frame each session.

Continue to request consent and ensure the service user is aware of any risks associated with the agreed upon follow-up action.

We document our Protection Case Management sessions to improve learning, bring accountability to our practice and to improve the quality of service delivery.

If you are ever unsure of what action to take, seek advice from your supervisor.

Up next

Module 5: Professional Development and Staff Care

This module is designed especially for senior caseworkers, supervisors, managers and human resources professionals. It provides the tools and insights needed to effectively support Protection Case Management staff, offering strategies to address the risks and challenges they encounter while prioritising their well-being and professional growth.

In this module, you'll find answers to the following questions:

- **How can I ensure staff care throughout the implementation cycle?**
  Providing core action to keep staff safe and healthy, as well as detailing the differing approaches to take for staff care through the entire Protection Case Management implementation cycle.

- **How should I approach team professional development and supervision plans?**
  Defining the elements of successful supervision, offering practical advice on implementing structured supervision systems that promote team development, knowledge exchange, and emotional support through regular debriefing sessions.

Annexes

Endnotes

1 This is part of a universal but ambiguous concept in social work called 'use of self'. There is a large body of literature on this subject. As a start, see: Dewane, Claudia J. Clinical Social Work Journal; New York Vol. 34, Iss. 4, (Dec 2006): 543-558. DOI:10.1007/s10615-005-0021-5

2 UNHCR, *Interview Learning Programme: My Workbook*, 42

3 UNHCR, *Interview Learning Programme: My Work Book*, 21

4 WHO, *Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity*, 2018, 21-24, available at: https://apps.who.intWHO_MSD_MER_16.2_eng.pdf;jsessionid=sequence=1

5 Active listening involves empathetically engaging with the service user's message and emotions by identifying feelings and perspectives behind their words, maintaining a non-judgmental attitude to create a safe space for open communication, reflecting their words to show comprehension and clarify any misunderstandings, and paying close attention to non-verbal cues such as body language and tone of voice. This approach ensures a deeper understanding of the service user's experiences. To learn more, read: Active Listening, Carl Rogers, or watch this short video: Carl Rogers Active Listening - YouTube

6 Additional information and tips on using active listening techniques are included in Basic Psychosocial Support Skills resources which can be found on the MHPSS MSP website: https://www.mhpssmsp.org/en/activity/activity-introduction-6#page-1

7 Center for Substance Abuse Treatment, *Trauma-Informed Care in Behavioural Health Services*, 2014, chapter 4, available at: https://www.ncbi.nlm.nih.gov/books/NBK207188/box/part1_ch4.box5/?report=objectonly

8 Excerpt adapted from I*nter-Agency GBV Case Management Guidelines*, Part IV, Chapter 3, 2017, available at: https://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf

9 In CRPD, and related General Comment on Article 12, available at: https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no-1-article-12-equal-recognition-1

10 Adapted from IRC, Guidance for Focus Group Discussions, *A Scoping Study on Strengthening Accountability & Inclusion of Persons with Disabilities in Humanitarian Action through Service user-Responsive Programming.*

11 Excerpt adapted from I*nter-Agency GBV Case Management Guidelines*, Part IV, Chapter 3, 2017, available at: https://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf

12 Even caregivers are rarely legally permitted to consent to or refuse support on behalf of a service user.

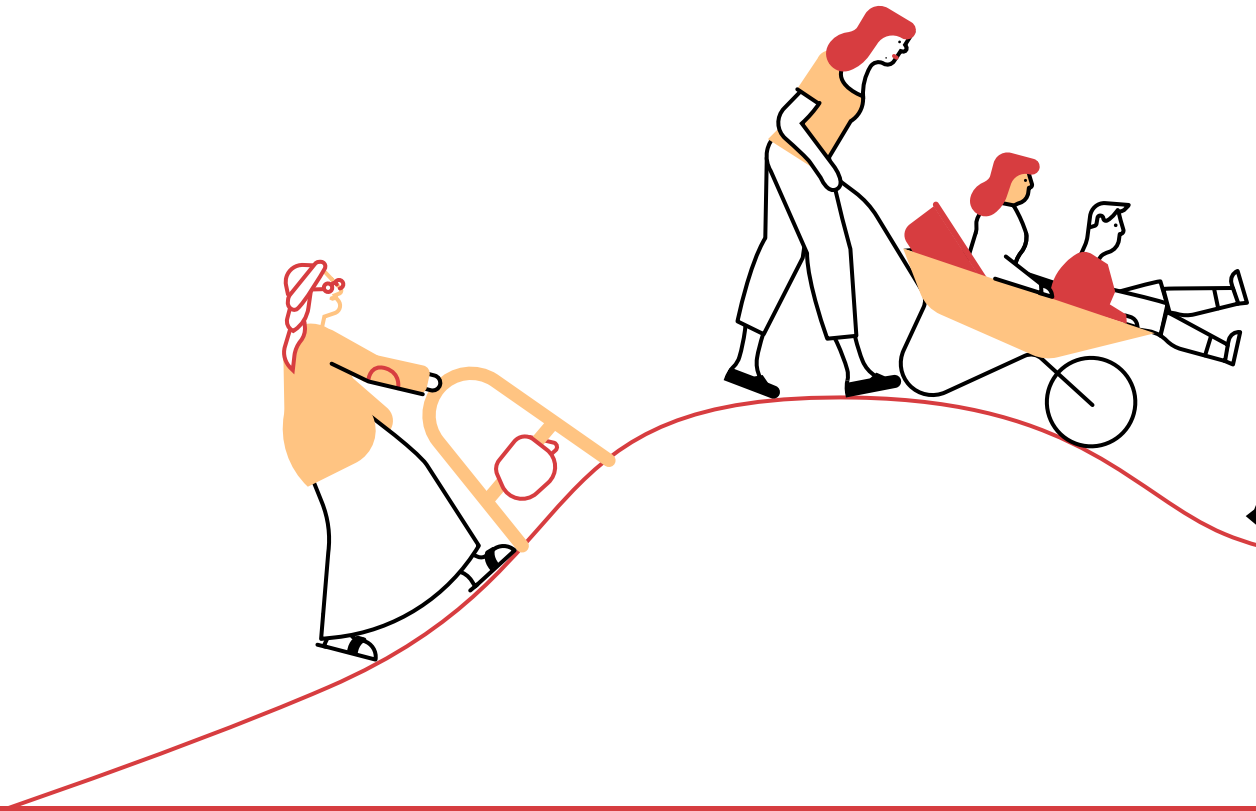
13 UNHCR, *Policy on the Protection of Personal Data of Persons of Concern to UNHCR*, 2018, 17, available at: https://www.refworld.org/policy/strategy/unhcr/2015/en/120873

14 Ibid. 14.

15 UN Convention on the Rights of Persons with Disabilities (CRPD) and optional protocol, Article 1.

16 From the statement of rationale for the Washington Group general measure on disability, available at: https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/

17 UNHCR, *Interview Learning Programme: My Work Book*, 74



18 Pulla, *A Strengths-Based Approach in Social Work: A distinct ethical advantage*, 2017

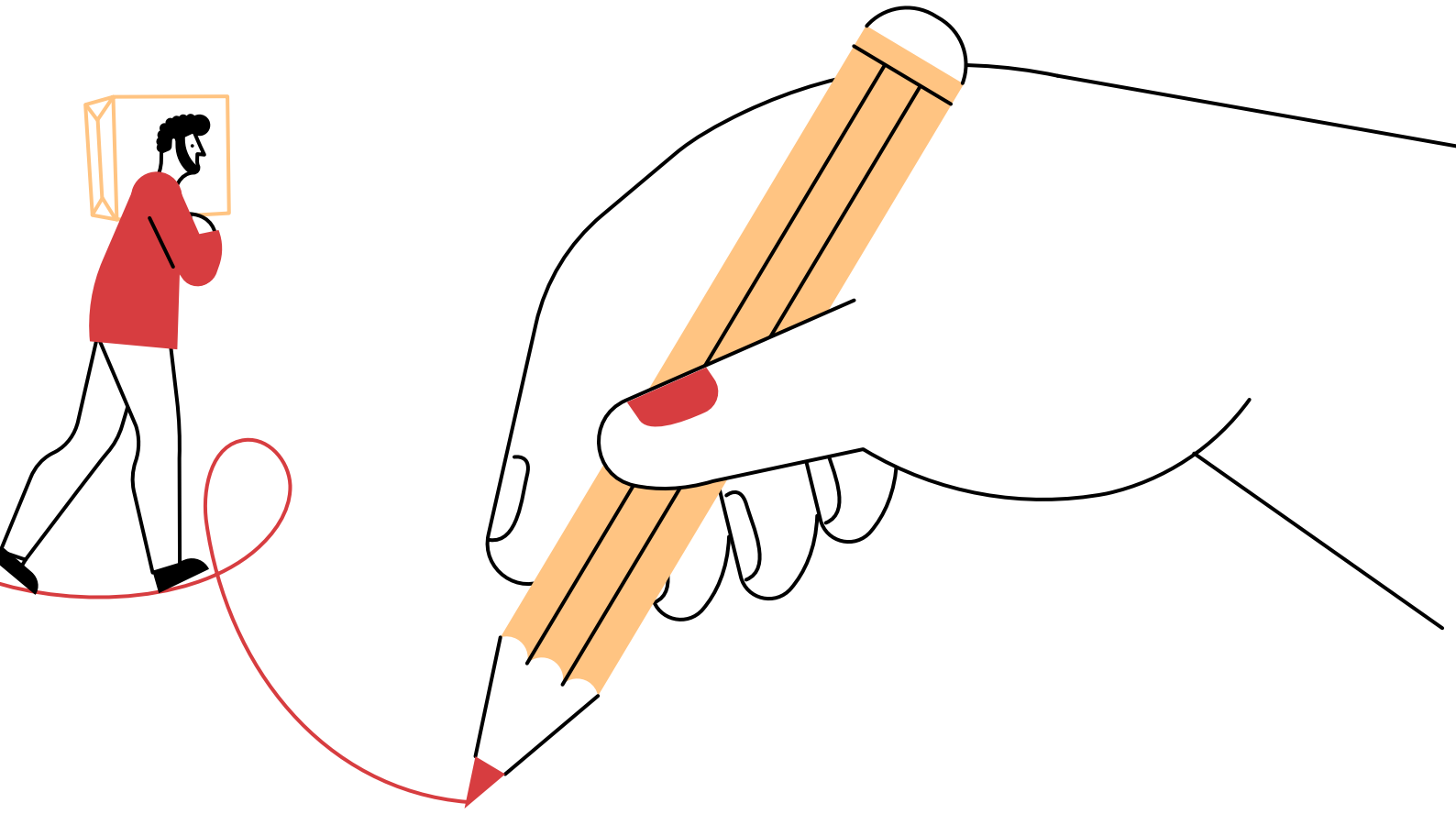
19 A common approach in social work case management practice. Promoted by the Social Care Institute for Excellence, available at: https://www.scie.org.uk/strengths-based-approaches/videos/concept

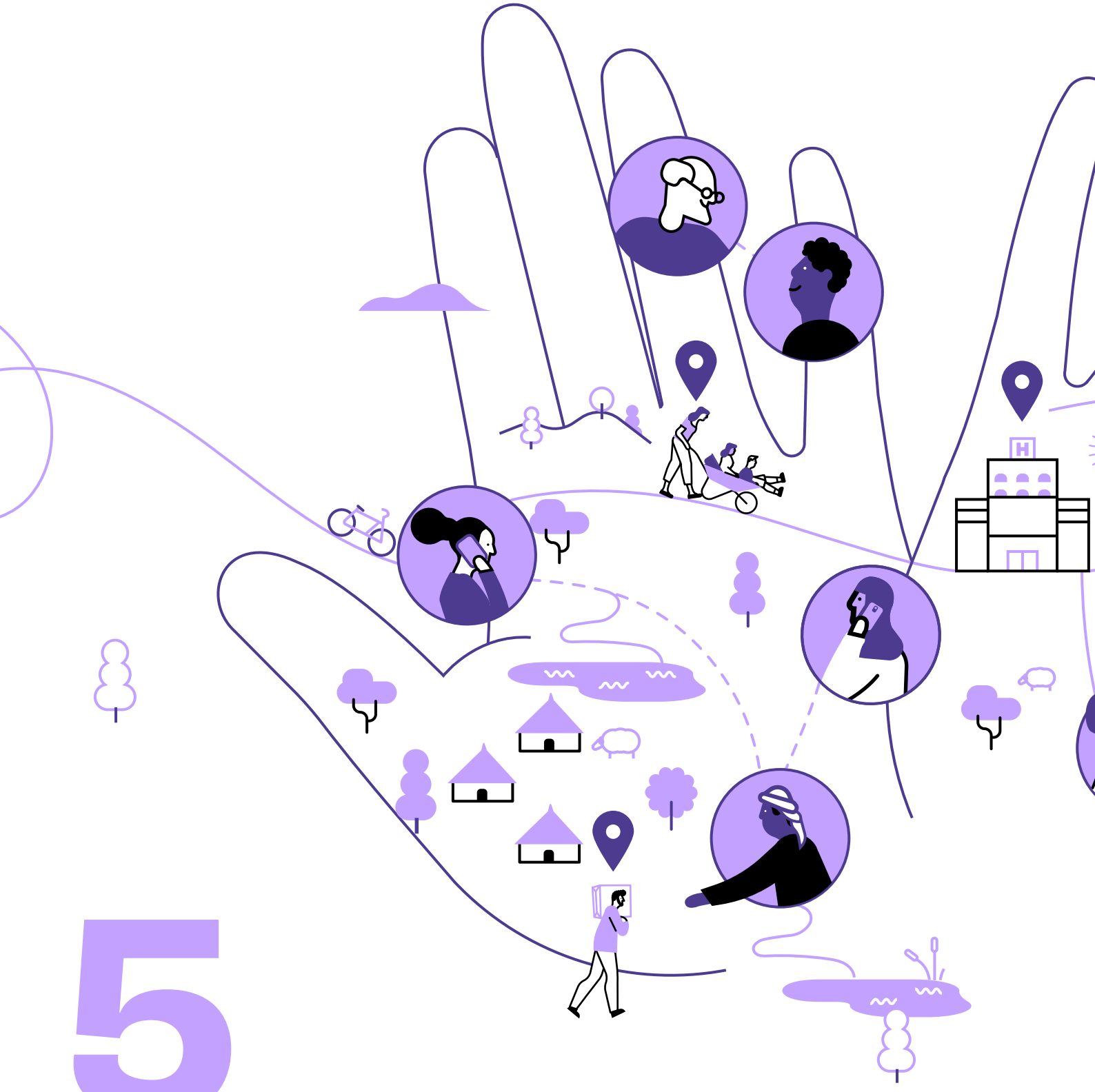
20 WHO, Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity, 2018, 27, available at: https://www.who.int/publications/i/item/WHO-MSD-MER-18.5

21 Ibid. 47

22 For a step by step guide see: GPC Protection Mainstreaming Toolkit, 2017, 70, available at: https://globalprotectioncluster.org/publications/64/policy-and-guidance/tool-toolkit/gpc-protection-mainstreaming-toolkit

23 Adapted from International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support and Suicide Prevention, and Suicide Prevention during Covid-19





5

Professional Development and Staff Care

Welcome to Module 5. This module is designed especially for senior caseworkers, supervisors, managers and human resources professionals. It provides the tools and insights needed to effectively support Protection Case Management staff, offering strategies to address the risks and challenges they encounter while prioritising their well-being and professional growth.

In this chapter, you will find answers to the following questions:

- **How can I ensure staff care throughout the implementation cycle?**
  Providing core action to keep staff safe and healthy, as well as detailing the differing approaches to take for staff care through the entire Protection Case Management implementation cycle.

- **How should I approach team professional development and supervision plans?**[1]
  Defining the elements of successful supervision, offering practical advice on implementing structured supervision systems that promote team development, knowledge exchange, and emotional support through regular debriefing sessions.

How can I ensure staff care throughout the implementation cycle?

Providing Protection Case Management services can be demanding, especially on the psychological well-being of caseworkers, staff and volunteers. Organisations have both a legal and moral obligation to safeguard and promote the welfare, mental health and psychosocial well-being of their employees. It is their responsibility to take reasonable steps to mitigate foreseeable risks to both the physical and psychological health and safety of staff.

Caseworkers and Protection Case Management team members often encounter stories, information and images involving conflict, suffering, loss, abuse, violence and torture on a regular basis. Many team members come from the same communities as their service users, which may also be affected by conflict and crisis. This puts them at heightened risk for vicarious trauma, as they might be personally impacted by the same events (e.g. loss of property, loved ones) or know individuals who have suffered, while facing personal risks themselves.

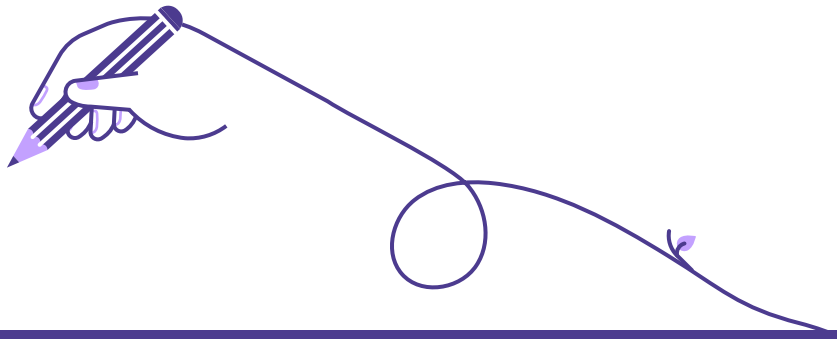
Hopefully your protection teams have done some thinking around staff care and training previously as part of duty of care. This module introduces supervision as a core method of supporting Protection Case Management staff. Supervision in social work and case management is a structured process in which a more experienced professional provides guidance, support and oversight to caseworkers. It aims

to ensure that practitioners deliver high-quality services while maintaining ethical standards,[2] developing their skills, and managing their emotional well-being. Supervision helps staff reflect on their practice, enhance their decision-making, and improve outcomes for clients by providing a safe space for feedback, learning and professional growth. It also serves as a way to monitor performance and ensure accountability in service delivery.

Table 1 provides core actions to keep staff safe and healthy when setting up and monitoring Protection Case Management services.

Table 1: Actions and suggested steps and resources to ensure care for Protection Case Management Teams

Core actions to care for Protection Case Management teams	Suggested steps and resources
☐ Establish policies and concrete organisational mechanisms to protect and promote the mental health and psychological well-being of caseworkers and other staff delivering Protection Case Management services. This may include clear policies for professional development and clear staff care policies, as well as providing care resources, such as benefits and compensation for professional support and time off.	☐ Gather resources and support by talking to your HR Department. ☐ Seek advice from other case management/ agencies. ☐ Talk to frontline staff about their practices. ☐ Document supervision sessions to identify opportunities for beneficial institutional change.



Core actions to care for Protection Case Management teams	Suggested steps and resources
☐ Ensure protection and gender analysis informs all aspects of operations, including recruitment practices. Actively seek to hire women and individuals from marginalised groups, as their perspectives are essential for tailoring Protection Case Management services. Employing staff from the affected population is invaluable for culturally responsive and gender-sensitive support.	☐ Include support teams in any protection analysis, seeking their recommendations. ☐ Click here for guidance offering several recommendations on adopting conflict-sensitive recruitment and staff support practices from Lebanon.
☐ Cite potential work-related stressors in recruitment postings; discuss them with candidates during the recruitment process to assess their suitability for the post.	☐ Contact your HR department to discuss introducing this standard across all job descriptions, not only Protection Case Management vacancies.
☐ Provide staff with information on the support services available during onboarding induction, including MHPSS services (e.g. peer-to-peer support systems, self-care resources) and how to access support.	☐ MHPSS skills you develop in your Protection Case Management training will provide information relevant to your staff and team as well. ☐ Supervision is an opportunity for support. See advice on staff care, below.
☐ Define working hours, monitor overtime and provide for rest and recuperation for both national and international workers. For example, ensure that staff have sufficient paid time off and promote an expectation that workers take sufficient breaks during the working day.	☐ Talk to your HR department to ensure this is included in orientation and inform staff if there are any changes. ☐ Make recommendations to your HR department based on feedback from your team.

Core actions to care for Protection Case Management teams	Suggested steps and resources
☐ Assess and monitor work that causes potential stressors and risks to mental health. Take action to address, mitigate or eliminate these risks.	☐ You have a shared duty of care along with your HR department and senior management, consult with them as required.
☐ Support your teams to help them look after their own mental health and psychosocial well-being, including ensuring teams have access to mental health care.	☐ Train teams on self-care and basic psychosocial support skills to help them to look after their own mental health and psychosocial well-being, as well as interacting with each other in a supportive way (see MHPSS MSP activity 3.2).
☐ Train all staff, including managers, supervisors, caseworkers and supporting staff on their role in monitoring and mitigating work-related stressors, as well as how to respond to workers who are experiencing distress or have experienced/ witnessed extremely distressing events.	☐ Use basic psychosocial support skills. ☐ Guide staff members or volunteers through reporting protocols. ☐ Connect them with available supports (see MHPSS MSP activity 2.1).
☐ Develop an explicit protocol for reporting on and responding to highly adverse/ distressing events, which should include offering basic psychosocial support immediately after the event (see MHPSS MSP activity 3.2).	☐ Adapt guidance in Annex 4.5: Working with Clients in Severe Distress, Self-harm and Suicidal Ideation in consultation with your local MHPSS working group/local mental health actors.
☐ Provide a forum for caseworkers, staff and volunteers to ask questions, express concerns about risks to themselves and their colleagues and share ideas for improvement.	☐ Supervision is great for this, see below. ☐ Opportunities to debrief outside the organisation is also useful. This can be external supervision or peer groups of staff working in similar fields.

Core actions to care for Protection Case Management teams	Suggested steps and resources
☐ Prevent and mitigate the effects of stress, provide easy, equitable and affordable access to culturally appropriate emotional support for all staff. Strategies and guidance can be found here.	☐ Ensure your budgets or medical insurance packages have a provision for mental health care. ☐ Discuss regularly with your team how to support each other and what the organisation can do to provide support. ☐ Consider inserting self-care practices at other moments in your team's day.

Establishing professional boundaries

The onboarding period should place emphasis on developing a strong understanding of a caseworker's roles and responsibilities. This will enable staff to make independent decisions within their role boundaries, maintain clear service boundaries, and effectively communicate these limits to service users and community members. Encourage staff to openly share their experiences, especially with new team members, on how they maintain a healthy work-life balance. These conversations can help foster a supportive environment. Some key areas to discuss as a team include:

- **Understanding boundaries for physical affection:** Explore what is comfortable and professional for each person.
- **Social media and personal information:** Set clear guidelines for online interactions and the sharing of personal details, including contact information.

- **Managing hospitality offers:** Develop strategies for responding to offers of hospitality during home or site visits while maintaining professional boundaries.

- **Establishing working hours:** Clearly define work hours and fairly distribute any on-call responsibilities to avoid burnout.

- **Seeking support:** Recognise when it's time to seek guidance or help from a supervisor.

- **Engagement after case closure:** Clarify appropriate boundaries and steps to take once a case has been closed.

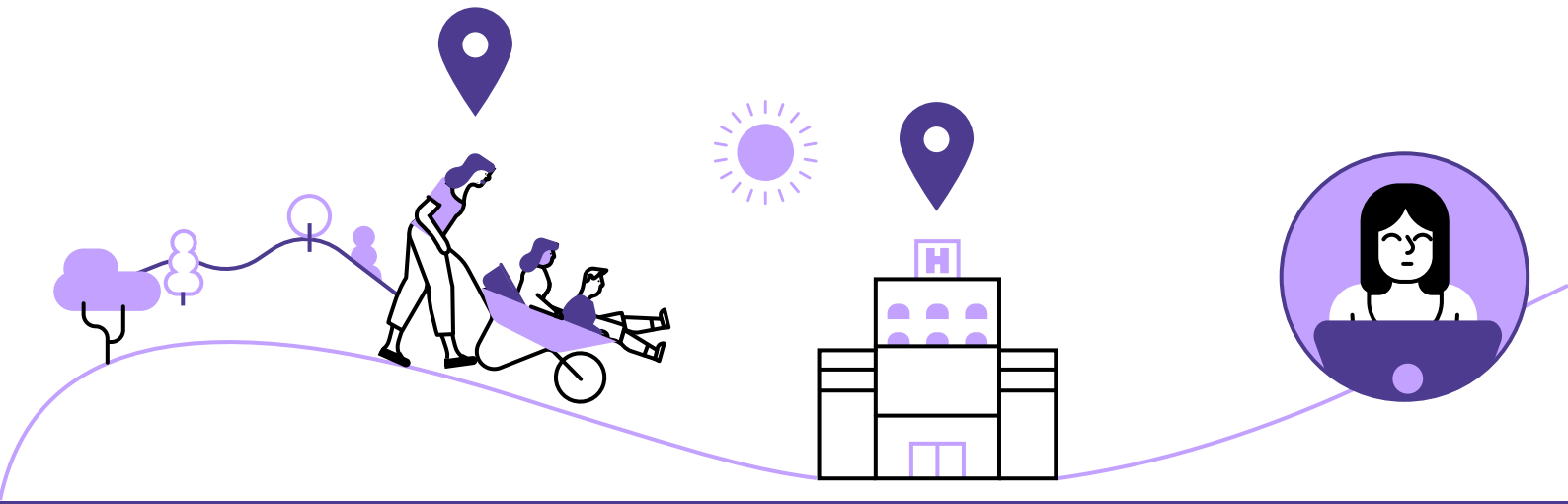
By addressing these aspects alongside other common challenges, there is a potential to positively influence cultural and social practices. Here are the key questions for you and your staff to reflect on:

- Could this action or behaviour affect my or a service user's safety or well-being, either immediately or in the future?

- Does this action or behaviour have the potential to undermine a service user's coping strategies and create dependency?

- Will this action or behaviour limit the level of control that either the participant or I have in the participant-caseworker relationship?

Encouraging thoughtful consideration of these questions helps ensure safe, supportive, and empowering interactions with service users.



Creating a collaborative supportive professional space

Creating a space where caseworkers can communicate freely, both in supervision sessions and within a supportive, collaborative professional culture, will enhance your team's well-being and the effectiveness of your supervision, thereby benefiting your programme. Discuss within your teams what strategies they would see as helpful in creating an openly communicative environment. Examples of this have previously included:

- Planning social events
- Celebrating and sharing caseworker and service users' successes
- Celebrating personal milestones in team members' lives like birthdays, graduations or promotions
- Investing in beautifying the workspace with art, plants, a private corner, or social area
- Developing a team motto and turning it into a poster or a team t-shirt
- Conducting a "rose-bud-thorn"[3] exercise on the last day of the week

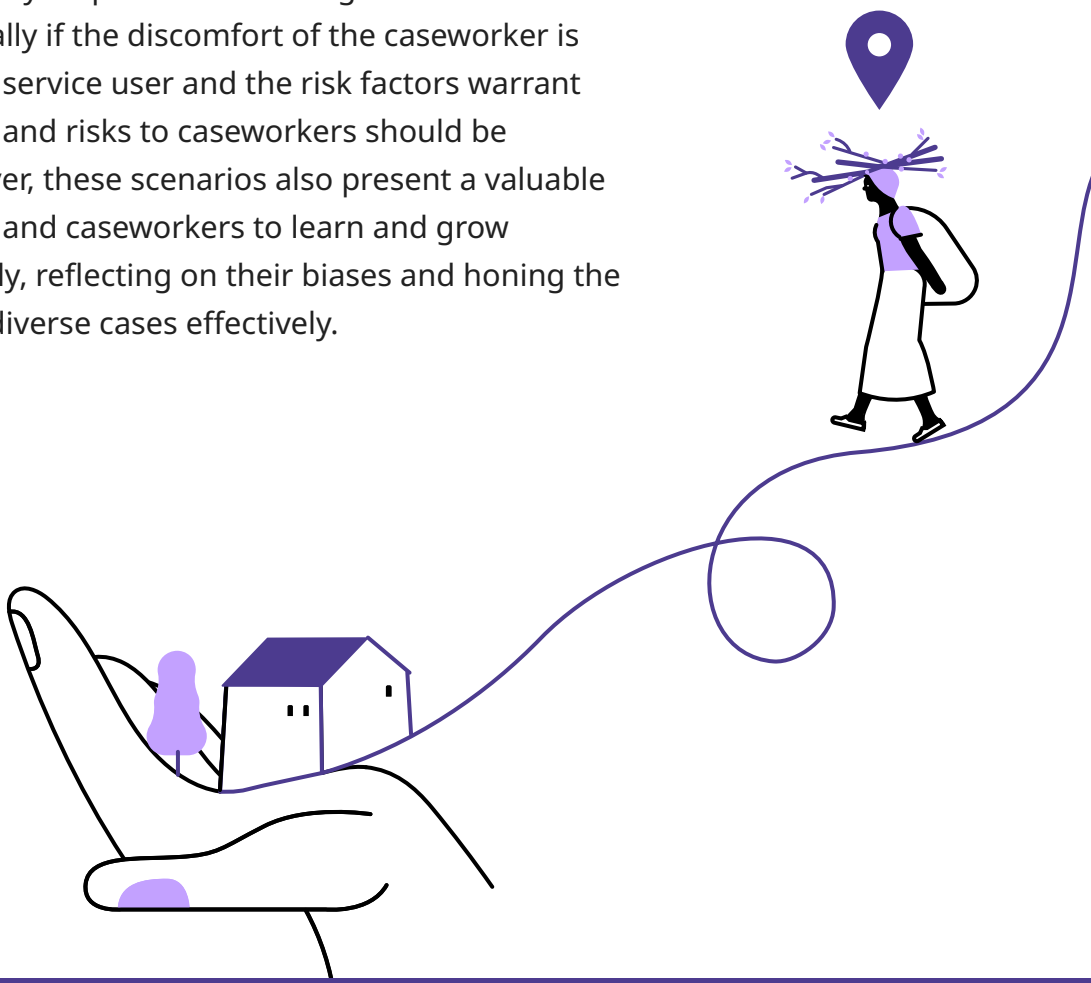
Ensure there is allocation in the budget to invest in creating a supportive workspace. Build strong collaboration across sections and include other teams, strengthening Protection Case Management work.

Case allocation

As noted in the Protection Case Management standards in Module 3, best practice dictates that caseworkers should not have more than 25 cases allocated to them at any one time. This standard should be reviewed and adapted, and potentially decreased, based on local nuances and the severity of the cases. As a supervisor or senior staff

member, you may have a role in allocating cases and ensuring your staff's wellbeing. Based on your staff's experience and the service user's profile and support needs, you may consider allocating fewer cases. Established programmes have reported allocating experienced caseworkers a maximum of five service users at a time due to the high risk involved. Other programmes have opted not to allocate high risk cases and reduce caseloads for new caseworkers as they develop their skills and understanding of Protection Case Management. Caseworkers managing a large caseload of clients exhibiting symptoms of severe distress may also benefit from a reduced caseload. This adjustment can help to ensure that the MHPSS needs of the service users are adequately met while also prioritising the well-being of caseworkers.

Caseworkers may experience discomfort with supporting certain cases. For example, a caseworker might prefer working with individuals of a specific age, gender, race, ethnicity or religion; or they may hesitate to engage with individuals from groups associated with negative past experiences. This tendency is known as bias - it is a natural aspect of human behaviour that everyone possesses. When managing such situations, it's important for the caseworker and supervisor to discuss a way forward together. It may be prudent to reassign these cases to another caseworker, especially if the discomfort of the caseworker is significant or impacting the service user and the risk factors warrant it. Both risk to service users and risks to caseworkers should be carefully considered. However, these scenarios also present a valuable opportunity for supervisors and caseworkers to learn and grow professionally and personally, reflecting on their biases and honing the skills necessary to address diverse cases effectively.



All volunteers, caseworkers, and supervisors should be trained to recognise their own biases and prejudices, challenge them, speak up against microaggressions, and handle situations respectfully with service users, colleagues and supervisors.

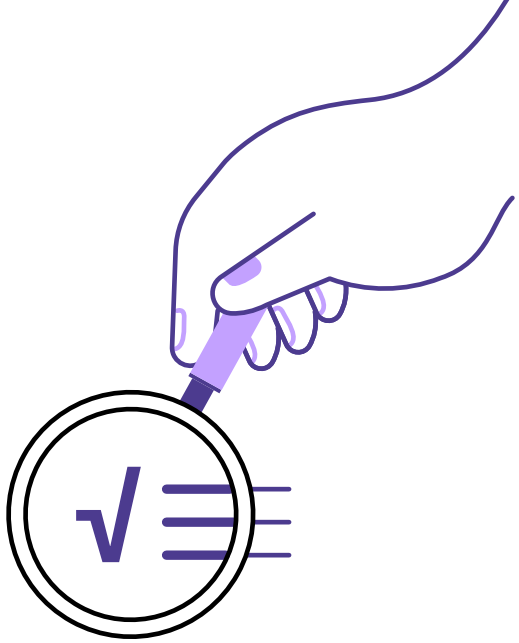
Staff care after a critical incident

Critical events are sudden, violent occurrences that threaten or claim lives. In a Protection Case Management context, caseworkers in the past have faced critical incidents such as the death of a service user, violent encounters with community members associated with a participant, and detention or threats from authorities due to association with marginalised under threat communities or caseloads, amongst others.

In Module 4, you will have learnt or reviewed how to anticipate and develop mitigation and response plans for critical incidents. To guide your response to a critical incident if it occurs, several resources are available. This resource from UNHCR provides a particularly detailed brief on how to recognise a critical event (page 14) and respond (page 32). Additionally, your organisation may already have support in place for staff in response to such an incident or guidance that your Protection Case Management team would benefit from being aware of prior to implementation.

A note on the role of human resources in staff care[4]
Workforce mental health, psychosocial well-being and staff care is the responsibility of management, human resources departments and occupational health departments (where they exist). The human resources department in your organisation plays an essential role in creating a supportive and healthy work environment, fostering staff wellbeing, satisfaction and productivity. While protection teams, particularly supervisors and caseworkers, may offer useful insights on workforce well-being strategies and the suitability of support services and organisational plans, it is crucial that these responsibilities remain primarily with management and HR departments.

How should I approach team professional development and supervision plans?



Ensure that your team's professional development and supervision plans are systematically integrated into broader programme or project plans. Revise and update these plans as regularly as you revise your protection analysis and intake criteria to make sure that training plans reflect the evolving needs of individuals prioritised for Protection Case Management services. For example, if your analysis identifies high mental health needs among the prioritised population, this may prompt you and your programme to ensure consistent and ongoing MHPSS training and technical support for your implementing team members. You should also revise these plans based on trends observed during supervision sessions, such as identified areas for team-wide development, trends in your current caseload or feedback from service users.

Whilst the focus of this module is on targeting caseworkers and supervisors, do not forget to ensure that support staff and senior management staff often require some level of training or other support to understand Protection Case Management processes. This can support them to promote and contribute to quality Protection Case Management programming in their roles. In addition to team plans, supervisors are responsible for developing a supervision plan for each

caseworker based on their capacity assessment and their changing needs. This plan should detail each supervision activity, including its frequency and scheduled dates. Organisations who have a human resources-led individual development plan process may opt to merge these two processes.

Training

Protection team members must complete adequate training for their role. For caseworkers, the five-day Protection Case Management training is a minimum standard prior to registering cases. When recruiting an individual staff member into an existing team without immediate planned training, consider having the new caseworker shadow a more experienced colleague until their training can be arranged. During this period, it's beneficial for them to study this guidance and other relevant resources (such as these) as a temporary measure until the next training opportunity becomes available.

After two to three months of field experience, caseworkers often benefit from a refresher Protection Case Management training. This can be adapted to address the challenges and concerns in a learning forum, building upon the foundations and experiences already developed. Whilst Protection Case Management training should be a priority, ensuring caseworkers are made available to attend other training relevant to their role/caseloads is encouraged, such as the below:

- How to support survivors of gender-based violence when a GBV actor is not available in your area
- MHPSS for caseworkers
- Wellbeing and Resilience for Frontline Staff and Managers
- Inclusive Humanitarian Action

If your team is implementing Protection Case Management, ensure service users have some emergency coverage while the team is engaged in training.

Similarly, Protection Case Management supervisors and managers must develop their capacity to protect and support the mental health of those being supervised, understanding when and how to provide support. Supervisors should receive a five day training in supervision and coaching, like this one developed by the Alliance for Child Protection in Humanitarian Action. Another strong resource for ongoing learning and capacity building of supervisors and capacity officers supporting teams providing MHPSS services is the Integrated Model for Supervision.

Roles and strategies of individual and group supervision in programme quality and staff care[5]

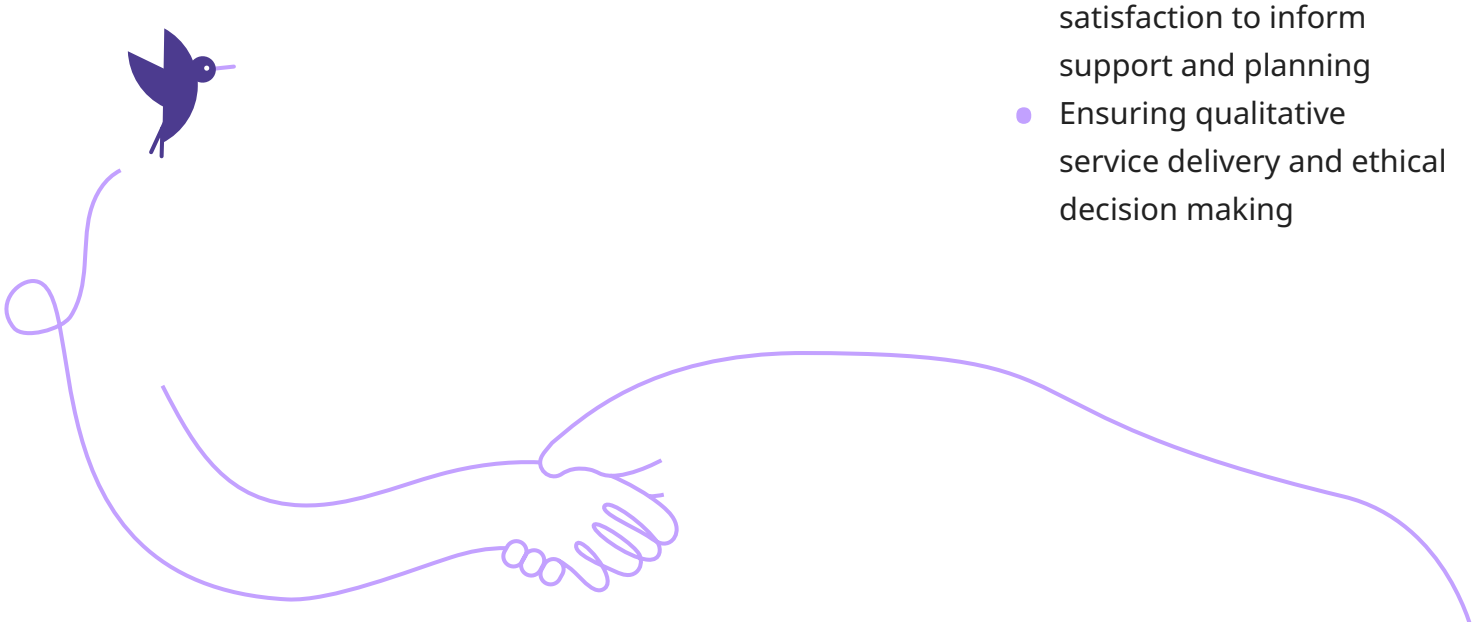
All Protection Case Management teams should have at least one case supervisor responsible for ensuring that staff are trained and prepared for their roles. To facilitate this role, case supervisors should:

- Regularly monitor caseworker and officer practices
- Provide support to ensure services are delivered in line with best practices
- Oversee no more than five to six caseworkers
- Be available for consultation in emergency situations
- Provide regular case supervision to caseworkers
- Develop and nurture impactful supervision practices through regular and structured sessions

The relationship built and maintained through these sessions is key to effective supervision. Supervisors may be dedicated solely to the supervision role or have additional responsibilities, depending on your staffing structure and the assigned duties within that structure. For more information, see Module 3: Staffing.

Table 2: Required functions of supervision within Protection Case Management

Functions	Purpose	Includes
Accountability and administrative	To ensure competent, accountable practice of staff	• Planning and assigning work • Coordinating with other actors • Documentation and reporting • Material and logistical support • Reinforcing programme protocols and ethical standards • Monitoring and evaluation e.g. using information on case profiles, workload and participant satisfaction to inform support and planning • Ensuring qualitative service delivery and ethical decision making



Functions	Purpose	Includes
Educational and professional development	To ensure staff are continually building knowledge and skills	• Assessing competencies • Collaborating on personal learning plans • Promoting reflective practices • Reinforcing guiding principles
Supportive	To ensure the emotional and psychological wellbeing of teams	• Creating a safe space for reflection • Promoting self-care and a work life balance • Having empathy and normalising feelings • Reinforcing realistic expectations and healthy boundaries • Offering recognition and encouragement • Sharing available resources and information

Supervision is important because it enhances service users' safety - supporting caseworkers to reduce errors, minimise neglect, offer a safer environment and provide quality Protection Case Management services.

Coaching is at the heart of supervision. It is an attitude that places the caseworker as the driver of their own development. The supervisor's role as coach is to use specific practices to help the caseworker recognise their strengths and challenges and assist them to set realistic goals towards achievement. Coaching also helps the caseworker to *reflect* upon his or her work and role.

Table 3: Overview of supervisor and caseworker roles in meetings

Supervisor role	Caseworker role
Prepares for supervision sessions in advance, including anticipating issues, creating an agenda, etc.	Comes prepared and actively participates in the supervision sessions to support reflective learning
Develops a safe space for the caseworker(s) to speak about their work in their own way.	Identifies practice issues which they need help in, and what supervision practice is useful to them
Gives useful, insightful feedback and supports the caseworker(s) to explore and clarify their thinking	Is open to feedback and seeks clarification if needed, proactively engaging to seek solutions
Share information, knowledge and skills appropriately	Develops a level of trust in supervision to share their work issues, wellness or personal issues/concerns/bias that impacts working with service users
Challenges practises that are considered unethical or risky, as well as personal and professional blind spots	Uses supervision to identify learning and development needs
Manages the time and structure of individual sessions and meetings	Uses individual sessions and meetings to review and reflect on current workload
Reviews and updates capacity building plan(s) during individual sessions and, when appropriate, during meetings	Identifies what supervision practice is useful to them/their colleagues
Ensures everyone is given space to participate in meetings	Supports the other caseworkers and respects confidentiality

Key supervision strategies

The effectiveness of supervision in Protection Case Management can be enhanced by implementing these key strategies for effective supervision:

1. **Regular and consistent supervision**
   - Schedule supervision meetings once a week
   - Set a consistent meeting time to allow both the caseworker and supervisor to prepare and set expectations
   - Provide ad-hoc support, when necessary, but ensure it does not replace regular supervision meetings

2. **Collaborative supervision**
   - Encourage staff to come to supervision meetings with an agenda, identifying the cases they want to discuss, specific questions and topical areas of technical support:
     - Give the caseworker the space to talk first before asking questions
     - When conducting group activities, provide an environment for discussion so that caseworkers can learn from one another
     - Problem-solve with the caseworkers, allowing them to lead the process before providing solutions
     - Discuss caseworkers' personal reactions to their work, including personal issues or biases that could impact their relationships with service users

3. **Opportunities for learning and professional growth**
   - Use supervision sessions to support caseworkers' learning and professional development:
     - Give the caseworker the space to talk first before asking questions
     - Provide concrete feedback on what the caseworker did well
     - Ask the caseworker to reflect on what they think could have been done differently or better and provide your feedback

- Offer opportunities for role-play to practise suggestions and demonstrate accurate techniques
- Emphasise the importance of showing what they did or said to the service user, not what they think they should have done, explaining this is the best way for them to learn and for you to provide support

4. **Creating a safe environment**
   - Ensure supervision meetings feel like a safe space for caseworkers:
     - Caseworkers should feel comfortable and supported
     - They should be able to make mistakes without judgement
     - They should receive constructive feedback, not criticism
     - Use a private space
   - Keep supervision meetings separate from any HR activities, such as performance monitoring meetings

Before you begin supervision

Supervision within Protection Case Management may be a new experience for your staff, especially if they do not have a background in social work, psychology or health, where this type of supervision is a common practice. Take the time to explain supervision to staff and be patient as they become comfortable with the process. Supportive actions to get off to a good start with supervision might include:

- An orientation session on what is supervision - HR should partner with you and attend to highlight the delineation between their practices and this one
- Scheduling a supervision session ahead of time with your caseworkers so they can prepare for it, including sharing any forms you will be collaborating on
- Holding a supervision session in a comfortable location away from the office to emphasise the distinction between this process and a performance review
- Beginning each supervision session with a briefing on the objective of the session, make time for the staff member to ask questions

Supervision approaches to support program quality and staff care

Individual supervision meetings

Individual supervision meetings with caseworkers are one of the best ways a supervisor can provide support to caseworkers and monitor the quality of their work. These meetings are regularly scheduled one-on-one sessions between the supervisor and caseworker that can address all three core functions of supervision. For more information, go to Record Form 1: Individual Supervision Meeting.

Frequency/duration

- Depending on the schedule of the team, individual supervision meetings can be held for an hour once a week or as frequently as the team decides is useful.

- There may be times when an urgent case discussion is required to address concerns or roadblocks in the care of high-risk service users. This is different from a structured individual supervision session, but ensures that caseworkers know they do not need to wait for their individual supervision sessions to raise urgent issues.

Guidance

Preparation: Both supervisors and caseworkers are responsible for preparing ahead of the meeting, depending on the week's activities and any other topics discussed in previous meetings or within a capacity building plan. This preparation can include:

- Specific cases to discuss

- Questions from the caseworker

- Feedback or guidance from the supervisor

- Supervisors should create an environment of openness where caseworkers are encouraged to reflect honestly.

Supervision components

- **Administrative:** The supervisor should discuss any administrative or logistical challenges and update and review the total caseload. If these updates are extensive, they might be set aside for a programmatic meeting outside of the supervision space.

- **Development:** The supervisor should review any skills, knowledge or learning that the caseworker or supervisor has identified as a priority. Supervisors should refer to Supervision Form 1: Caseworker Capacity Assessment.

- **Supportive:** The supervisor should use this time to check in with how the caseworker is feeling in their practice and managing their stress levels generally. The supervisor should explore and review self-care strategies or additional support services if needed.

- **Feedback on Supervision Practices:** Supervisor can provide constructive and positive feedback based on whatever supervision practices have been completed that week (e.g. observation visit, case files reviewed, shadowing visit)

- **Case Discussion:** The supervisor should review a challenging case with the caseworker - as outlined in Supervision Form 5: Case Discussion.

Group supervision meetings

Group supervision meetings are regularly scheduled gatherings between the supervisor and the team. These group meetings can address the functions of supervision, but should not be used as a replacement for individual supervision. They are useful for promoting learning exchanges between caseworkers, as well as providing technical support on common challenges the supervisor has identified across caseworkers. For more information, go to Record Form 2: Group Session Meeting.

Frequency/duration

- Group supervision meetings should be held once every 1 to 2 weeks at the same time for a minimum of 1 hour, depending on the context and needs.

- It is recommended that the supervisor organises an extended meeting once a month for at least one hour, focusing on skill development or staff care and well-being.

- Regardless of the frequency of meetings, they should be held consistently and according to a schedule (e.g. the first Tuesday of every month) so that caseworkers and supervisors can set aside time in their schedule.

Guidance

Preparation: Supervisors are responsible for regularly scheduling and organising meetings with their teams. Caseworkers are expected to undertake necessary preparation and participate fully in the meeting. The supervisor should facilitate collaborative discussions between team members and encourage caseworkers to offer suggestions and facilitate the discussion.

Supervision components

- **Case discussion:** The supervisor assigns a caseworker to discuss an interesting or challenging case from which other staff can learn. Case presentations can follow the agenda outlined in the case discussion activity form (see Supervision Form 5: Case Discussion).

- **Topical sessions:** The supervisor should either choose the topic in advance, based on the technical support identified as a priority, or ask the caseworkers to identify topics for which technical support is desired.

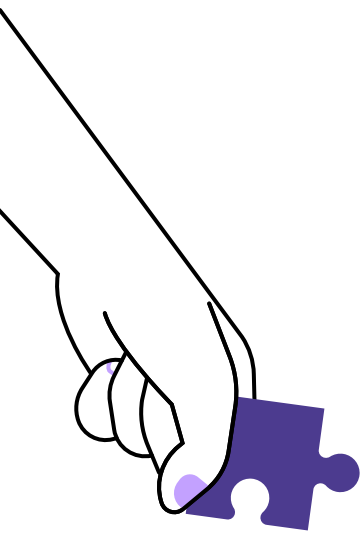
- **Teach back:** The supervisor can identify a caseworker with a particular strength or who has been successful with a new strategy to lead the group session and "teach" their colleagues. The supervisor must inform the caseworker in question of their plan for the group session.

- **Guest speaker:** The supervisor may invite technical experts to share information on a specific protection issue or a skill to be developed within the team. Supervisors can also request a presentation to be made by a representative from a community service (e.g. legal, police, medical or mental health professional, registration, etc.).

Capacity assessment

A capacity assessment is a supervision practice used to examine a newly recruited caseworker's attitudes, knowledge and skills. It outlines areas where further development and support may be needed to perform effectively in the role. These are minimum competency standards for all caseworkers providing Protection Case Management services. It is important that caseworkers do not feel evaluated or punished if they do not demonstrate accurate knowledge and skills. Instead, we want them to understand that the questions and the role-plays included in the skills part of the assessment form are to support the caseworker's skills development. For more information, go to Supervision Form 1: Caseworker Capacity Assessment.

For additional assessment tools and e-learning resources for trainers and supervisors to improve the quality of their team's MHPSS skills, please visit the platform the EQUIP platform, hosted by WHO and UNICEF. EQUIP is for trainers and supervisors to improve the quality of their team's psychosocial and mental health helping skills. For onboarding and consultation support, Protection Case Management teams should contact the EQUIP helpdesk at: EQUIP-helpdesk@unicef.org.

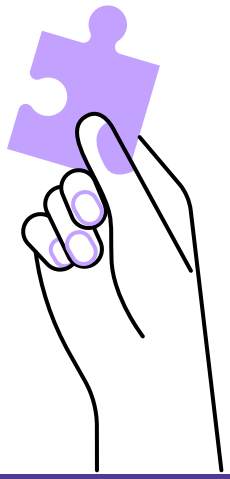


Frequency/Duration

- The capacity assessment should be conducted immediately after the caseworker is recruited.
- It should be reassessed in three to six-month intervals, depending on organisational capacity, staff ratios and needs.

Guidance

- The assessment is used upon recruiting a new caseworker and should continue at regular intervals.
- Supervisors can use this form during initial individual supervision sessions to understand caseworkers' strengths and areas for development.



- Ideally, administer the assessment before caseworkers start working directly with service users at risk.

- The assessment outcomes should inform the capacity building and development actions that supervisors provide in both individual and group supervision sessions.

Shadowing

This is a useful and effective practice to show new or inexperienced caseworkers how to engage with service users by modelling best practice. During a shadowing visit, the caseworker acts as a neutral observer to learn and develop by reflecting on interactions between the senior caseworker/supervisor and the participant. Reflections and discussions of shadowing sessions should occur in individual supervision sessions. For more information, go to Supervision Form 3: Shadowing.

Frequency/duration

- Five to ten shadowing visits should occur during a caseworker's first month of employment.

Guidance

- Shadowing sessions can be implemented during all stages of the Protection Case Management process.

- Whilst particularly useful for new caseworkers, it can benefit all caseworkers regardless of experience level.

- Supervisors should determine which cases should be observed according to the caseworker's capacity building plan.

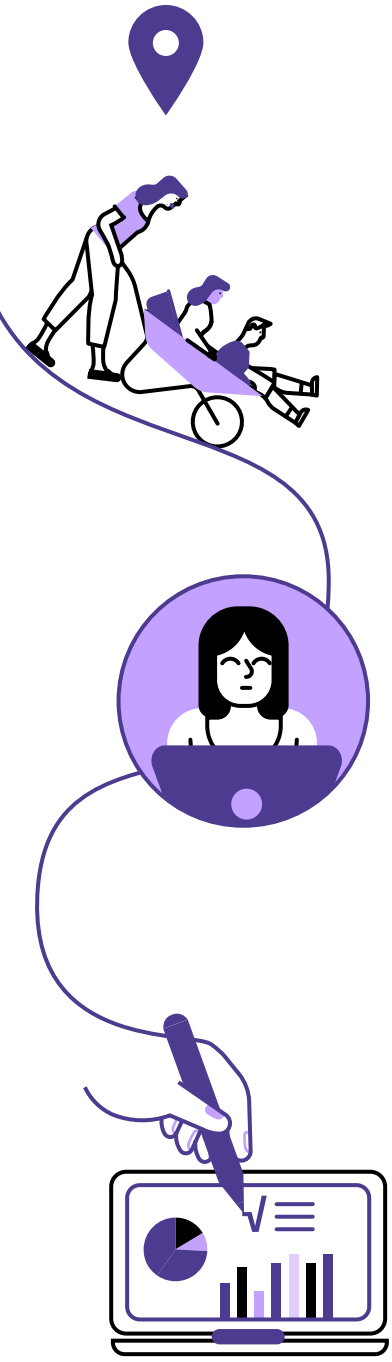
- Always consider the confidentiality and safety of the participant as a priority. Consider the service user's current vulnerability, safety and wellbeing according to the "do no harm" principle.

- It is essential that informed consent is sought from the participant prior to the meeting and the purpose is clearly communicated.

- Invite only one caseworker to shadow a session to avoid overwhelming the participant.

Observation

This is a supervision practice used to assess a caseworker's application of Protection Case Management competencies during a face-to-face interaction with a participant. During the observation, a caseworker conducts a meeting with the service provider. The supervisor is a neutral observer during this contact unless it is essential to intervene i.e. due to a Protection Case Management principle being significantly violated or if the caseworker explicitly asks for support or feedback. The goal of the exercise is for a supervisor to observe participant/caseworker interactions in order to support the caseworker's development in applying Protection Case Management best practices. For more information, go to Supervision Form 2: Session Observation.



Frequency/duration

Observations should occur regularly, around once every two weeks with new caseworkers, and around once every two months for more experienced caseworkers.

- Caseworkers and supervisors should determine together which cases to observe according to the service user's vulnerability, safety and well-being.

Supervisors should reassure caseworkers to not feel they are being evaluated or will be punished if they do not demonstrate accurate knowledge and skills. It is essential to obtain the service user's permission beforehand, explaining it is to support the caseworker's learning and that all information disclosed will remain confidential.

Protection Case Management file check[6]

Supervisors should also review case files on a regular basis, focusing on active cases to make sure that services are consistent and meeting the quality markers outlined in the local standard operating procedures, documented case details are relevant, clear and to standard, and supervisors identify areas of development and support beneficial for caseworkers. For more information, go to Supervision Form 4: Case File Checklist Tool.

Frequency/duration

- A supervisor should review three to five files per a month for **each** caseworker.

Guidance

- Supervisors should select some cases (can be open or closed) randomly for an independent review. Provide feedback to the caseworker in individual supervision sessions and follow-up on progress during subsequent supervision sessions.

- Address trends within the case files, such as common record-keeping mistakes or misunderstandings during group supervision sessions. Discuss and provide guidance to improve practices.

- Supervisors can use a checklist to independently review multiple files in a short period of time.

Case discussion

A case discussion is a supervision practice to support a caseworker process and analyse a case, explore potential options and determine ways forward. Case discussions can be used as a learning opportunity to reflect on how guiding principles were applied and how difficult situations were managed through a collaborative dialogue. For more information, go to Supervision Form 5: Case Discussion.

Frequency/duration

- Cases should be reviewed frequently, based on a caseworker's needs and in accordance with organisation standards.

Guidance

- Case discussions can take place in an individual supervision session or group supervision session.

- To start, the caseworker presents the background, concerns and status of the case. Following the presentation, open a discussion, including questions, brainstorming options and agreements on next steps.

- To maintain confidentiality, the discussion should occur in a private space without using identifying information, adhering to the 'need to know' principle. No details related to the case should be discussed externally.

Supervision Forms

Supervision Form 1: Caseworker Capacity Assessment

Supervision Form 2: Session Observation

Supervision Form 3: Shadowing

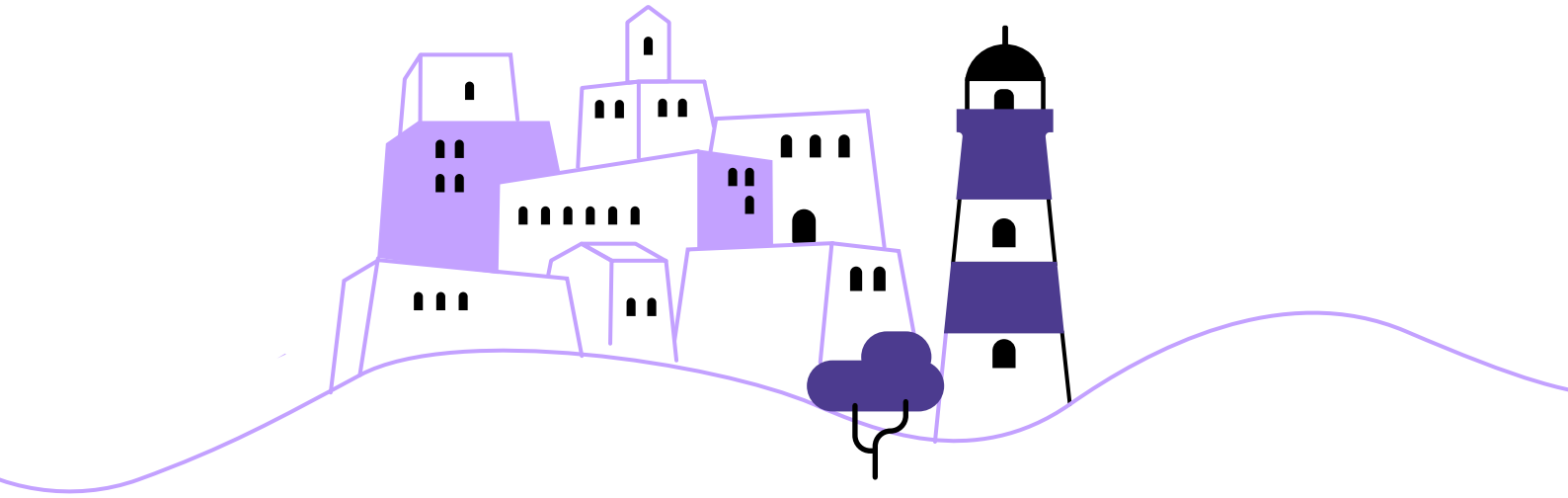
Supervision Form 4: Case File Checklist Tool

Supervision Form 5: Case Discussion

Record Forms

Record Form 1: Individual Supervision Meeting

Record Form 2: Group Session Meeting



Endnotes

1 This entire section draws heavily from The Alliance for Child Protection in Humanitarian Action, Case Management Task Force, Child Protection Case Management Supervision and Coaching Training Package, 2018.

2 See, for example: International Federation of Social Workers (2018) Statement of Ethical Principles. https://www.ifsw.org/global-social-work-statement-of-ethical-principles/

3 Each team member identifies their rose, bud or thorn of the week. A rose is a highlight, success, small win or something positive that happened. A thorn is a challenging experience or something requiring more support. A bud is a new idea that blossomed or a new learning opportunity.

4 Key consideration: Staff responsible for providing MHPSS to people affected by humanitarian emergencies should not also be responsible for workforce well-being - MHPSS MSP

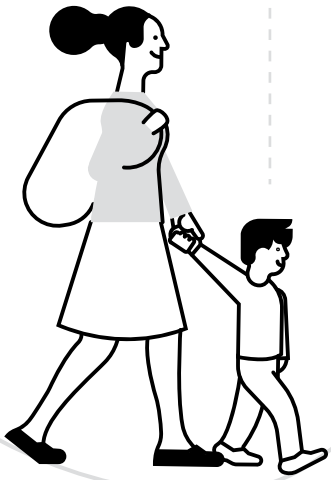
5 All the Supervision content in this guidance here draws heavily from The Alliance for Child Protection in Humanitarian Action, Case Management Task Force, Child Protection Case Management Supervision and Coaching Training Package, 2018.

6 This is different to spot checks that supervisors, information management or other staff (as assigned in your staffing structure) should conduct on your data protection. For this guidance, please see Module 3.

Annexes and Forms

Annex 1.1
Protection Risk Criteria for Protection Case Management

Sub-categories of risks faced by Protection Case Management service users[1]	Violence	Coercion	Example risk definitions	Comments and considerations
(Forced) family separation		✔	Adult individuals requiring a caregiver are at risk after being separated from their family or other usual caregivers.	Does not include children who are alone or separated from their families.
Abduction, kidnapping or enforced disappearance	✔	✔	Individuals are at risk of detention or have been detained or victim to enforced disappearance. Those responsible refuse to acknowledge the detention or they conceal the concerned person's fate and whereabouts, which places the person outside the protection of the law.	



Sub-categories of risks faced by Protection Case Management service users[1]	Violence	Coercion	Example risk definitions	Comments and considerations
Arbitrary or unlawful arrest and/or detention			Individuals have been deprived of their freedom due to an unlawful arrest or detention. An arrest is considered unlawful if, for example, an individual is not informed immediately of the reason in a language they understand, or if they are not promptly brought before a judge to confirm the legality of the arrest or detention.	
Death or injury through deliberate or non-deliberate attacks by armed groups	✔		Individuals are at risk of death or injury or injured during an attack, either accidentally or deliberately.	
Extortion	✔		Individuals subject to actual or threatened force, violence or intimidation to gain money or property from an individual or entity.	For instance, at checkpoints or by levying informal 'taxes' in return for safety.

Sub-categories of risks faced by Protection Case Management service users[1]	Violence	Coercion	Example risk definitions	Comments and considerations
Forced labour or slavery		✔	Adult individuals are coerced to work through the use of violence or intimidation, or by more subtle means, such as accumulated debt, retention of identity papers, or threats of denunciation to immigration authorities. This includes debt bondage and slavery. Slavery is the status or condition of a person or persons over whom any or all of the powers of ownership are exercised. It includes the purchasing, selling, lending, or bartering of a person or persons, and other similar deprivation of liberty.	Local coordination will be required to ensure there is alignment with gender-based violence responses.
Forced recruitment into armed forces/groups		✔	Any manner in which an adult is forced, coerced, threatened, or intimidated to join an armed force or group.	Local coordination will be required to ensure their alignment with children and armed conflict responses.

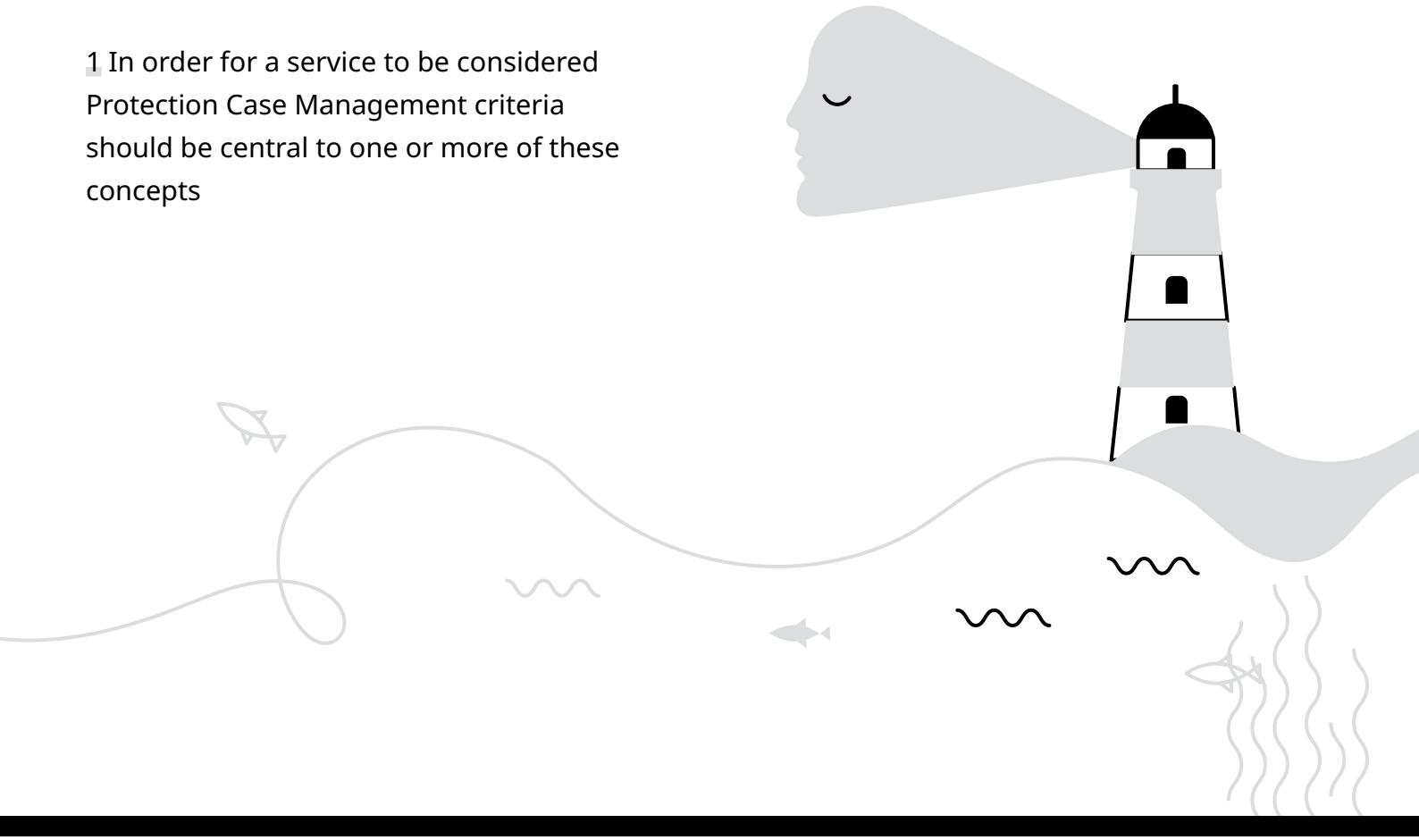
Sub-categories of risks faced by Protection Case Management service users[1]	Violence	Coercion	Example risk definitions	Comments and considerations
Maiming or mutilation	✔		Individuals who have been threatened with, or who have suffered, physical injuries that degrade the appearance or function of any living body. Maiming or mutilation may constitute torture or result from the presence of explosive ordnance.	In the case of maiming or mutilation as a result of explosive ordinance, coordination with mine action to ensure there is alignment with mine action responses. Coordination with health actors may also be relevant.
Physical assault or abuse (not related to sexual and gender-based violence)	✔		Adults at risk of, or who have experienced, physical violence that is neither gender-based nor sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, or any other act that results in pain, discomfort, or injury.	Local coordination will be required to ensure there is complementarity with child protection and gender-based violence responses.

Sub-categories of risks faced by Protection Case Management service users[1]	Violence	Coercion	Example risk definitions	Comments and considerations
Psychological/ emotional abuse	✔		Adult individuals who are suffering mental or emotional pain, injury or distress. Examples include: threats of violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a menacing nature, destruction of cherished things, etc.	Local coordination will be required to ensure there is alignment with gender-based violence responses.
Torture or inhuman, cruel, or degrading treatment	✔		Adult individuals who are at risk of or who have suffered severe physical and/or mental pain or suffering by a perpetrator for a specific purpose.	Although physical assault or abuse can constitute torture, it is not always torture. Torture requires the existence of a specific purpose behind the act – to obtain information, for example. Local coordination will be required to ensure there is complementarity with gender-based violence responses.

Sub-categories of risks faced by Protection Case Management service users[1]	Violence	Coercion	Example risk definitions	Comments and considerations
Human trafficking		✔	Adults who have been recruited, transported, transferred, or harboured through threats, coercion, abduction, fraud, deception, abuse of power or vulnerability, or payments to those controlling them, for the purpose of exploitation.	Local coordination will be required to ensure there is alignment with child protection and gender-based violence responses.

Endnotes

1 In order for a service to be considered Protection Case Management criteria should be central to one or more of these concepts

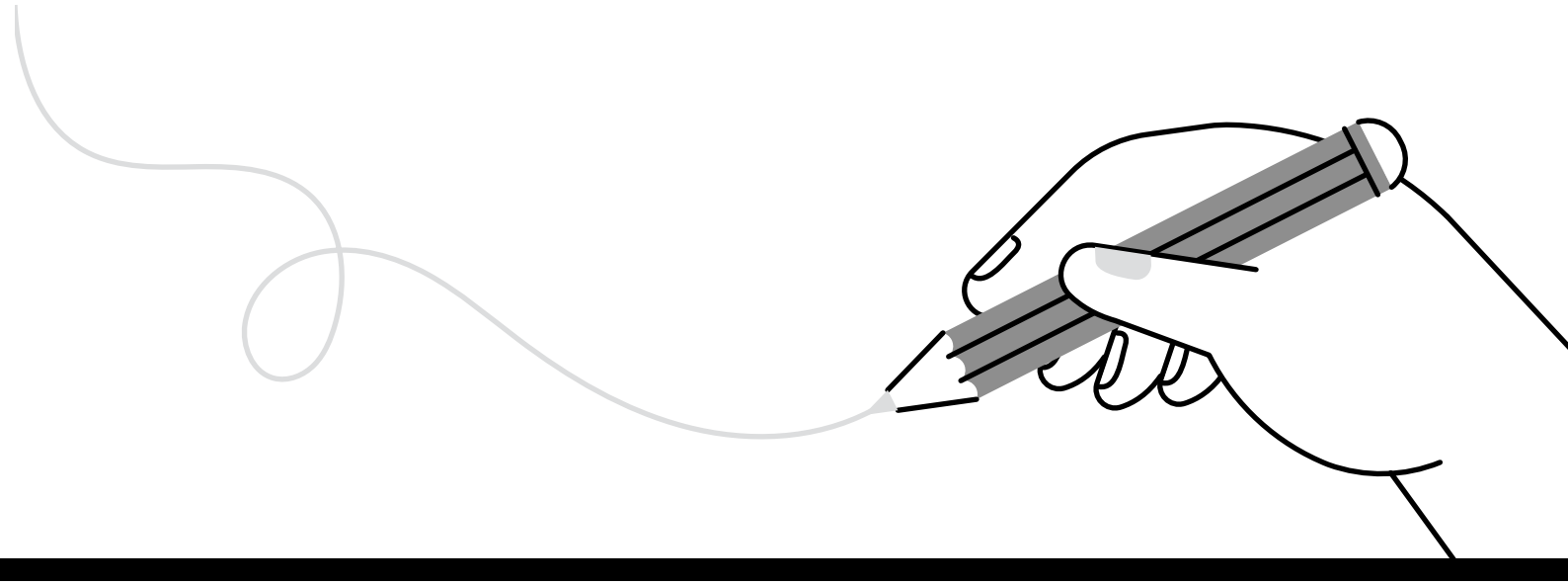


Annex 1.2

Protection Case Management Theory of Change (ToC)

Table 1: Protection Case Management Theory of Change

Impact Pathway	**Protection risks are mitigated, and people at risk recover from experiences of harm, including discrimination, violence, reduced access to services, and threats to their integrity, safety, and life.**	
Protection Outcome (Level II)	1. People at risk achieve improved psychosocial wellbeing through Protection Case Management support.	
Protection Outcomes (Level I)	1.1 People at risk are less impacted by protection risks through Protection Case Management support.	1.2. People at risk with mental health needs demonstrate a reduction in symptoms of severe distress through Protection Case Management support.



Process & Quality Pathway	**People at risk have access to quality, and client-centered Protection Case Management services when they need it.**						
Process & Quality Outcomes *(interim)*	1.1 People at risk are eligible for and receive PCM services.	1.2 PCM services are sufficiently staffed and resourced.	1.3 Case-workers possess the skills, knowledge, and attitude necessary to support clients through PCM services.	1.4 PCM services are delivered in a client-centered way that is accountable to clients, inclusive, and in line with their needs and preferences.	1.5 PCM services are delivered in line with quality standards and protocols (as articulated in the PCM guidance).	1.6 Case-workers establish strong relationships with clients based on a foundation of empathy, inclusion, support and trust.	1.7 PCM clients are successfully referred to relevant services (including specialized mental health services, legal support, and health and education services).
Problem	**During protracted and acute crises, state and/or community-based structures to mitigate and respond to environmental risk factors are often disrupted, leading to fewer resources and available support structures, leaving vulnerable people at risk of experiencing safety concerns or other rights violations.**						

Problem Statement

The relevance of protection case management in a humanitarian context is rooted in its potential to respond to the problem statement that during protracted and acute crises, state and/or community-based structures to mitigate and respond to environmental risk factors are often disrupted, leading to fewer resources and available support structures, leaving vulnerable people at risk of experiencing a rights violation. There is an increasing recognition in the humanitarian community that case management is an effective approach to addressing this risk, through the provision of individualised support

to vulnerable individuals. While the specific 'problem' that a case management response seeks to address will vary considerably from case to case, this overarching problem statement encompasses these, rooting the need for case management support in the broader structural conditions that result from crises and conflicts.

Process & Quality Interim Outcomes

Protection case management addresses the above problem statement through multiple mechanisms and activities, from training case workers to direct service provision and referrals for clients to quality feedback. The process and quality interim outcomes in the ToC refer to the characteristics of case management that should be in place as initial changes resulting from implementation. In other words, the process and quality pathway ensures that people at risk have access to quality, and client-centered protection case management services when they need it should be achieved in order for case management services to contribute towards the overall protection outcomes and goal. When designing PCM programming, it is useful to consider as many of the process and quality interim outcomes as possible, and interventions and activities should focus on achieving the specific interim outcomes as immediate goals.

- Process & Quality Interim Outcome 1: People at risk are eligible for and receive PCM services. In order to benefit from PCM support, people at risk must be eligible for the PCM services which are available and able to access those services in practice. This outcome may be challenging to achieve in practice, particularly where significant barriers to information and movement exist.
- Process & Quality Interim Outcome 2: PCM services are sufficiently staffed and resourced. PCM services must be sufficiently staffed and resourced to ensure that services can be provided to all eligible persons and that quality standards can be maintained.
- Process & Quality Interim Outcome 3: Case workers possess the skills, knowledge, and attitudes necessary to support clients through PCM services. Effectively supporting a client through the PCM process requires considerable knowledge and skills, as well as the appropriate attitude and personal commitment. (Critical knowledge and skills that caseworkers should possess are detailed in the PCM Guidance.)
- Process & Quality Interim Outcome 4: PCM services are delivered in a client centred way that is accountable to clients, inclusive, and

in line with their needs and preferences. In order to ensure that PCM is collaborative and accountable, driven by the client's needs and preferences, it is important that services are client centred. As detailed in the PCM Guidance, principles of client centred case management include: situating the client in his or her environment; building on a client's strengths and capacities; and applying a trauma-informed approach.

- Process & Quality Interim Outcome 5: PCM services are delivered in line with quality standards and protocols (as articulated in the protection case management guidance). Much of the value of a case management approach lies in the process and structure used to guide the response to each individual case. This supports the case manager to ensure that the response is implemented in line with standards for good practice, promoting the quality of PCM support.
- Process & Quality Interim Outcome 6: Case workers establish strong relationships with clients based on a foundation of empathy, inclusion, support, and trust. Emerging evidence suggests that the relationship between the case worker and the client is one of the key factors determining whether case management services deliver results for clients.
- Process & Quality Interim Outcome 7: PCM clients are successfully referred to relevant services (including specialized mental health services, legal support, and health and education services). Protection case management services are not designed to lack the specialisation to address the diverse range of needs and risks experienced by clients. Instead, the case management response involves coordinating and advocating for a client's access to specialized services. This occurs both through referring clients to relevant services and supporting them to access these, and by ensuring that complex and intersecting needs are addressed holistically. Unfortunately, in practice, the availability of referral services can be a significant challenge and is often outside the control of programming interventions designed to strengthen PCM.

According to the change pathway in the ToC, if process and quality interim outcomes 1 – 7 are achieved, then the process and quality change pathway – that people at risk have access to quality, and client-centred protection case management services when they need it – will also be met.

Protection Outcomes

The next step in the change pathway is the link between the process and quality interim outcomes and the level I protection outcomes in the change pathway: that people at risk are less impacted by protection risks (Protection Outcome 1.1), and people with mental health needs demonstrate a reduction in symptoms of severe distress (Protection Outcome 1.2). These outcomes correspond to the prevention and response aspects of case management work. They are broadly defined to encompass the diverse protection risks and experiences of harm faced by PCM clients, and capture the change that is expected to result from case management work: which seeks to shift the balance between risk factors (vulnerabilities) and protective factors (capacities) to improve outcomes for clients.

According to the change pathway in the ToC, if people at risk have access to quality and client-centred protection case management services when they need it (the process and quality pathway), then people at risk will be less impacted by protection risks (Protection Outcome 1.1), and people with mental health needs will demonstrate a reduction in symptoms of severe distress (Protection Outcome 1.2).

The next step in the theory of change is the link between the level I protection outcomes and the level II protection outcome: improved psychosocial wellbeing. Psychosocial wellbeing encompasses the holistic welfare of the client across a range of dimensions, including functioning and competence; affect and emotions; autonomy and empowerment; coping, resilience, and hope; and relationships and social support. Measuring changes in psychosocial wellbeing is an effective approach to capturing PCM outcomes across diverse cases. Improvements in an individual's psychosocial wellbeing are likely to reflect improvements in other areas of interest, such as improved safety, improved access to basic needs or services, improved mental or physical health, and so on.

According to the change pathway in the ToC, if people at risk are less impacted by protection risks (Protection Outcome 1.1) and if people with mental health needs demonstrate a reduction in symptoms of severe distress (Protection Outcome 1.2)., then people at risk will achieve improved psychosocial wellbeing through protection case management (Protection Outcome 2).

You can read more about the Protection Outcome Monitoring Framework on Module 3, Annex: Protection Case Management Outcome Monitoring Guidance.

Impact

The final step in the theory of change is the link between improved outcomes for individual case management clients and the broader population level impact that in humanitarian crises, people at risk are able to realise their rights and live in safety and with dignity. It is clear from the change pathway that protection case management can make a substantial contribution to this goal through mitigating protection risks, while people at risk recover from experiences of harm, including discrimination, violence, reduced access to services, and threats to their integrity, safety, and life (the impact pathway). Yet this impact will also be shaped by other protection interventions, particularly interventions that target protection risks at community or society-wide levels.

According to the change pathway in the ToC, if people at risk achieve improved psychosocial wellbeing through protection case management (Protection Outcome 2), then in humanitarian crises, people at risk are able to realize their rights and live in safety and with dignity (Impact).

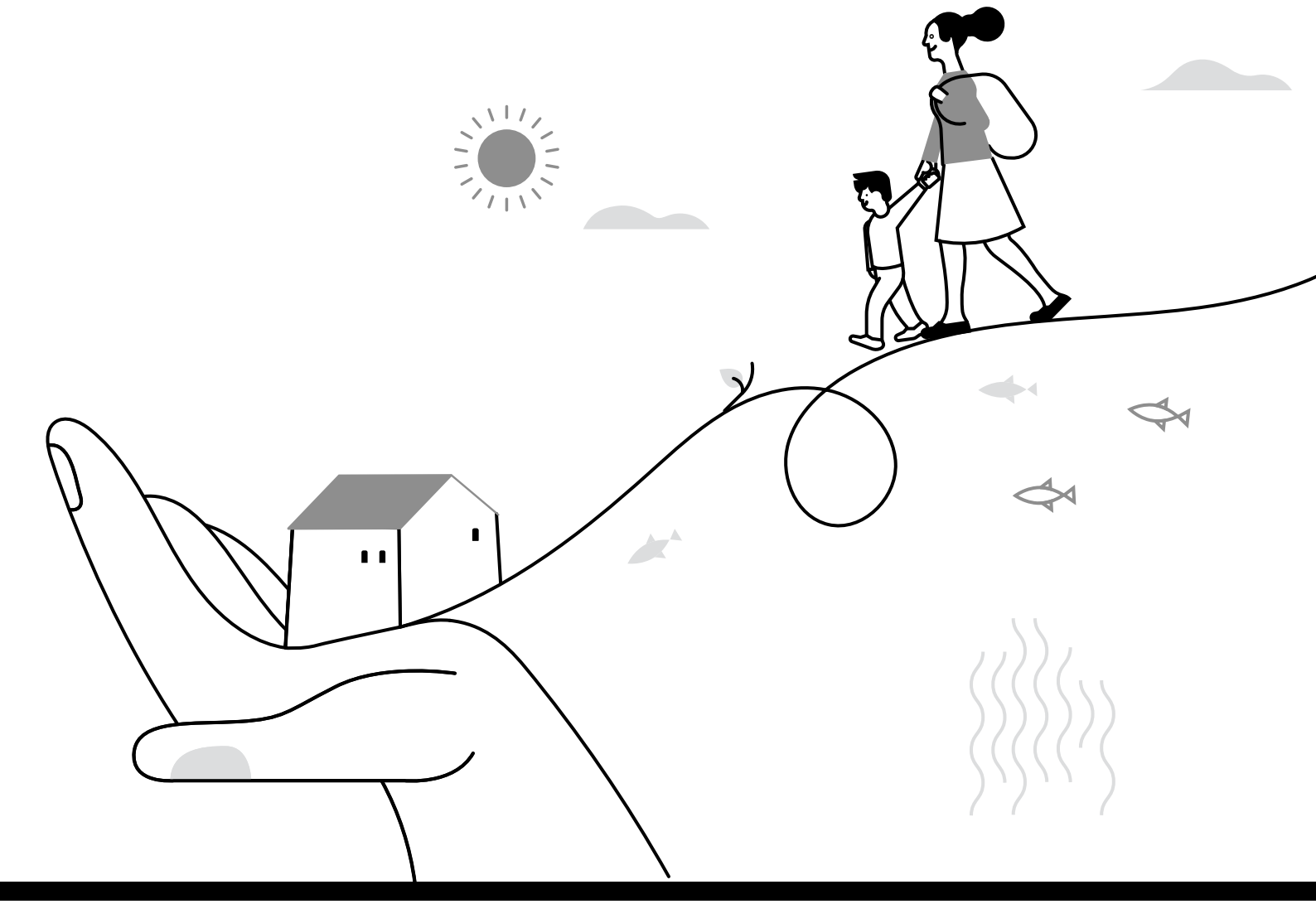
You can read more about the indicators you can use to measure the Protection Outcome Theory of Change on Module 3, Annex: Measuring the Protection Case Management Theory of Change.

Form 0

Intake and response criteria

Developing and updating Form 0	*Form 0 is a tool organisations can use to define their intake and response criteria. It should be developed based on protection analysis, consultation, and coordination with impacted individuals, local services, and ensures Protection Case Management is complementary to other supports. Teams often make necessary adjustments in the implementation phase - based on their early experience using the tool. It should be reviewed every 6 months if there is a major change in the context.*
What is Form 0?	*This form captures the organisation's intake criteria, supporting caseworkers to identify an individual's eligibility for Protection Case Management. It also outlines the response timeframe at each stage of Protection Case Management in relation to their level of priority.*
Who uses Form 0?	*Caseworkers/supervisors use Form 0 on a daily basis to help them determine eligibility of service users at intake and as a guide to determine their priority level throughout the Protection Case Management process. Priority levels determine the response time of the caseworker at each Protection Case Management step. This is a guide only and service users may not be represented in Form 0. Where Caseworkers are unsure of a service user's eligibility or priority level, they should discuss with their supervisor. If supervisors are unsure, they should seek support of senior staff (determine a focal point locally).*

	High priority	Medium priority	Low priority	Not eligible for Protection Case Management
Definition of risk level	• Individuals significantly harmed or at immediate serious risk of harm. • Urgent response and frequent follow up required.	• Individuals harmed or at risk of serious future harm. • Response and follow up required.	• Individuals at risk of harm. • Some monitoring required to ensure harm is removed and there is positive wellbeing of the individual.	• Individuals are no longer at risk. • No further monitoring required.



	High priority	Medium priority	Low priority	Not eligible for Protection Case Management
Response times by risk level	• Assessment should be conducted immediately after registration, before leaving the individual. Urgent action is taken prior to the safety plan. • Case planning should be conducted within three days after the assessment. The case plan should be reviewed and approved by the supervisor. • Follow-up should be conducted at least twice a week - as soon as care plan implementation has started. • A case review meeting should take place at least every week	• Assessment should be conducted within three days after registration. • Case planning should be conducted within one week after the assessment. • Follow-up should be conducted at least once a week - as soon as care plan implementation has started. • A case review meeting should take place every two weeks.	• Assessment should be conducted within one week after registration. • Care planning should be conducted within two weeks after assessment. • A follow-up should be conducted at least once every two weeks - as soon as a care plan implementation has started. • A case review meeting should take place at least every month.	• No action required or case closure recommended.

Urgent concerns to be addressed immediately - before any next steps in the Protection Case Management process

- ✔ **Healthcare and safety concerns examples:** If an individual is injured or requires medication or medical attention within a specific timeframe. In cases of sexual assault within the past 120 hours, an urgent medical referral is necessary, as this falls within the critical window for life-saving interventions: legal evidence collection within 48 hours, HIV prevention within 72 hours, and emergency contraception within 120 hours. Additionally, if there are signs of ongoing abuse within the family, such as concerns about the individual's personal safety at home or in the community or the family/caregiver's willingness to protect them from further harm, this should also be addressed urgently.

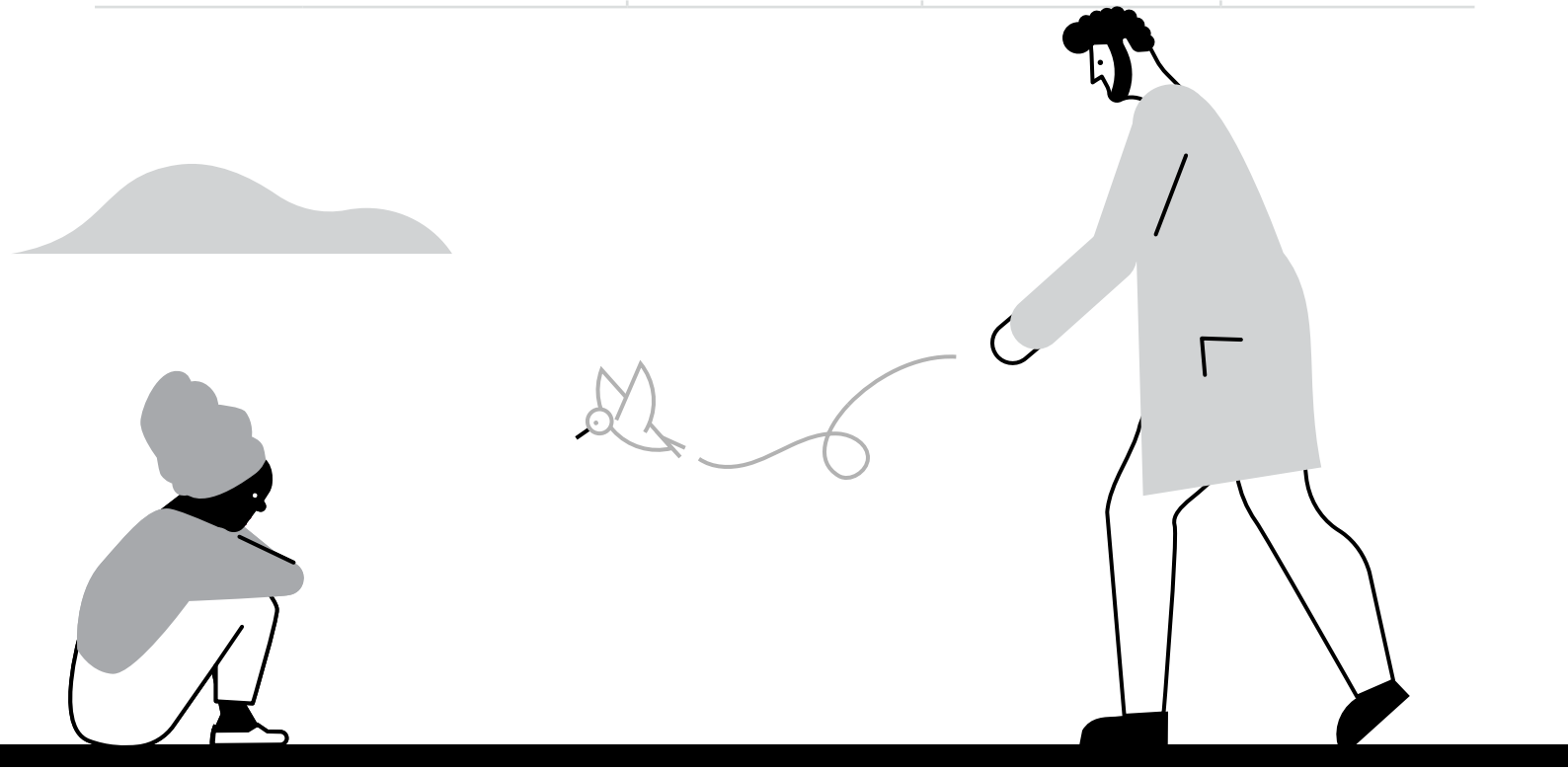
- ✔ **Suicidal intention:** Provision of an immediate response to ensure the safety of the individual (e.g. presence, accompaniment to care, increased check-in if referral is impossible).

- ✔ **High risk GBV/CP cases:** Provision of an immediate response to ensure safety of the individual while an urgent referral can be facilitated.

Protection risks (examples)

	High priority	Medium priority	Low priority	Not eligible for Protection Case Management
Torture and inhumane, cruel, degrading treatment or punishment	• Incarcerated individual reporting torture, inhumane, cruel, degrading treatment or punishment. • Recent serious injury as a result of torture. • Individual attempting suicide/ self-harming. • Individuals showing severe signs of psychological distress.	• Past serious injury as a result of torture with impact on daily life. • Important signs of psychological distress as a result of torture.	• Past injury as a result of violence with limited impact on daily life. • Signs of psychological distress.	• Impact of previous torture addressed and coping mechanisms in place.
Physical violence	• Recent serious injury. • Proven imminent risk of physical abuse, domestic violence. • Individual attempting suicide/ self-harming. • Collective violence against FPA[1].	• Past serious injury as a result of violence with impact on daily life (physical or psychological). • High risk/ credible threat of physical abuse (especially for FPA).	• Past injury as a result of violence with limited impact on daily life. • Part of a population regularly threatened with violence and experiences fear/ distress as a result.	• Impact of previous physical violence addressed and coping mechanisms in place.

	High priority	Medium priority	Low priority	Not eligible for Protection Case Management
Psychological violence	• Individuals are being persistently belittled, isolated, or humiliated by a significant caregiver (esp. older person or persons with disability). • Individuals are persistently isolated and verbally abused by most in the community. • Individual attempting suicide/ self-harming.	• Individuals are exposed to harassment and verbal abuse regularly when doing daily tasks out of the home. • Important signs of psychological distress and self-isolation.	• Individuals are exposed to belittling and insults when completing specific activities outside of the home (e.g. visit of government office).	• Factors causing the emotional harm have been addressed or positive coping mechanisms have been put in place.



High priority	Medium priority	Low priority	Not eligible for Protection Case Management

Outside of the scope of protection case management

Refer to ICRC for cases of ongoing detention/report of torture.
Refer to GBV case management services for cases of:

- **Gender-based violence.** The term refers to violence used against women, girls, men and boys to assert and reproduce gender roles and norms There are six GBV categories: Physical violence, psychological violence, denial of opportunities, forced marriage, rape, and sexual abuse.
- **Sexual violence** can occur at an interpersonal or collective level. Sexual violence incorporates non-consensual sexual contact and non-consensual non-contact acts of a sexual nature, such as voyeurism and sexual harassment. Acts qualify as sexual violence if they are committed against someone who is unable to consent or refuse for example because of age, disability, misuse of authority, violence or threats of violence.
  - **Rape** is defined as "physically forced or otherwise coerced penetration, even if slight, of the vulva or anus, using a penis, other body parts or an object."
  - **Sexual coercion** is defined as "the act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against his / her will." [2]

GBV case management services will lead on these cases.

For children: Refer to child Protection Case Management services for cases where children require protection from violence, exploitation, abuse, and neglect as per the definition of child protection in the UN convention on the rights of the child. Child protection services will lead on these cases.

Protection Case Management actors will provide immediate response in high priority cases to ensure safety of the individual while a referral to a dedicated CP or GBV partner can be secured (see above on immediate action).

Endnotes

1 Families with perceived affiliation

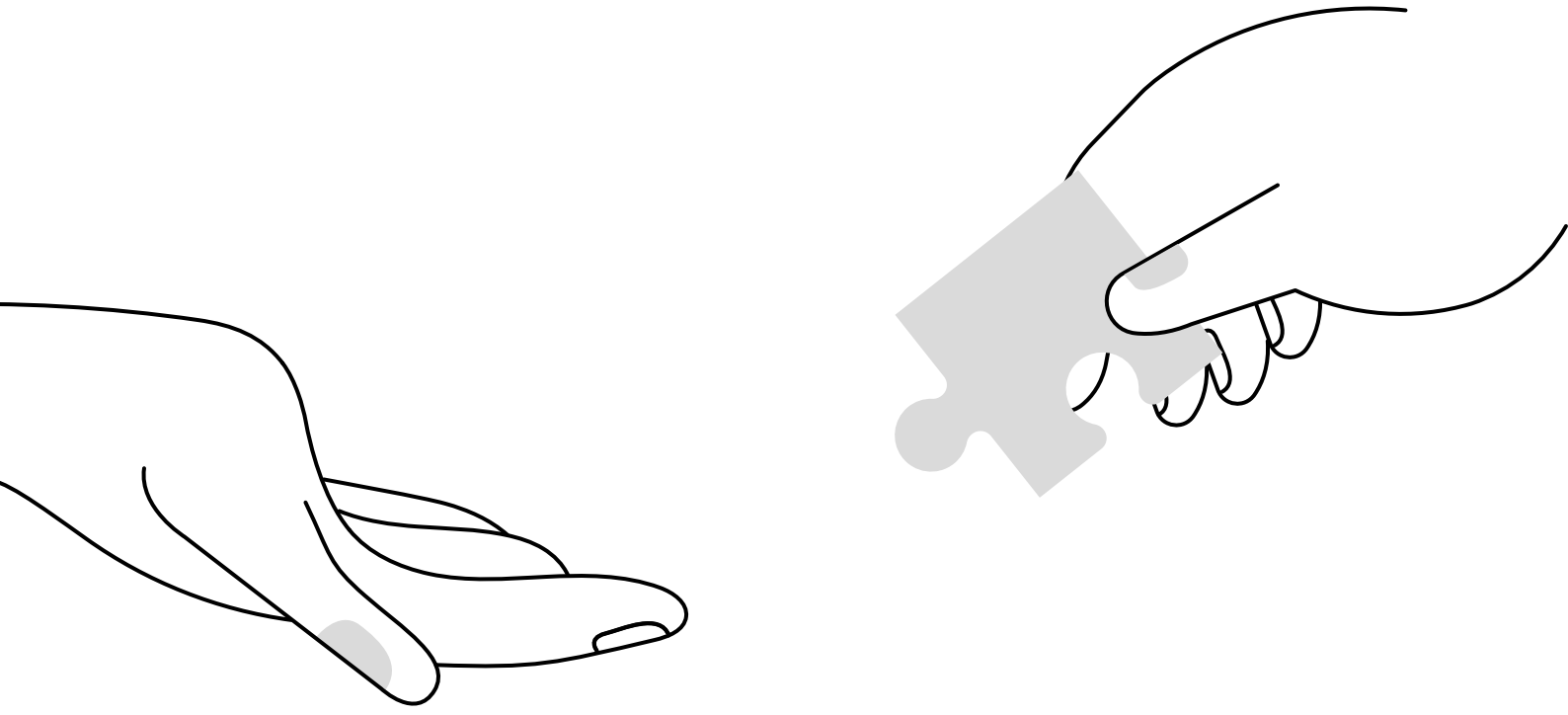
2 Definition used in Protection Case Management Guide, Form 0 template.

Annex 2.1
Protection Analysis Capacities

Capacities to Consider from Protection Analytical Framework:

- Access to education
- Access to information
- Active hostilities (impeding humanitarian operations and movement of affected population to aid)
- Activity of armed groups
- Asylum-seeker entry and access to asylum process after entry
- Community tensions/disputes
- Conditions of detention
- Conflict prevention and resolution mechanisms
- Documentation
- Effective remedy (as the victim)
- Energy
- Expenditures
- Fair trial (as the accused)
- Food accessibility
- Food availability
- Food utilisation
- Freedom of association/peaceful assembly
- Freedom of opinion/expression/information
- Freedom of religion/thought/conscience
- Health status and risk
- Health system performance
- Household (negative) coping mechanisms
- Hygiene and sanitation
- Identity documents, residency and other documentation related to civil status
- Infant feeding practices
- Infrastructure, systems and assets
- Leadership and governance
- Malnutrition

- Physical environment (obstacles related to terrain, climate, lack of infrastructure)
- Presence of mines and other explosive ordnance
- Right to marry/start a family
- Shelter infrastructure and material
- Shelter/building conditions
- Sources of income
- Teaching and learning
- Cash assistance
- Community support, infrastructure and services
- Core relief items/non-food items
- Core relief items assistance
- Food assistance
- Health assistance/provider
- Health resources and services availability
- Law enforcement (police/security)
- Legal/protection counselling
- Legal aid service
- Livelihoods/services
- Protection incident monitoring system
- Psychosocial assistance
- Registration UNHCR or Government
- Safe housing
- Shelter assistance
- Skills training



Annex 2.2
Key Questions for Protection Analysis

Current threats to the population

What are the threats?

- Type/manifestation: threats are external to the person; it is the potential for physical or psychological harm caused by a perpetrator. It represents the source of the risk/cause of the risk.

What are the main characteristics of the threat?

- Frequency/Prevalence
- Geographic area
- Is it a formal or informal practice (harmful cultural tradition, poor urban design): how do individuals in affected communities regard these practices? What happens if we remove this risk factor; will other risk factors appear**?**
- What is the community's perception of the risk factor?

What are the main sources of the threat? What are their main characteristics (i.e structure, behaviour, approachability)

- Are they an individual actor vs. group actor?
- Is the threat coming from within the individual's community or externally?
- What is their relationship to the affected individual/population?
- What is their structure and where does decision-making power lie?
- Where relevant, is their chain of command ambiguous or clear/loose or tight?
- What are their incentives for action/inaction, the reasons for this, and understanding why they act or do not act
- Is the actor a duty-bearer?
- Are we (INGOs/LNGOs/UN/) a threat? Do we exacerbate the threat? Practices of staff? Compliance with internal policies/procedures, or readiness to comply?

Current threats to the population

What are the main drivers of the threat or factors driving the behaviour of duty bearers and perpetrators?

- Motivations to mistreat the individual/population: economic, political, legal, social
- Formal and informal policies and practices, or absence thereof
- Relevance of governing norms—social, religious, legal (domestic, international)
- Attitudes, ideas, prejudices, stigma and/or beliefs driving behaviour
- Power dynamics. Who has power, what gives them power, what is the relationship between the actor responsible for threats and the affected or targeted individual/population?

What is their (duty bearers and/or perpetrators) will and capacity to comply with IHL, HRL, Refugee Law and other protective norms?

What are the possible incentives to change their policy, practice, attitudes and beliefs?

Has the risk factor changed over time? What has prompted this change?

What is the severity and the likelihood this will occur?

What are the disincentives to comply with norms/make the desired behaviour change?

Threats effects on the population: Age, gender, diversity factor analysis. Due to ones context these factors can increase likelihood of a rights risk.

What are the individual characteristics, which contribute (positively or negatively) to protection risks?

Are there particular characteristics/circumstances an individual may experience at the same time which intersect and due to their environment often enhance ones experience of discrimination and power? (i.e. being a woman and from a marginalised group)

Threats effects on the population: Age, gender, diversity factor analysis. Due to ones context these factors can increase likelihood of a rights risk.

What can the impacts/consequences of these threats/risk factors be in relation to the vulnerability if not countered by capacities? (physical, social, legal and psychological effects)

- Life-threatening
- Permanent injury or disability
- Non-life-threatening injury
- Short or long-term impacts on mental health and psychosocial wellbeing
- Loss of access to life-sustaining resources
- Loss of access to essential services
- Loss of ability to sustain life and health
- Marginalisation/exclusion
- Separation from family
- Recruitment into armed forces
- Detention

Are there any groups of people who might be affected or disproportionately affected or exposed to risks/ experience greater impact because of their individual characteristics?

What are the coping strategies of the population groups affe

Existing Capacities to address protection threats

1. **What resources, capacity, and strengths exist to prevent or mitigate the risk of and/ or risk itself? (these could be physical, social, psychosocial, legal, material capacities)**

2. **What resources, capacity, and strengths exist to minimise the consequences/impact of the risk or risks?**
   - Individual and Household levels, Family and Community levels, Structural and Institutional levels
   - Physical, psychosocial, moral dimensions
   - Human, economic, social, religious, legal, material, moral, etc.
   - Internal and external to the affected individual, including traditional or social norms
   - Accessibility of these resources, capacity and strength for the affected individual
   - Has the capacity to protect themselves changed, grown, diminished over time?

Are the resources and services identified accessible and available?

Existing Capacities to address protection threats

3. **What protective mechanisms exist within the community/family/individual which can be reinforced/supported?**

4. **What synergy exists between local organisations, community structures and families to provide protection?**

5. **Identify the duty-bearers, key stakeholders, social welfare, civil society, local representative organisations or advocates, INGOs who are responding and how they are linked to current community-based initiatives/protective measures.**

6. **What did the protective environment look like prior to the crisis/emergency?** (Health services, mental health and psychosocial support (MHPSS) services, child and family welfare, legal/judiciary system, workforce, etc.) What is functioning? What referral pathways exist?

7. **At each level (individual, family, community, structural, institutional, national) what are the relevant points of influence and leverage?** Where are the linkages within the protective system (environment) where a change in one factor can influence a positive change in another?

8. **Why and how are individuals motivated?**

9. **Do we understand the interconnectedness of the system, the resources, capacities, strengths to identify entry points and integration of services to support the resilience?**

10. **Where are the opportunities that can be tapped into? (Partnerships, entry points)**
    - Individuals
    - Local representative organisations
    - Existing or non-existing services
    - Community-Based Protection mechanisms

11. **How can we strengthen capacities, existing skills, and community/individual strengths?**

Annex 2.3
Protection Risk Identification

RISK OF:	COERCION	VIOLENCE	DELIBERATE DEPRIVATION
IN THE FORM OF:			
FROM:			
FACED BY:			
RISK OCCURRENCE BASED ON EXISTING DATA			

THREAT 	**VULNERABILITY** 	**CAPACITY** 
What is indicating **THREATS?**	What is indicating **VULNERABILITIES?**	What is indicating **CAPACITIES?**

1 MONTH | 6 MONTHS | 1 YEAR | 2 YEARS | 5+ YEARS

THREAT 	VULNERABILITY 	CAPACITY 
What changes can we have in **THREATS?**	What changes can we have in **VULNERABILITIES?**	What changes can we have in **CAPACITIES?**

1 MONTH | 6 MONTHS | 1 YEAR | 2 YEARS | 5+ YEARS

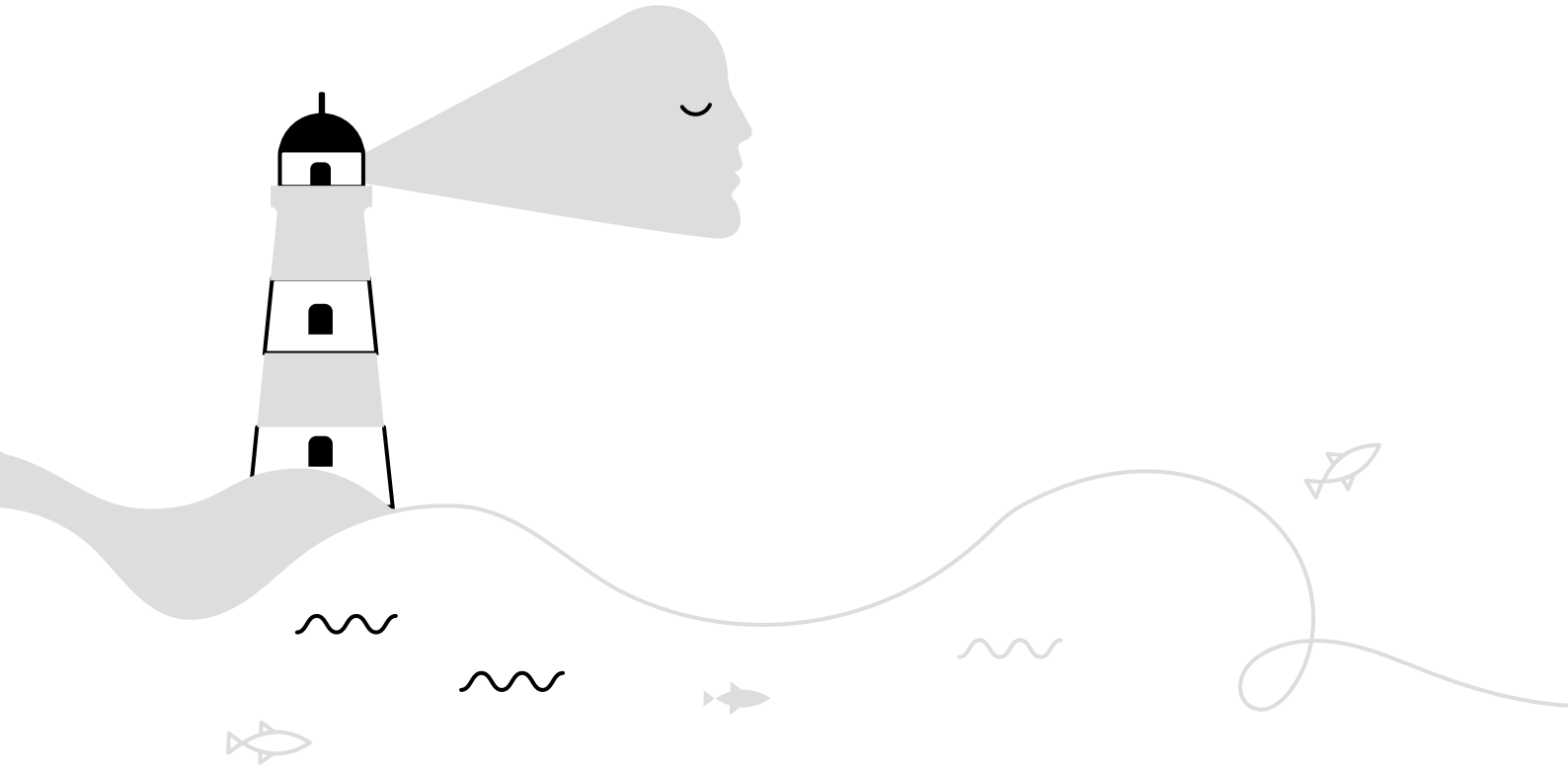
Annex 2.4
Workshop Agenda

Day/Time[1]	Subject	Outcomes
00:00 – 00:00	Welcome and Introductions	
00:00 – 00:00	Protection Risks, Threats, Vulnerabilities and Capacities	Participants understand the foundational definitions and concepts behind Protection Case Management (including the protection risk equation)
00:00 – 00:00	What is Protection Case Management?	Participants are able to define Protection Case Management
00:00 – 00:00	Review of secondary protection data and information	Participants understand the risks, threats, vulnerabilities and capacities affecting the affected population and have the opportunity to provide validation/feedback Local organizations/civil society actors and community representatives contribute in validation/verification exercise
00:00 – 00:00	Protection Analysis Key Questions	Participants collaborate on analysis against key questions

Day/Time	Subject	Outcomes
00:00 – 00:00	Drafting Form 0	Participants review and understand the Form 0 and start to populate it based on protection analysis findings
00:00 – 00:00	Next Steps (Form 0 Reviews, Risk Mitigation Plan finalisation and SOP Development)	Participants are assigned responsibilities associated with next steps and agree on timelines.

Endnotes

1 The amount of time these sessions take will depend on the familiarity of the team with the concepts being presented. For new teams early on in the humanitarian response, this may take up to 2.5 days or more. Don't forget to also consider if additional time is required for interpretation during the workshop.



Annex 3.1
Accessibility and Reasonable Accommodation

What is accessibility?

Accessibility is one of the eight principles under which all rights in the Convention on the Rights of Persons with Disabilities should be interpreted, and is the right that persons with disabilities have to *"access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas*."[1] Accessibility is a precondition to the inclusion of all persons with disabilities.

What is reasonable accommodation?

Reasonable accommodation means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.[2]

How are accessibility and reasonable accommodation different?

Both strategies aim to guarantee equal access and avoid discriminatory situations, however, they are different in the way they apply. Accessibility applies without regard to the need of a particular person with a disability, for example, to have access to a building, a service or a product, on an equal basis with others, following Universal Design principles.

Universal design is an approach to increasing accessibility and means "the design of products, environments, programmes and services to be **usable by all people**, to the greatest extent possible, without the need for adaptation or specialized design."[3] The principles of universal design, when applied in accessibility, facilitate access to a larger population, including persons with disabilities.[4]

Therefore, accessibility comes first. Reasonable accommodation must be provided from the moment that a person with a disability requires access to non-accessible situations or environments, or wants to exercise his or her rights. Therefore, reasonable accommodation is provided ad hoc and can vary based on an individual person's needs, even if accessibility overall has been addressed. The table below provides more information on how accessibility and reasonable accommodation are different:

Bridging the gap between accessibility and individual adjustments

Accessibility	Reasonable accommodation
Can be implemented in time	Has to be provided immediately, otherwise there is discrimination
Is a general solution	Is an individual solution
Applies regardless of the need of persons with disabilities to access infrastructures, services or information	Applies from the moment that a person requires access to a non-accessible situation
Is guided by general principles of universal design	Is tailored to the person and designed together with the person concerned
Is ruled by accessibility standards	Is ruled by a proportionality test: is not relevant, available or affordable by the project

Accessibility and reasonable accommodation are not exclusive to each other; rather, they are strategies that should be combined to effectively address barriers, guarantee access, and improve participation of all IRC's clients. At a minimum, IRC's case management processes should aim to improve accessibility through universal design, while also instituting a process for reasonable accommodation to address situations when people with disabilities, older people, and other people in all their diversity report a lack of access.

Accessibility/ Universal design

Reasonable accomodation

Equal access

Examples of accessibility and reasonable accommodation?

- A woman with a physical disability requires access to a building where IRC services are provided. She is able to enter to the building (e.g. there are no steps, or there is a ramp), circulate through the building (there are elevators, or services are in the first floor, doors are wide, handles easy to open), or use all facilities and services (information is provided in different formats, displayed at a level where it can be read - video announcements have subtitles, leaflets are easy to read, toilets are accessible) without requiring any support. This is an example of **accessibility**, as the building has followed universal design principles: parents with their children, older people, and pregnant women will also benefit from this accessible environment that welcomes all.
- A second woman with a physical disability comes to the same building to attend a consultation, but finds it difficult to circulate through all facilities, and requires a support person to come with her to open doors or provide support to use the toilets. Paying for the costs of that support person is an example of providing **reasonable accommodation**.

- An outreach team refers a girl with an intellectual disability to come to the same service; the costs for a family member to come with her are covered; this is providing **reasonable accommodation**.
- The NGO organizes a consultation in this building, and a participant who is deaf is invited to participate. The team gets in touch with the participants to check for reasonable accommodation requirements, confirms if they would like a sign language interpreter and if so, covers the costs of a sign language interpreter for her; this is providing **reasonable accommodation** for participation.
- If the building above was not accessible at all, we could **retro-fit accessibility** (if there is time and resources for it, as it tends to be more expensive), or provide **reasonable accommodation measures**: having a transportable ramp, providing services in out-reach capacity or other facility (e.g. a tent outside).
- **Remember!** All reasonable accommodation measures should be dignified! (e.g. avoid segregating measures: do not open a "tent for persons with disabilities" only, if possible, prioritize solutions which persons with disabilities can use independently.)

As you see in the examples above, even in accessible infrastructures, there can be a need for additional support to ensure access for individual people. ***Accessibility*** refers to how a space is designed and whether the design allows for most people to easily access the space; ***reasonable accommodation*** provides support to ensure that individuals with specific needs can fully access services.

Endnotes

1 CRPD, art. 9.

2 CRPD, Art 2

3 CRPD, art. 2.

4 http://universaldesign.ie/What-is-Universal-Design/The-7-Principles/

Annex 3.2
Guidance Note on Provision of Assistive Devices

This guidance note is based on the Global report on assistive technology by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), which provides data, evidence, and recommendations on how to achieve universal coverage of assistive technology. Assistive technology is essential for the well-being of a diverse range of people across the life cycle, as it enables and promotes their inclusion, participation, and engagement in society.

By facilitating better functioning and participation, accessing assistive technology can also have protection outcomes – especially for groups at risk of marginalization, discrimination, and exclusion – by empowering them to navigate their environments, communicate effectively, and access essential services. For example, children and adults accessing spectacles can access lifesaving information and educational and economic opportunities, while replacing lost assistive devices to persons with disabilities fleeing conflict ensures their mobility, communication, and independence, mitigating protection risks.

However, many people who need assistive technology do not have access to it, due to various barriers and challenges, such as lack of awareness, affordability, quality, availability, services, policies, and human resources.

Some of the people who may need to be referred to services to access assistive technology can include:

- People who have lost their assistive devices because of the crisis.
- People who have sustained recent injuries.
- People who evacuated their home with built-in accommodations. For example, an older client with low vision may not have needed assistance in his own home but would need assistive device or other supports in a large congregate shelter.

People who face a lot of difficulties in doing functional activities or can't do at all based on answering the Washington Group Short Set of Questions. This can include older persons and women and girls with sexual and reproductive health related conditions, such as obstetric fistula, incontinence, and other conditions that adversely affect their lives.

Assistive technology should not be seen as 'products to be dispensed' but as a set of interventions that require assessment, fitting, education of the people who need them and their carers, as well as ongoing follow up. Protection case workers often work closely with persons who may benefit from assistive devices, however it is essential that they link with the appropriate skilled personnel in the health sector to provide assistive devices safely and effectively. **Due to the potential for harm associated with the incorrect use or unsuitable prescription of such aids, ONLY health workers and trained workers**[1] **with some experience in providing assistive technology should facilitate access to these products.** Protection case workers with adequate training can provide referrals or use cash to support the purchase of assistive devices, again, only if in coordination with specialized service providers.

Assistive technology' is an umbrella term for assistive products and their related systems and services. It enables and promotes the inclusion, participation and engagement of people with disabilities, older people, people with communicable and noncommunicable diseases (including neglected tropical diseases), people with mental health conditions, and people with gradual functional decline or loss of intrinsic capacity[2].

Assistive devices can improve a person's functioning in areas such as cognition, communication, hearing, mobility, self-care and vision. They can be physical products like wheelchairs, glasses, hearing aids, prostheses, orthoses, walking aids or pads; or digital products like software and apps that help with communication and time management. They can also be changes to the physical environment, such as ramps or rails.[3]

Many people use more than one type of assistive product, depending on their needs.

The main types of assistive products provided in an emergency context are:

- **Mobility aids:** Used for sitting, walking, or standing with assistance (elbow crutches, wheelchair)
- **Prefabricated splints:** Used for upper limbs, lower limbs, and the trunk and neck (ankle-foot orthoses, wrist splint)
- **Specific items:** Assist with Activities of Daily Living (ADL), positioning (grab claw, wedge pillow)
- **Consumable:** Hygiene materials (disposable gloves, adult diapers)

If the assistive **product is not well matched** to the needs of individuals, or they are not given enough education and fitting to use the product safely and comfortably:

- The assistive product will likely go unused,
- It may even cause serious harm
- Deteriorate the situation of the person
- Increase unreversed complications such as bone deformities.

Due to the potential for harm or deterioration associated with the incorrect use or unsuitable prescription of such aids, its recommended that ONLY health workers/ trained workers[4] with some experience in providing assistive technology should facilitate access to these products.

Endnotes

1 For example, WHO's online Training in Assistive Products (TAP) is designed to prepare primary health and other personnel to fulfil an assistive technology role. This may include identifying people who may benefit from assistive technology; providing simple assistive products such as magnifiers, cruthes and dressing aids; or referral for more complex products and other services.

2 Global report on assistive technology-WHO

3 https://cdn.who.int/media/docs/default-source/assistive-technology-2/3128-emp-summary-landscape-local-print-081222.pdf?sfvrsn=37f41429_5

4 For example, WHO's online Training in Assistive Products (TAP) is designed to prepare primary health and other personnel to fulfil an assistive technology role. This may include identifying people who may benefit from assistive technology; providing simple assistive products such as magnifiers and dressing aids; or referral for more complex products and other services.

This form has been adapted from the Child Protection Case Management Supervision Package developed by the Child Protection Case Management Task Team

Annex 3.3
Staff Roles and Responsibilities

	Major Responsibilities
Role	**Responsibility**
Caseworker	• Identify and receive referrals of persons at heightened risk • Conduct household visits and center-based interviews to assess the needs of individuals and families • Provide information to individuals and families about their rights and entitlements, including what services are available • Work with identified individuals and families to develop and implement an action plan in accordance with their needs, capacities and goals • Assess risk and support clients to understand risks relevant to their situation • Maintain a supportive therapeutic relationship with the client and provide MHPSS services and referrals as needed
Protection Case Management Officer (Supervisor)	• Ensure case management interventions adhere to international best-practice standards and guiding principles • Oversee the development, maintenance and rollout of case management processes (service mapping, protocols, referral pathways, SOPs, etc.) where necessary • Provide support to case workers in handling complex cases and depending on the complexity of the case seek guidance from the specialist • Coach, train, supervise and mentor direct-report staff • Ensure caseworkers have access to staff wellbeing services including MHPSS services • Develop a case management quality strengthening action plan and schedule based on identified need and gaps • Conduct trainings as identified in the capacity building plans • Lead in the organization, development and facilitation of training, technical support provision, regular coaching sessions

Major Responsibilities

Role	Responsibility
Information Management Officer	• Support the development and implementation of regular monitoring and evaluation activities for case management activities • Ensures quality information management including case management databases
Volunteer	• Provide information to community members about how to access protection case management services and refer cases to caseworkers • Liaise with community leaders and members to introduce program activities and encourage community involvement in program implementation and activities • Facilitate client's access to services through the dissemination of up to-date information • about existing local services that are available within their communities

Major Responsibilities

Role	Data and Reporting
Caseworker	• Ensure complete and updated documentation related to each individual case • Manage, file and store data, ensuring the confidentiality of the information collected • Prepare and submit weekly and monthly work plans • Support the implementation of monitoring and evaluation tools and report on problems in the implementation of the program
Protection Case Management Officer (Supervisor)	• Ensure that the case management teams maintain complete, accurate, and confidential-case files • Compile and produce weekly and monthly protection case management reports • Support the implementation of monitoring and evaluation tools • Input into donor reporting on activities, indicators and achievements, particularly around case management staff capacity development • the supervisor analyze data collected through the supervision tools
Information Management Officer	• Identify and execute strategies to improve data collection methodology • Identify any new or potential risks to clients and staff due to data collection • Conduct data quality checks and regular data cleaning • Manage the development of protection case management databases • Analyse qualitative data collected from site visits, focus group discussions, key information visits and other qualitative methods; identify relevant trends and patterns.

Major Responsibilities

Role	Coordination
Caseworker	• Contribute to the maintenance of an up-to-date service mapping of the service providers • Receive cases referred from other agencies • Advocate on behalf clients to access services and support clients to effectively represent their views, needs and capacities in all meetings affecting them.
Protection Case Management Officer (Supervisor)	• Work with service providers to implement standard operating procedures and monitor adherence to referral pathway • Participate in local working groups
Information Management Officer	• Support the timely information sharing regarding challenges and needs at the field level

Qualifications

Role	Work Experience
Caseworker	• At least two years of experience in counseling or humanitarian assistance. Experience working within relevant context preferred.
Protection Case Management Officer (Supervisor)	• Proven practical experience of providing direct case management. Demonstrated understanding of case management processes, protocols, service provision and referral systems. At least three to five years' experience providing technical coaching and mentorship for case management or MHPSS programs. Practical experience providing direct case management. Previous experience in managing a team.
Information Management Officer	• At least two years of experience working with data analysis. Experience producing quantitative analysis and reports. Full professional competency in Microsoft Office Suite, especially Word, Excel, Outlook, and PowerPoint.

Qualifications

Role	Demonstrated Skills and Competencies
Caseworker	• Ability to maintain confidentiality, respect, non-discrimination and safety of clients at all times. Good communication skills. • Excellent interpersonal and problem-solving skills, creativity and flexibility. • Works effectively with people from all backgrounds, and develops strategies to address barriers faced by individuals most at risk of discrimination. • Communicate without judgement and demonstrate empathy.
Protection Case Management Officer (Supervisor)	• Ability to maintain confidentiality, respect, non-discrimination and safety of clients, staff, and volunteers at all times. Good communication skills. • Excellent interpersonal and problem-solving skills, creativity and flexibility. • Works effectively with people from all backgrounds, develops strategies to address barriers faced by individuals most at risk, and identifies and addresses discriminatory biases in supervised staff. • Communicate without judgement and demonstrate empathy.
Information Management Officer	• Strong analytical and reporting skills with attention to detail. • Excellent organizational and time management skills. • Good interpersonal skills and ability to work as part of a team.
Volunteer	• Well respected by the community. • Committed, motivated and willing to learn. • Good communication skills including the ability to gain trust and build relationships with the community. • Excellent interpersonal and problem-solving skills, creativity and flexibility.

Annex 3.4
Caseworker Capacity Assessment[1]

Purpose of the Form:

This helps supervisors to understand the extent of newly recruited caseworker's attitude, knowledge and skills. It contains minimum competency standards for all caseworkers providing client-centered case management services. The results of the assessment should inform the capacity building and development actions that a supervisor provides in individual and group supervision sessions.

How to administer the form:

Before:

The Supervisor Should
Step 1: Organize an individual supervision session in a comfortable and private space. The supervisor should set aside between 2-3 hours for this assessment or if it is preferred, this process can be broken down into 2 or 3 separate sessions.

During:

The Supervisor Should
Explain the purpose of the assessment to staff and ask staff to answer honestly and be self-reflective. This will be most helpful in identifying areas where staff can benefit from further coaching and staff development**.**

Supervisor can say: *"This form has been developed to capture some of the key standards that are expected of a protection caseworker. We don't expect you to be an expert and have perfect*

answers from the very beginning. It takes time to understand protection case management guiding principles and how to apply them with clients. During our first weeks together, this assessment will determine the areas where we can provide you with more technical support. After the assessment, we will continue working together to build your knowledge and skills. After a few months, we will revisit the assessment to see how you are progressing."

Step 3: Explain the form is divided into three sections (attitudes, knowledge and skills). Explain that the attitude assessment is a self-administered assessment where the caseworker will be given 20 minutes alone to answer these questions. Once this has been completed, the knowledge and skills assessment will be administered through a verbal interview with the supervisor. Explain that you will be taking notes in order to remember her/his responses. Invite the caseworker to raise any questions about the form or the process to ensure s/he feels comfortable. The supervisor should ask the questions on the questionnaire in order and give the caseworker time to explain/describe their answer. Allow the caseworker to speak openly and ask clarifying questions. Supervisors are encouraged not to provide answers, but should respond if there are some alarming issues that require immediate discussion and direction. For the attitude scale simply mark the scoring and don't ask for further elaboration.

Once the assessment is complete, the supervisor and caseworker should discuss what are the suggested priorities in each area for technical capacity building and development.

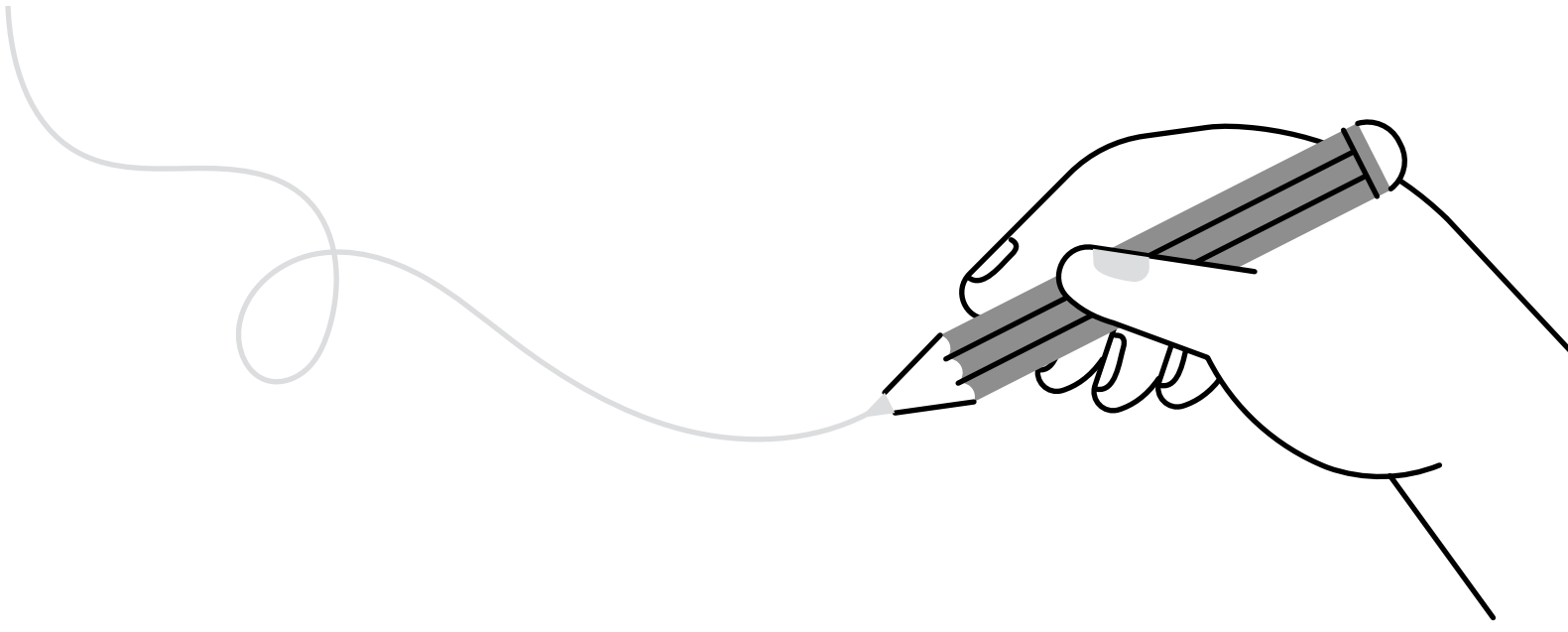
If the staff member does not meet, or only partially meets the required attitudes, knowledge and skills it may not be appropriate for them to work with persons at heightened risk until s/he undergoes personal reflection of the harmful values and/or beliefs or reviews the way case management services should be delivered. If this is the case, supervisors will need to handle this conversation carefully and sensitively.

After:

The Supervisor Should

During regular individual supervision sessions, the supervisor should refer back to the capacity assessment in order to provide ongoing coaching to the caseworker. If several caseworkers need guidance in the same area, the supervisor can organize a training or development session during group supervision. The supervisor should also arrange shadowing sessions for the caseworker to observe the application of guiding principles in practice.

After approximately 3-6 months, the supervisor should re-assess the caseworker to determine her/his progress and continuous development needs.



Caseworker Capacity Assessment

Date: _____

Caseworker: _____

Supervisor: _____

Part One: Protection Attitudes and scoring

This is made up of 15 statements to assess personal beliefs and values. The scale can measure their attitudinal readiness for working directly with persons at heightened risk and highlight areas for further learning and training.

Statements	Does the caseworker:				Caseworker's Response and Notes from Discussion	Development Priority?
	Strongly Agree	Agree	Disagree	Strongly disagree		
1. People with developmental disabilities and mental health conditions have something to offer the community and should be able to move freely	4	3	2	1		
2. Violence can sometimes be a person's own fault and is justified	1	2	3	4		
3. People of all political and religious beliefs and values have the right to express them and live in safety and dignity.	4	3	2	1		

Statements	Does the caseworker:				Caseworker's Response and Notes from Discussion	Development Priority?
	Strongly Agree	Agree	Disagree	Strongly disagree		
4. People who experience traumatic events cannot recover or become productive members of society.	1	2	3	4		
5. A caseworker should always consider a person's opinion and wishes when making a decision that will affect them.	4	3	2	1		
6. It is acceptable for caregivers to make decisions and provide consent on behalf of a person with developmental disability or and older person because they know best.	1	2	3	4		
7. Violence within a household is a family matter and should be handled within the family	1	2	3	4		
8. Services should always be designed with persons with permanent disabilities in mind	4	3	2	1		

Statements	Does the caseworker:				Caseworker's Response and Notes from Discussion	Development Priority?
	Strongly Agree	Agree	Disagree	Strongly disagree		
9. Retaliation from community members against former combatants is acceptable	1	2	3	4		
10. Men don't experience mental health concerns	1	2	3	4		
11. It is my job to determine whether a client is telling the truth	1	2	3	4		
12. Poor people often say that they have been excluded from assistance or don't have support so that they can get attention or money	1	2	3	4		
13. If a person can't answer the question properly or needs time, he/she is making up the case	1	2	3	4		
14. Locking someone up with a disability or mental health concern is normal in some situations	1	2	3	4		

Statements	Does the caseworker:				Caseworker's Response and Notes from Discussion	Development Priority?
	Strongly Agree	Agree	Disagree	Strongly disagree		
15. A former member of an armed group should not be accepted for protection case management	1	2	3	4		
Total Score (supervisor should sum the total score in each column and then add these together for the total score)						

The below scores should be used as a guide but are not definitive.

- **50-60:** Scores in this range indicate that the caseworker has a person at risk friendly attitude –they have positive beliefs and values for working with people at heightened risk. However, you can still consider supporting the caseworker on certain issues as needed.
- **35-50:** Scores in this range indicate some troubling attitudes that may be harmful to clients. Managers and supervisors should use their discretion in allowing staff to work on cases and may want to consider "coaching" the staff person before they work independently with person at risk.
- **34-0:** Scores in this range indicate that an individual is not ready to work with person at risk. Managers and supervisors should work independently with an individual who scores below 34 to address negative beliefs and attitudes and identify immediate actions to address these gaps.

Actions to be taken	Supervisor:	Caseworker:

Part Two: Case Management Knowledge

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
1. What are the Guiding Principles for working with people at heightened risk?	1. Respect confidentiality and its limitations 2. Promote client safety and security 3. Everyone is entitled to human rights equally and without discrimination 4. Participation: Clients should be supported to make their own decisions, their views and opinions should be respected 5. Empowerment: I should look to enhance a person's strengths and capacities for coping 6. Do not harm 7. Client-centered approach		
2. What can be possible consequences of violence for a person	1. Physical harm such as injury or disability 2. Psychological harm such as mental health problems (depression, anxiety, low self-esteem, isolation, hopelessness) 3. Difficulty trusting people and maintaining relationships 4. Difficulty accessing services 5. Stigma		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
3. What are the limits to confidentiality when working with persons at heightened risk?	1. If there are mandatory reporting laws in place 8. If the client is at risk of harming themselves 9. If the client is at risk of harming another person (possible homicidal) 10. If a person has been legally assessed to lack capacity for consent and all possible steps have been taken to support informed consent process with him/her 1. Where the client is a child and is at risk of harm we must act in the child's best interest		
4. Why might it be difficult for someone to leave an abusive situation?	1. Has nowhere safe to go 2. No economic resources of their own. Dependant on the abuser economically 3. Has hope that things will change 4. Is scared no one will provide care or support 5. Worried about breaking up the family 6. Worried what people in the community will say (stigma) 7. Unable to independently move or voice their concerns due to barriers		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
5. When and how should a caseworker obtain informed consent/assent?	When: 1. Before the identification meeting prior to intake into case management services for permission to hear the persons story, record and take notes 2. After the identification meeting prior to intake into the case management services to request for permission to participate in services 3. For referrals to other services providers How: 1. Address any barriers identified for informed consent with the client 2. Ensure the client fully understands the case management process 3. Ensure that the client fully understands confidentiality including how their information will be collected, stored and shared 4. Ensure the client fully understands the limits to confidentiality 5. Ensure the client fully understands their options and the potential risks and benefits of them 6. Provide time for any questions 7. Ask the client whether he/she wishes to proceed by signing/verbal consent		
6. What are the possible consequences of sexual violence on men?	1. HIV/AIDS or other STIs 2. Mental health problems (depression, anxiety, other) 3. Stigma 4. Relationship problems 5. Isolation in community		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
7. What are some of the reasons a client may not want to report violence or tell you their story?	1. Fear of retaliation from the perpetrator 2. Fear or worry that no one will believe them 3. Shame 4. Self-blame 5. Lack of transportation 6. Lack of money to pay service fees 7. Do not trust the authorities or service providers 8. Believe agencies only support certain people like children		
8. What are the steps of case management?	1. Identification and registration 2. Risk assessment 3. Case action planning 4. Safety planning 5. Implementation of the case action plan 6. Follow up and monitoring 7. Case closure 8. Case management service evaluation		
9. What body language can you use to make the client feel more comfortable (for example, how you are sitting)?	1. Sit face to face with client, but not at a desk 2. Make eye contact appropriately according to local customs 3. Keep a calm and relaxed body posture 4. Lean in toward the client as she/he speaks 5. Nod your head to show understanding 6. Keep a warm and friendly disposition		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
10. What are some things you can do to create trust and show respect to a client during your meeting?	1. Give full attention to client (don't take phone calls, etc.) 2. Don't interrupt; give time to talk and don't be in a rush 3. Use respectful language which mirrors the clients 4. Don't promise anything you cannot do 5. Give complete and honest information 6. Follow through - do what you say you will do 7. Don't tell them what they "should" do, give information to help them make their own choice.		
11. Describe how you should start your first meeting with the client (introduction, identification)	1. Greet the client 2. Introduce yourself, role and agency as well as anyone else present 3. Create a private and safe space 4. Assess any immediate risk to personal safety and security 5. Address any barriers to participation 6. Explain the case management process and the persons rights (can stop, refuse to answer, ask any questions) 7. Explain confidentiality and its limits including data protection 8. Explain any potential risks or benefits 9. Understand the persons general situation 10. Identify whether the person is at risk of/has experiences a rights violation 11. Determine the risk-level 12. Ask permission to proceed either for intake into case management services or to conduct a quality referral only		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
12. What are some key considerations when developing a case plan?	1. Develop within two weeks of the risk assessment 2. The client should drive the process of setting their goals 3. We should build on the client's strengths 4. Content of case plan should reflect the clients risk assessment 5. Should set specific, time-bound actions outlining who is responsible for what		
13. How can a caseworker support client-centered approach to case management ultimately support the client's empowerment process	1. View people as rights claimants and support them to access their rights 2. Listen to the client's opinions and requests without judgment and action their wishes 3. Assess a person's individual and environmental risk-factors and protective-factors to a violation and address these 4. Support clients to draw on their protective factors such as the resilience, strengths and resources inherent within them and household or community to build the action plan 5. Provide full information to the client of the types of services available, how to access them and possible risks 6. Where appropriate, safe and requested by the client support the families/household's commitment to the outcomes, goals and tasks outlined in the case plan		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
14. What are key healing statements you can use with clients	1. I believe you 2. You are not to blame 3. I am here to support you 4. What you are feeling is a very normal reaction to this situation 5. I am sorry you are in this situation/ this happened to you		
15. What are the main criteria for knowing when to close a case?	1. Goals within the case plan have been met as much as possible and follow up is complete 2. The client explains that they are able to address on-going challenges now themselves 3. The child and family relocate and the case file can be closed or transferred as appropriate 4. The client is transferred to another case management stream or due to relocation 5. No client contact for more than a specific period (i.e 2 months) 6. The death of a client		

Where a caseworker is able to answer most of these questions with the possible correct responses or similar responses (such as 5 criteria per answer) it indicates that the member of staff meets the core case management requirements and is able to work independently with person at risk with ongoing supervision. Where they were consistently below this level of response only providing 3 criteria or less and/or completely unable to answer some of the questions this indicates that a capacity building plan should be in place as there is not sufficient knowledge as well as where necessary one on one mentorship and trainings and shadowing staff.

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?

Overall Final Evaluation

Actions to be taken:	Supervisor signature:	Caseworker signature:

Part Three: Case Management Skills

This form is intended to guide a **process** of learning allowing a case worker to put their knowledge and attitude to practice. It is not an evaluation of the caseworker's performance. These questions can guide a discussion or role play. It lists skills associated with good case management practice and describes the correct answers/approach to look for. The form is for the supervisor only and is intended to help the coaching process because it provides a structured method to identify in which topics/issues caseworkers the most need support.

Please note: It is very important that the form itself and the written comments are not shown to the caseworker (so as not to make them nervous). Supervisor should take notes separately and once the supervision session is finished document their feedback on the form

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
1. Show how you would introduce yourself to a potential client in your first meeting.	1. Introduce themselves warmly as well as their role and agency 2. Ask the person what their name is 3. Check the space and ask whether the client feels comfortable, private and safe 4. Check whether there are any immediate safety concerns 5. Ask whether they need any support to fully participate in the meeting		
2. Show how you would use your body language to help a client feel safe and comfortable	1. Uses appropriate eye contact 2. Mirrors the words and phrases you use 3. Stays calm and comforting throughout the interaction 4. Using a short and gentle voice 5. Friendly facial expression 6. Leans towards you when speaking		

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
3. Show how you would explain confidentiality and its limits to the client?	Explaining that confidentiality means that *"I won't tell anyone what you tell me"* *Exceptions when confidentiality has to be broken. "There are a few situations in which I may have to tell someone else what you share with me but it is only for safety reasons-- if I think you may hurt yourself, or hurt someone else.* Ask if the client has any questions		
4. Explain what you would do if a client walks-in and starts to talk about what happened to him/her immediately	1. Let the client finish what she/he is saying. But do not ask further questions. 2. Politely let them know that you understand that she/he is in distress and that you would like to listen and help 3. Explain that before you can do that you need to explain a few things which are important for her/him to know.		

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
5. How should a caseworker respond if a client becomes hostile or angry during an interview?	1. Remain composed and calm 2. Do not raise your voice 3. Attempt to calm the person down; try determining what is causing the anger and recognize their feelings 4. Give the person space and time to think 5. Be alert for possible aggression and 6. leave the situation if it feels unsafe 7. Carry a cell phone and use it (where appropriate) 8. Conduct interviews with a colleague to mitigate risks if needed and as advised by your supervisor		
6. What are some important considerations when interviewing a client who has experienced abuse?	1. Do not push the client to speak about their experience 2. Tell the client they can take their time 3. Do not ask heavy questions that might re-traumatize the client they will speak to you about these issues at their own accord 4. Tell the client that you are here to help		

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
7. How can a you demonstrate empathy and respect for clients	1. Pay attention to verbal and nonverbal cues 2. Determine what is important to the client 3. Show a genuine desire to understand their situation 4. Keep an open mind 5. Create an environment of respect and acceptance 6. Listen for an acknowledge difficult feelings and encourage honest discussion		
8. Can you demonstrate with a few questions how you would start a discussion with a client about what happened to him/her?	Tell me about what brought you here today / I'd like to hear about what brought you here today Would you like to tell me about what happened? Use an open tell, explain or describe question.		
10. Can you show me how you would assess safety and do a safety plan?	1. Ask the client how safe they feel at home or in the community 2. With the client identify strategies and resources in the client's life that can help reduce the risk for harm 3. Use safety assessment or suicide assessment as needed		

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
11. Can you explain to me how you would come up with a coping skills plan with a client?	1. Ask the client 'when you feel sad or lonely or scared, who can you talk to?' Have the client (or you write down) list the people they feel comfortable with. 2. Identify the activities the client enjoys and the feelings associated with those activities. Build on the information you gathered from the psychosocial assessment. 3. Based on the client's answers, help them come up with a plan to talk to, spend time with the people they identified and to do the activities that make them feel better. Explain that they can use this plan whenever they feel [insert appropriate feeling]. 4. Ask the client if there is anyone, they would like to share their plan with who can help remind them of it.		
Actions to be taken	**Supervisor:**	**Caseworker:**	

Annex 3.5
Standard Operating Procedure Data Management and Protection

SCOPE

This SOP applies to all data managed by staff involved in Protection Case Management. The following datasets are included within the scope of this SOP:

Dataset(s) name(s)	Description	Sensitivity level
Client Protection Case Management Forms	• Registration • Intake and Protection Assessment • Safety Plan • Action Plan • Follow up • Case closure	High
Protection Outcome Forms		High
Supervisor forms	• Capacity Assessment (knowledge and attitude • Case File Check List • Observation Form • Shadowing Form • Case Discussion Form	Medium
Client Feedback Form		High

PURPOSE SPECIFICATION

The data will be collected, stored, and analyzed for the following purposes:

- To provide continuity of services to the client through the documentation of case characteristics.
- To analyse case progress and gaps
- In support of donor reporting and engagement

ROLES AND RESPONSIBILITIES

See Roles and Responsibilities

Case Manager

- Is responsible for ...

Supervisor

- Is responsible for ...

Coordinator

- Is responsible for ...

IT Focal Point

- Is responsible for ...

Protection Information Manager / MEAL staff

- Is responsible for ...

DATA RESPONSIBILITY IN THE PROTECTION CASE MANAGEMENT DATA CYCLE

1. **Planning**
   a. [X] will conduct a Data Risk Analysis of the Protection Case Management initiative.
   b. [X] will conduct a minimization exercise, review of the data fields to ensure only the necessary data is collected.
   c. [X] will ensure that all staff involved in protection case management are trained and aware of the data protection protocols, the security implications of sensitive data and have a strong understanding of the importance of confidentiality.

d. [X] will ensure there is an obligation to adherence to data protection policy in staff contracts.
e. [X] will ensure that all clients and caseworkers will be allocated a code based upon an agreed standard coding format.
f. [X] will ensure that data protection protocols are followed and updated regularly (i.e. when contextual changes occur).

2. **Collecting/Receiving**
   a. [X] will confirm the data protection measures are implemented during the protection case management process.

3. **Storing**
   a. [X] will store the data on the following secure storage modality: [STORAGE MODALITY]
   b. [X] will ensure that all data protection measures within the data protection checklist are implemented and updated when required.
   c. [X] will monitor whether access to the data to staff is limited to that needed to fulfill the purpose of the data management activity.

4. **Assuring Quality**
   a. [X] will revise protection case management data using the following methods and tools: [METHODS AND TOOLS FOR QUALITY ASSURANCE].

5. **Sharing**
   a. [X] will share the data for referral using [INSERT CHANNEL].

6. **Analyzing**
   a. [X] will take the following measures to prevent exposure of sensitive data during analysis or visualization: [RISK MITIGATION MEASURES].

7. **Retaining and Destroying**
   a. [X] will be responsible for retaining the data as needed and destroying the data once the retention period ends. The retention period of the data is the following: [RETENTION PERIOD].
   b. For the duration of the retention period, the data will be retained on the following infrastructure: [Infrastructure].
   c. [X] will regularly reassess the value and sensitivity of retained data to ensure that retention is still appropriate.

d. [X] will destroy data at the end of the retention period using a tool such as ¨Secure Erase¨, preventing data retrieval, rather than just deleting the data.

DATA BACK UP

Two backups exist of all data in table 1:

- **One site:** one stored in the location of the database and backed up each week data is entered. The on-site back up is an external hard drive which is kept locked in a filing cabinet, and the off-site back up is done through emailing the database to the designated receiver (most likely Head of Program) as an encrypted, password-protected file.
- **Off-site:** the database copy sent to Head of Unit or the Information Management Officer once a month. This off-site back-up ensures that the main database can be restored in case of technical problems, or destroyed in an emergency evacuation without this meaning the loss of all electronic data.

EMERGENCY EVACUATION/RELOCATION

In the event of an evacuation/relocation, the following actions will take place:

- Management will ensure that the computer(s) where the database is setup, its back up systems and paper files are moved to a safe location.
- When moving database assets and paper files is not possible, management will ensure assets are destroyed and papers burnt. Information saved in back-up systems will then become the only source of information on clients.
- It should be noted that in some circumstances, it may not be necessary to destroy files and therefore is more important to ensure they are properly secured and protected during the period of evacuation/relocation.

Evacuation/relocation drills are carried out on a [X] monthly basis.

INCIDENT NOTIFICATION

Data incidents are events involving the management of data that breach the data protection protocols. All staff involved in PCM are responsible to report any breach to their supervisor. [X] should be informed within 24 hours in case of the following data incidents: unwarranted or unauthorized disclosure of data, or; loss, destruction, damage, or corruption of data.

GOVERNING LAW

Actors involved in the [ACTIVITY] may be subject to different national and international legal frameworks and should consult their legal focal point to identify any specific legal requirements or restrictions related to data management for the [ACTIVITY].

Annex 3.6
Staff Data Protection Agreement

Data protection and data security is the responsibility of every staff member who works with clients or has access to client information. Staff should be clear about why they are collecting data and should not collect or share any personal information other than in accordance with organization´s data protection standards.

Protection data is particularly sensitive. It should only be collected, stored, or shared with the individual's explicit, written consent, adhering to the principles of 'need to know,' and according to protocols developed in country.

By my signature below, I affirm that I have been advised of, understand, and agree to the following terms and conditions of my access to information (please initial each point and sign below):

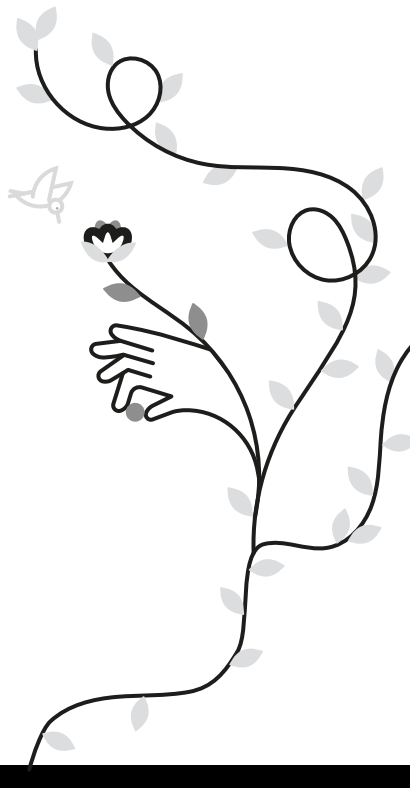
- I understand that my access to data, information, and records containing information about clients is limited to my need for the information in the performance of my job duties.

- I will not disclose information about clients without their appropriate and informed consent. I understand and agree that my obligation to avoid such disclosure will continue even after I leave my employment.

- I will be careful to protect information against accidental or unauthorized access, disclosures, or destruction.

- I agree to abide by all organizational data protection policies.

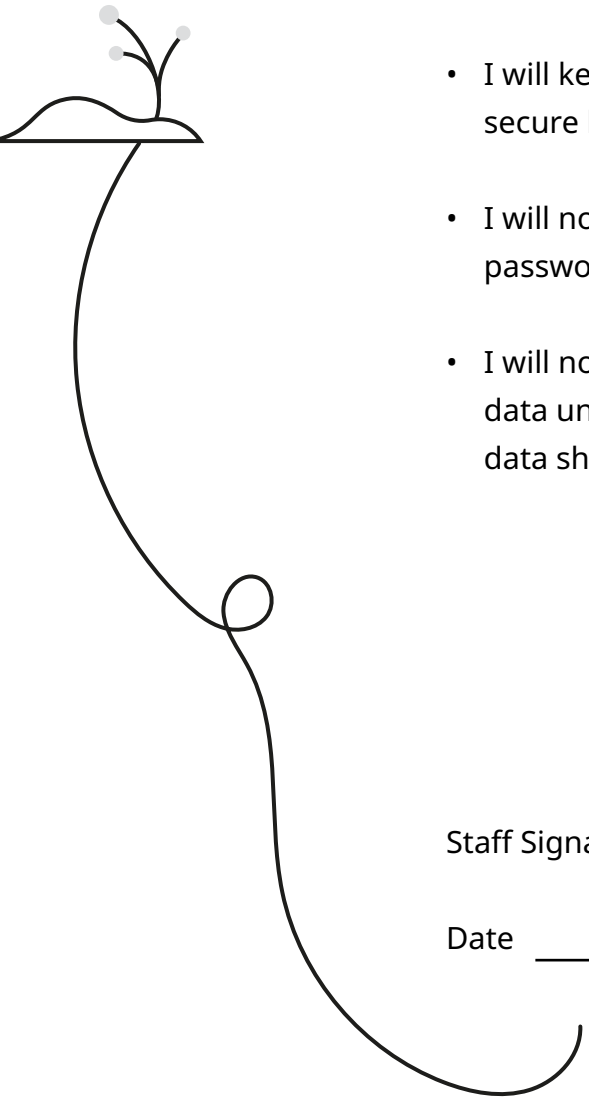
- I will not access the protection information management database(s) or other client files or records in a public, non-private setting. I will not connect to a public WiFi network with the device used to access client files.



- I will not share any personally identifiable client data with anyone outside of my organization without the express written permission of the client and a data sharing agreement in place.

- I will not share any aggregate anonymized client data without following the proper protocols at my office. Inter-agency data sharing must go through/be approved by a central focal point, for example, the head of unit.

- I know that clients have a right to access their personal information therefore I will be accurate and non-judgmental in what I write about clients and other organizations.



- I will keep all paper files containing personal information locked in a secure location (lockable filing cabinet, safe) per the office protocol.

- I will not share my log-in information or passwords. I will update my password regularly, as per the office protocol

- I will not leave the screen or open documents containing sensitive data unattended. I will not print out sensitive data - only de-identified data should ever be printed out.

Staff Signature _____

Date _____

Annex 3.7
Software Requirements Specifications

Purpose

The purpose of this document is to provide a detailed description of the recommended software specifications required for a digital PCM information management system. These software requirements operationalize the core case management principles, including “privacy” for the client and “do no harm”. This document is based on consultation sessions with users and technical experts and should be complemented with any additional organization and country specific requirements.

I. Software System Attributes

I.I. Availability and resources required

- Ability to collect data offline and through standard mobile devices.
- Ability to host media and documents.
- Configurable workflows/processes following the steps of case management.
- Ability to be customize to country contexts
- Country level customization and maintenance is user friendly and tailored to the resource constraints protection organizations face, including for teams without advanced programming capacity, using drag and drop and bulk upload functionalities to tailor global tools to country level requirements.
- Crisis level license costs or payment structure are not prohibitive for smaller response organizations.
- Interoperability with outside systems for referral purposes.

I.II. Security

- Access to client-specific information limited to need to know basis.
- Ability to hide client identifying information from anyone beside the individual service provider assigned.

- Administrator controlled username and password access
- Automatic timeout/log-off
- Administrator controlled user level read, write, edit, and delete capabilities.
- Administrator controlled user level module and sub-module access
- Automated audit trail
- Security industry standard encryption and SSL certifications
- Back-end server(s), including data encryption and transmission.

II. User Interfaces

II.I. Login Interface

- Web interface login screen to enter username and password.

II.II. Form Selection

- User interface is role specific: users can access relevant forms based on their role.

II.III. Data Entry and Validation

- Available to use on mobile devices and desktop.
- Data entry and validation is possible offline.
- System possible in multiple languages.
- Questions and response options are locally customizable based on country/project contexts.
- Client Listing and Detail
- Caseworkers and supervisors can filter and see a listing of clients' case files and their status.
- Selecting a client/case file enables user to see more detail about the client/case.
- Caseworkers and supervisors can track specific cases over time, and update or add to the information about the case that is saved.
- Once a client/case file is selected, a caseworker can edit existing information .

II.IV. Supervisor performance monitoring and feedback

- The system provides some level of performance monitoring for the supervisors.
- Interactivity between supervisors and caseworkers

- Supervisor feedback can be tracked as part of the case file.
- Supervisors can re-allocate cases to other caseworkers.

II.V. Data Presentation and Dashboards

- Aggregated anonymized information is available to support decision making, donor reporting and general programming protection activities.

II.VI. Data Export

- Filter and search options for clients and case files
- Ability to select specific and all case files to export aggregate, anonymized datasets

III. Functional Requirements

III.I. User class 1: The case worker

III.I.I. Administering consent

- Ability for case worker to administer consent to:
  1. Proceed with intake and
  2. Share information to support referrals.
  3. Share information as part of donor reporting
  4. Participate in client feedback mechanisms.
  5. Informed consent (talking through client with risks and benefits) for service (updateable as new courses of action come up)
  6. This consent is verbal, or documented as part of the case file via a digital signature or by uploading a picture of the signed form.

III.I.II. Engage an interpreter.

- Ability for case workers to engage an interpreter, take the interpreter's name and contact details.
- Administer non-disclosure agreement (NDA) to interpreter.

III.I.III. Search and Register

- Ability to search for case before starting a new one to determine if client has been registered in the system.
- Identification and registration of an individual for case management (tracking of individual and their protection issues after enrollment)

III.I.IV. Assessment and enrollment

- Conduct a protection case management intake.
- Ability for case work to capture both individual and group reporting of incidents.
- Ability to adjust small errors in previously entered data.
- Ability to update data in case of a change in client conditions.
- Ability to halt intake and return to unfished intake at a later date.

III.I.V. Action planning

- Assessment of client needs and desired outcomes.
- Ability to propose actions, including steps, responsibilities persons/organizations.
- Ability to pause any form at any time to conduct a safety assessment and return to complete the original form afterwards.

III.I.VI. Safety Planning

- Assessment of client safety needs when required during the process.
- Ability to propose actions, including steps, responsibilities persons/organizations.

III.I.VII. Follow-up

- Ability to document the status of each goal
  - Document if there's progress in the case.
    - Including outside services received/not received.
  - Document any challenges faced and resolutions made.
- Ability to document specific assistance the case worker provided during the follow-up.
- Ability to upload any new documents/ evidence.
- Ability to document next steps/ actions taken.

III.I.VIII. Referral

- Referral outside of the system
- Ability to track referrals, including type of service provision and successfulness of the service.
  - Ability to refer a client for services not provided by the IRC project, clearly indicating the referral method.
  - Ability to share client-level information across agencies/ organizations to facilitate a referral.
  - Ability to document contact details of the receiving officer, and a short description of the case as part of the referral.

- Ability to share relevant materials (evidence) as part of the referral.
- Ability to document and retain history of client specific referrals, including follow up.

III.I.IX. Case Closure

- Ability for a case worker to mark a case for closure documenting if case was resolved and how it was resolved.
- Ability to ask for approval of case closure documentation from supervisor.
- Ability for case worker to enquire if client wants to participate in a satisfaction survey which can be self-administered, conducted by either the case-worker's supervisor, a different case worker or by the M&E department

III.I.X. Performance Metrics

- Ability for case worker to see a snapshot of key performance indicators on cases (open, closed)including case profiles

III.II. User class 2: Supervisor

III.II.I. Case review and feedback

- Ability for a supervisor to assess the sensitivity/risk of a case prior to intake.
- Need supervisors to be able to give feedback on cases.
- Need case staff to receive feedback on cases.
- Need role-based access to limit viewing to those in supervisory chain.

III.II.II. Re-assign cases

- Need ability to reassign cases to a different case worker.

III.II.III. Case Referral

- Ability for a supervisor to review and approve or reject a referral.
- Ability for supervisor to refer a case with similar privileges to 2.1.1.8. "Referral."

III.II.IV. Case Closure

- Ability for a supervisor to review and approve or reject a case closure.

- Ability for supervisor to close a case with similar privileges to 2.1.1.9. “Case Closure.”
- Ability to re-open a case

III.II.V. Client Satisfaction Survey

- Ability of a supervisor to administer client satisfaction survey when clients consent for one.

III.II.VI. Performance Metrics

- Ability for a supervisor to see a snapshot of key performance indicators includingincluding case profiles for their direct reports
- Total number of new cases registered
- Total number of active case (active as in actively being worked on as opposed to pending which amounts to the unresolved cases)
- Number of caess open
- Number of cases closed
- Case/Case worker ratio
- Total number of successful referrals
- Total number of cases by violation/incident type
- Total number of cases by risk level
- Number of clients that require a safety plan
- Number of cases by time from case opening to case closure (less than one month, 1-3 months, 3-6 months, more than 6 months)
- Number of clients who received cash assistance through protection case management

III.III. User class 3: Coordinators

III.III.I. Review Complex Cases

- Search and view complex cases e.g., those involving multiple beneficiaries.
- Ability to provide guidance to supervisors and case workers on these complex cases.

III.III.II. Reporting and Data Analysis

- Ability to access a dashboard with Key performance indicators and case profiles to support decision making.
- Ability to generate organizational reports with aggregate information to facilitate information sharing.

- Ability to compile organizational aggregate reports.
- Ability to generate ad-hoc reports or statistics.

III.III.III. Access data export for further analysis

- Capacity to export data for further analysis to CSV or XLS formats, including stripping identifiers from the data (i.e., names)

III.III.IV. Access data export for quality control

- Access randomly selected case files as part of the case audit.
- Ability to access a dashboard with Key performance indicators to support quality control.

III.IV. User class 3: Information Management Officer

III.IV.I. Customization

- Review digital application against local form customization.
- Documenting request for change and sharing with TAs for approval.
- Ability to translate from in all relevant languages.
- Ability to generate ad-hoc reports or statistics.
- Ability to add users and assign them roles in the system.
- Ability to disable users in the system.

III.IV.II. Access data export for further analysis

- Capacity to export data for further analysis to CSV or XLS formats, including stripping identifiers from the data (i.e., names)

IV. Performance Requirements

IV.I. Promoting Accuracy

This system will utilize data assurance techniques, such as:

- Default configuration based on harmonized minimum data set.
- Drop down questions with standardized response options.
- Share database names between fields on multiple forms to reduce duplicative data entry.
- Skip logic to show specified data fields when relevant.
- Logic or validation warnings (e.g., a date of birth after the date of incident, issues an error notice)

IV.II. Timing

The system should be available for use 24/7 except during periods of system maintenance. Once data is synchronized or entered in real-time on the Internet, it will be available to those with authorized access. A hosting vendor should be carefully chosen for agile response times and ability to respond to data security concerns. The hosting vendor will ensure that system updates, software updates, and regular system maintenance are completed in a timely manner, ideally not during business hours unless in case of an emergency.

IV.III. Capacity Limits

The server hosting vendor will ensure that the server has the capacity to store the requested cases for a period of three years as well as associated storage capacity for retention of historical data and reporting.

IV.IV. Customization and flexibility

It is expected that the software product owner will be requested to continually update and improve the software. The software should also be flexible and customizable to suit organizational needs and inter-agency updates.

Annex 3.8
Data Protection Checklist

You can use this checklist to assess whether you have minimum standards in place when collecting, storing or sharing your client's data. If after going through this checklist you determine that you don't meet these standards you should contact your technical advisor or head of unit for support.

Data Protection Measures	Y/N
Is there a Staff Data Protection Agreement in place? (see Annex X) • Is it signed by staff interacting with protection case management data and stored as part of their HR files?	
Have staff been trained on confidentiality, data protection protocols and the process for seeking informed consent? • Has adherence to the data protection policies been included within staff contracts? • Are documents and accompanying training updated updated regularly (i.e. when contextual changes occur)?	
Are staff informed about and comfortable discussing applicable and functioning local mandatory reporting mechanisms? • Do staff know the applicable and functioning mandatory reporting requirements and how they are applied in the program (the process and outcomes)? • Have the risks to clients mandatory reporting been discussed in the program?	

Data Protection Measures	Y/N
Paper file security: are records/files stored in a safe location? • Are paper files being kept in a locked cabinet / drawer, accessible only to responsible individuals specified by the Managers? • Are all staff aware of the importance of being vigilant as to who is entering the room where they work and for what purpose? • No one else should be given independent access to the paper files without permission and there should be limited access to keys • Are electronic devices with client information locked in a safe location? (This includes laptops, external hard drives, USB/flash drives) • Is paper documentation for each case is stored in its own individual file, clearly labeled with the case number, not the name of the client? • Are the consent form and the identification and registration form in a separate folder to the rest of the client's case file?	
Is there a protocol for safe destruction of paper forms (shredding, burning and wetting)? • Are staff aware of appropriate times and places to do this? • Is there an emergency protocol in place for safe destruction/transfer of files in case of staff evacuation or imminent security threat?	
Is electronic data protected? • Do electronic case management systems meet minimum standards (see Annex X) • Are mobile devices appropriately protected with a strong pin, two-factor authentication? Are device operating systems and applications up to date? • Are laptops and computers protected by a strong, alpha-numeric password? Are device operating systems and softwares up to date? • Are staff aware of the sharing protocols, including that information should be transferred by encrypted and password-protected files whether this is by internet or USB/memory sticks? • Are all electronic devices set to screen lock after 3 minutes of inactivity?	

Data Protection Measures	Y/N
Are clients informed of their rights in terms of data collection, storage and sharing? • The right to request that their story, or any part of their story, not be documented on case forms. • The right to refuse to answer any question they prefer not to. • The right to tell the caseworker when they need to take a break or slow down. • The right to ask questions or ask for explanations at any time. • The right to request that a different caseworker of a different gender or organization be assigned to their case. • The right to refuse referrals, without affecting our willingness to continue working with them. • The right to access their personal information at any time.	
Is data access limited to ´need to know´ basis? • Are clients and caseworkers allocating a code based upon an agreed standard coding format? • Access to information on clients should be limited only to those who need to know it and to whomever the clients have agreed to know it through giving their informed content to store their data. • Information is not being passed to a third party without the informed consent of clients and/or their caregivers and following the data sharing protocols. • Agreed mandatory fields are shared with supervisors only, or when cases require and consent to referral.	
Are applicable data protection laws in the country of operation abided by • What are they? Has this been discussed in the program? Have required measures been implemented?	

Annex 3.9
Data Sharing Agreement Template

TEMPLATE DATA SHARING AGREEMENT

This Data Sharing Agreement (hereinafter "agreement") is designed to outline the process for the sharing of protection case management client data between *{Organization XX}* and *{Organization YY}* in *{location}* for the purposes of referral. It details the role and responsibilities, the protocols for data sharing, access and storage, as well as the required data protection measures.

1. TRUST STATEMENT

{Organization XX} and *{Organization YY}* recognize the benefits of sharing data in a responsible, safe, and purposeful manner to provide responsive and remedial support to a person at heightened risk of a rights violation through service provision.

The parties understand the risks of sharing and not sharing, and commit to sharing and receiving data and information according to the humanitarian principles and in line with protection and information management principles[1] and respective organisational policies on the same.

2. PURPOSE AND OBJECTIVES

The purpose of data sharing as part of this agreement is to facilitate Safe, accountable and timely referrals to connect client to essential basic, protection and specialised services. Information, including personally identifiably data on specific clients, with their informed

consent, is shared by *{Organization XX}* to *{Organization YY}* to:

- Facilitate **referrals** of clients and enable follow-up on these referrals.
- Facilitate **payment** by organization XX for specific services.
- Facilitate **analysis of aggregate outputs** and the development of lesson learnt documentation.

3. HUMAN AND TECHNICAL CAPACITY

{Organization XX}

Data consolidation, analysis and processing within *{Organization YY}* is governed by the following established policies {list relevant organizational policies and relevant HR structures to implement these policies and this DSA}.

{Organization YY}

Data consolidation, analysis and processing within *{Organization YY}* is governed by the following established policies *{list relevant organizational policies and relevant HR structures to implement these policies and this DSA}.*

Both organizations are committed to the PIM principles when collecting, analyzing and sharing data, including those of informed consent and do no harm.

{Organization XX} and *{Organization YY}* commit to ensuring that the designated focal points within the respective organizations can access the data shared. Authorized designated focal points are employee of the organizations in this agreement and access any data on a 'need to know' basis. Specifically, this will include *{roles to be modified as relevant}.*

- YY Referral focal point
- YY Protection supervisor
- YY Protection assistant
- XX Referral focal point
- XX Medical Team supervisor
- XX Medical assistant

Adding any additional staff as authorized persons will require written prior approval between the two parties.

4. CHARACTERISTICS DATA

This agreement governs the sharing of protection cases management client data between *{Organization XX}* to *{Organization YY}* including:

{Add list variables that will be shared. If this list exceeds 10 variables, provide a detailed list within an Annex. For each variable, clarify the specific purpose of sharing. Example list:

Variable:	**The purpose of sharing this data is to...**	**Sensitivity Classification**
Date of identification	*Enable case prioritisation and monitor follow up*	*Restricted*
Full name	*Schedule appointment with client*	*Strictly Confidential*
Phone number	*Schedule appointment with client*	*Strictly Confidential*
Address: governorate, district, sub-district, village/neighbourhood	*Offer services closest to clients location.*	*Strictly Confidential*
Preferred means of communication	*Ensure client can be reached using the most effective and preferred communication method*	*Restricted*
Details on individual's urgent needs and reasons for referral	*Provide a service tailored to the needs of the client. Avoid the client having to explain their situation multiple times.*	*Strictly Confidential*
Information related to the individual's situation in relation to the service eligibility criteria	*Ensure client can access available service*	*Strictly Confidential*
Any characteristics requiring accommodation from the receiving agency, such as disability status.}	*Ensure client can access available service, safely.*	*Strictly Confidential*

One or more variables within this dataset can be classified as "Strictly Confidential"[2], meaning that it contains formation or data that, if disclosed or accessed without proper authorization, are likely to cause severe harm or negative impacts d/or damage to clients and/or humanitarian actors and/or impede the conduct of the work of a response. These characteristics can only be shared if associated risks have been noted in the DRA as mitigatable.

5. PLANNED ACTIVITIES AND EXPECTED RESULTS

Prior to the referral, clients should be asked whether they consent to the referral and having their contact information and personal situation shared with the receiving organization for the purpose of referring them.

{Organization XX} will:

- Initiated by the designated focal point when (1) the person referred seems to meet the eligibility criteria and (2) gave their informed consent for their data to be shared with the receiving organization. The informed consent must be specific to the referral procedure and noted in the referral form.
- This referral form will be shared {detail sharing mechanism, e.g. e-mail, hard copy to designated focal point}. It includes an explanation of the services they are referred to as well as the data protection measures put in place.

{Organization YY} will

- The receiving agency should immediately inform the sending agency that the referral was received.
- Inform the sending agency about outcomes and follow up actions taken on all cases including whether the person referred was assessed, registered, whether the services were provided, what type of service and outcome. If the referral was not successful, the receiving agency will explain any challenges faced.
- In case of a data breach {Organization YY} will inform {Organization XX} within one working day.
- Client data will be destroyed after services has been provided or in line with organization policy.

6. OWNERSHIP OF THE DATA

The client retains full ownership of all data shared. As such, the client can request modification to already shared data, as well as the deletion of one or more types of data. {Organization YY} is to honor this request within 10 working days.

7. DATA USE AND SHARING WITH THIRD PARTIES

The data shared is considered confidential. The data can only be used in support of the objectives outlined in chapter 2 ¨Purpose and objectives¨.

The data is shared with {name of Department / Team within organization YY}. The data cannot be shared with other departments or teams unless previously approved by {Organization XX} in writing, and with informed consent of the client. The data cannot be shared with any other third party unless previously approved by {Organization XX} in writing, and with informed consent of the client.

8. EFFECTIVE DATE, DURATION, AMENDMENTS, AND TERMINATION

This Agreement may be modified, amended, or replaced with a new version if all Parties agree in writing. A Party may terminate this Agreement at any time but must provide at least one month's written notice to the other Party.

This Agreement becomes effective on the date of written confirmation of the Agreement by both parties and will remain in effect for (twelve (12) months).

9. USE OF DATA FOR REPORTING PURPOSES

Anonymized aggregated data can be used by both organization for overall service and caseload analysis. Any agreed use of anonymized data for statistical purposes will be created as per donor requirements.

Individual responses will never be published in full. If quotes are published, identifying details will be removed to protect the confidentiality.

10. DISPUTES

Should disputes arise out of this sharing agreement they will be resolved between the signatories. In case of problems not being resolved to the satisfaction of both parties the matter will be escalated to the responsible line managers.

Date:
For and on behalf of XX:
Signature:
Name:
Position:

Date:
For and on behalf of YY:
Signature:
Name:
Position:

Endnotes

1 http://pim.guide/essential/a-framework-for-data-sharing-in-practice/

2 See Information Sharing Protocol Sensitivity Classification IASC Operational Guidance Data Responsibility in Humanitarian Action 2023 https://docs.google.com/document/d/1lElv51jJCZoyf8Y8d4TRu3pNAusEknr3appKzSszaEc/edit

Annex 3.10
Common MEAL Terms and Definitions

MEAL	Monitoring, Evaluation, Accountability, and Learning (MEAL) is a way of assessing the impact and effectiveness of humanitarian interventions, and improving the quality and accountability of humanitarian action
Monitoring	Refers to the ongoing process of collecting and analyzing data on program activities and outputs, to ensure that they are implemented according to plan and to identify areas for improvement.
Evaluation	The periodic, user-focused, systematic assessment of the design, implementation and/or results of an ongoing or completed project.
Accountability	Ensures that clients' voices are heard and considered in program design and implementation. It allows organizations to solicit feedback from those they serve, making programs more responsive to the needs of the community
Learning	Having a culture and processes in place that enable intentional reflection. The aim of learning is to make smarter decisions
Outcome	Refers the tangible and measurable results or changes that occur as a result of providing protection services and support to individuals or communities facing various forms of vulnerability, risk, or human rights violations
Output	Refers to the immediate and direct results or products of a protection case management intervention or program. These outputs are typically the activities and services provided to individuals or communities facing various forms of vulnerability, risk, or human rights violations.

Data analysis	Refers to the process of systematically examining and interpreting data and information related to protection cases and the services provided to individuals or communities facing various forms of vulnerability, risk, or human rights violations. This analysis is a critical component of protection case management and aims to inform decision-making, improve program effectiveness, and ensure that the needs of beneficiaries are adequately addressed.
Activity	Are the specific actions, interventions, and services that professionals or organizations provide to individuals or communities facing various forms of vulnerability, risk, or human rights violations. These activities aim to address the unique needs and circumstances of each case, with the ultimate goal of improving the well-being, safety, and protection of the affected individuals.
Reporting	The process of documenting and communicating information about the status, progress, and outcomes of protection cases and the services provided to individuals or communities facing vulnerability, risk, or human rights violations
Data interpretation	The process of analyzing and making sense of the data collected while managing protection cases. This interpretation is a critical step in understanding the outcome of protection interventions, identifying trends and patterns, and informing decision-making for ongoing and future cases.
Information management system	Refers to a software or digital platform designed to support and streamline the processes and tasks involved in case management. Case management IMS systems are commonly used in various fields, including healthcare, social services, legal, and protection, to enhance the efficiency, organization, and documentation of case-related information
Client	An individual who is enrolled in protection case management services

Intake	The activity during which a possible client is identified, based on the context specific eligibility criteria. The total number of intakes exceeds the number of cases, as some people will not receive protection case management, but will instead be referred to a different service or activity.
Open case	A case that is active at the time of measurement.
Closed case	A case that has been closed, as part of the last step of protection case management, for instance when a client's needs have been met to the extent possible within the context, or if case worker has not been able to reach the client for predetermined period of time.
Total cases	Total number of cases open and closed.
Protection risk	The potential or actual exposure of a population to coercion, violence, or deliberate deprivation.
Psychosocial wellbeing	Psycho-social wellbeing is a holistic measure of a clients' welfare. It captures both subjective wellbeing, the degree to which a client is 'feeling good', and psychological functioning, whether a client is 'functioning well' in their daily life. Psycho-social wellbeing should increase as a result of case management support.
Psychological distress	Psychological distress focusses on a client's mental health. Someone with moderate or high levels of severe distress is experiencing a compromised state of mental health that interferes with their ability to function in their daily life. Disabling distress should decrease as a result of case management support.

Annex 3.11

Measuring the Protection Case Management Theory of Change

What we are aiming for

Impact: In humanitarian crises, people at risk are able to realize their rights and live in safety and with dignity.

Pathway: Protection risks are mitigated, and people at risk recover from experiences of harm, including discrimination, violence, reduced access to services, and threats to their integrity, safety, and life.

Category	Statement	Indicator(s)
Protection Outcomes (Level II)	2. People at risk achieve improved psychosocial wellbeing through protection case management support	• **PO-01:** % of clients who demonstrate improved psychosocial wellbeing after receiving protection case management support
Protection Outcomes (Level I)	1.1 People at risk are less impacted by protection risks through protection case management support.	• **PO-02:** % of clients who report being less impacted by protection risks after receiving protection case management support • **PO-04:** % of PCM clients who report that they are better equipped to reduce or mitigate the protection risk after receiving PCM support
Protection Outcomes (Level I)	1.2. People at risk with mental health needs demonstrate a reduction in symptoms of severe distress through protection case management support.	• **PO-03:** % of clients with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving protection case management support

Category	Statement	Indicator(s)
Process & Quality Pathway:	People at risk have access to quality, and client-centered protection case management services when they need it.	
Process & Quality	1.1 People at risk are eligible for and receive to PCM services.	• **PQ-01:** % of intakes eligible for PCM • **PQ-02:** # total protection case management clients • **PQ-03:** # of new cases registered for protection case management (originally CP-09) • **PQ-04:** % of cases closed due to meeting objectives of the action plan • **PQ-05:** % of clients who received cash assistance through protection case management
Process & Quality	1.2 PCM services are sufficiently staffed and resourced.	• **PQ-06:** Average # of clients per case worker per month
Process & Quality	1.3 Case workers possess the skills, knowledge, and willingness necessary to support clients through PCM services.	• **PQ-07:** % of caseworkers whose knowledge assessment score is at least 70% • **PQ-08:** % of caseworkers whose attitudes score is at least 80% • **PQ-10:** # of case workers trained on protection case management
Process & Quality	1.4 PCM services are delivered in a client-centered way that is accountable to clients, inclusive, and in line with their needs and preferences	• **PQ-11:** % of clients that felt they were involved in decisions during their case management • **PQ-12:** % of clients that are satisfied with the case management services

Category	Statement	Indicator(s)
Process & Quality	1.5 PCM services are delivered in line with quality standards and protocols (as articulated in the protection case management guidance)	• **PQ-09:** % of case files reviewed that meet 80% of criteria of a case file checklist
Process & Quality	1.6 Case workers establish strong relationships with clients based on a foundation of empathy, inclusion, support and trust.	• **PQ-11:** % of clients that felt they were involved in decisions during their case management • **PQ-12:** % of clients that are satisfied with the case management services
Process & Quality	1.7 PCM clients are successfully referred to relevant services (including specialized mental health services, legal support, and health and education services).	• **PQ-13:** % of successful referrals
Case Characteristics: *Who are the people at risk?*	• % of cases by protection risk • % of cases by risk level • % of cases by duration • % of clients that have a disability • % of clients with a finalized safety plan • % of clients reporting symptoms of moderate to severe distress in the 14 days prior to survey completion *Disaggregation by gender, age group, and disability are industry-standard and should be used along with any other contextually-relevant vulnerabilities.*	

Annex 3.12
Client Feedback Modalities

When deciding on the most appropriate feedback channels, take into account the clients' preferred format and modalities, as well as any resource constraints and client literacy levels. The client should be provided with multiple options to provide feedback: it is recommended to establish at least one proactive feedback channel, such as a survey with clients, and one reactive feedback channel.

Reactive channels: Through reactive feedback mechanisms, such as toll-free hotlines, suggestion boxes and social media outlets, clients can provide feedback in a format and at the time they choose. This type of information complements insights collected through proactive channels. These channels are specific to PCM services or are, more commonly, part of a programme wide feedback mechanism system, that clients can access to provide feedback on any type of intervention received from a specific organization or sector. Ensure accessibility to these channels through targeted information dissemination.

Proactive channels: As part of protection case management, a survey with the client is the most common proactive feedback mechanism. It is the key instrument to measure client's level of satisfaction with the services. The following table details the advantages and disadvantages of the different modalities that can be used to administer such surveys:

	Modality	Advantages	Disadvantages
Recommended	A feedback survey is self-administered by the client[1]. The survey is kept anonymous.	The anonymous nature of a self-administrated survey can result in more open and honest feedback.	• Low literacy levels impede access. • As the survey is anonymous, it is not possible to follow up on client specific issues identified.

Recommended	A feedback survey is administered by a supervisor, case worker (other than the case worker assigned to the case) or another trusted member of the PCM team.	• A conversation with a trusted case worker can provided more detailed and feedback than a self-administered survey can. • Allows for immediate follow up to client specific issues identified. • Accessible to those with lower levels of literacy.	• Clients can consciously or subconsciously be motivated to respond in a positive way. • Additional workload on the team.
Alternative	A staff member external to the PCM team conducts the feedback survey, for instance a member of the MEAL team.	• Reduced workload on the PCM team. • Allows for immediate follow up to client specific issues identified. • Surveyor can be seen as more neutral and trusted. • Accessible to those with lower levels of literacy.	• High level of expertise of PCM required to understand the sensitive nature of case management and go beyond generic questions. • Possible confidentiality concerns around high-risk cases.

Timing

Clients are encouraged to provide feedback at any point during the case management service, by using reactive channel or during conversations with their case managers. The Client Feedback Survey can be completed at the end of the case management process, or after the case action plan has been (partly) implemented with the client. Administering the form at the end of the process, ensures that the full service is taken into consideration, while administering the form while the process is on-going allows for any issue to be immediately addressed.

Endnotes

1 Such a survey can be handed out at a service delivery point and/or shared by e-mail, WhatsApp or other digital platforms.

Annex 3.13
Outcome Monitoring Guidance

Part I: Introduction to PCM Outcome Monitoring

Since 2020, IRC has been working with partners in the humanitarian community to develop an approach for using case management to respond to protection risks in crisis situations. The approach is described in 'Your Guide to Protection Case Management', a global tool that provides guidance and support to practitioners delivering protection case management (PCM) services. This guidance note was developed to complement the PCM guide, and, in particular, to support PCM teams to **gather evidence on the outcomes of protection case management for individual clients.**

Outcome monitoring is only one part of the broader monitoring, evaluation, accountability and learning approach for PCM. The 'Monitoring, Evaluation, Accountability, and Learning (MEAL) Guidelines for Protection Case Management (PCM)' is a comprehensive resource designed to support PCM teams to implement MEAL activities. The MEAL Guidelines provide guidance, tools and resources for monitoring the outcomes of PCM, the process and quality of PCM work, and the profiles of the clients and cases accessing PCM services.

Why measure outcomes of PCM?

Historically, monitoring and evaluation of case management services has focussed on monitoring the outputs of case management (e.g. the number of clients reached, the number of cases closed) or the outputs of interventions intended to strengthen the quality of the case management services (e.g. the number of case managers trained). Outcome monitoring goes a step further – it seeks to measure the **impact of PCM services** on individual clients' lives, or the **change** that results from PCM work.

Outcome data about PCM interventions can be used to:

- Understand the results of PCM services for individual clients, including how these vary across different populations of clients and protection risks;
- Inform changes to strengthen PCM approaches and more effectively meet clients' needs[1];
- Generate evidence for best practice in PCM service delivery;
- Report on the results of PCM to key stakeholders, including clients, communities, donors, and partners.

Ultimately, this will support our primary goal: improving service provision for clients.

Outcome monitoring is also a useful tool for case workers: it can support case workers to track a client's progress and inform the case management response itself.

What are the PCM outcomes we are seeking to measure?

This guidance addresses three different protection case management outcome areas.2

1. **Psychosocial wellbeing**

Psychosocial wellbeing is a holistic measure of a clients' welfare. It captures both subjective wellbeing, the degree to which a client is 'feeling good', and psychological functioning, whether a client is 'functioning well' in their daily life. Psychosocial wellbeing should increase as a result of case management support.

2. **Psychological distress**

Psychological distress focusses on a client's mental health and well-being. Psychological distress can be defined as painful mental and physical symptoms that are associated with normal fluctuations of mood in most people. Individuals with moderate or high levels of psychological distress may experience a compromised state of mental health, impacting their well-being, functioning, or quality of life. Psychological distress can be a precursor to a mental illness. However, experiencing psychological distress does not always indicate the presence of a mental health disorder. Symptoms of psychological distress should decrease as a result of case management support.

3. **Protection risk reduction**

This outcome aims to capture whether the PCM response has contributed to reducing the impact of a protection risk on a client. While case management may not be able to eliminate an external threat or undo harm that has already been experienced, it can reduce a clients' vulnerability to that threat and increase their capacity to cope with harm. The impact of a protection risk on a client should decrease as a result of case management support.

PCM outcomes and corresponding indicators

Outcome area	PCM Outcome	Outcome Indicator
Psychosocial wellbeing	People at risk achieve improved psychosocial wellbeing through protection case management support	• **PO-01:** % of clients who demonstrate improved psychosocial wellbeing after receiving protection case management support
Psychological distress	People at risk achieve reduced psychological distress through protection case management support	• **PO-03:** % of clients with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving protection case management support
Protection risk reduction	People at risk are less impacted by protection risks through protection case management support	• **PO-02:** % of clients who report being less impacted by protection risks after receiving protection case management support • **PO-04:** % of clients who report that they are better equipped to reduce or mitigate the protection risk after receiving PCM support

Do I need to measure all PCM outcome indicators?

It is not necessary to monitor all three PCM outcome areas. As set out in the MEAL Guidelines, during the initial planning process, PCM teams select and customise the indicators that are relevant to their context, donor specifications, and learning objectives.

It is recommended to measure both the psychosocial wellbeing outcome and the protection risk reduction outcome if possible. These two outcomes are complementary: while psychosocial wellbeing captures the eventual outcome of PCM for the client, protection risk reduction captures a more direct outcome of PCM support – the degree to which the relevant protection risk affecting each client has been addressed (from the client's perspective). Risk reduction outcomes can enrich teams' understanding of why psychosocial wellbeing has or hasn't improved and how that relates to the PCM response.

Measuring the psychological distress outcome is optional. As will be described in greater detail in Section III, 'Compiling and Analysing Results', this outcome was developed to capture the degree to which PCM leads to improved mental health outcomes for the population of PCM clients with more serious mental health needs. PCM teams can determine whether this is relevant / a priority area for them.

If it is only possible to monitor one outcome, it is recommended to monitor the psychosocial wellbeing outcome. However please note that the protection risk reduction outcome doesn't require additional data collection, and draws on information gathered in the protection risk assessment and case closure forms (see section II below).

Part II: Gathering data on PCM outcomes

Tools for gathering data on PCM outcomes have been incorporated into the broader PCM toolkit, and data for outcome monitoring can be gathered by the case workers as part of the PCM process. The case worker is likely in the best position to collect data because he or she will have the strongest and most trusting relationship with the client.

It is important to keep in mind that outcome monitoring is NOT intended to assess the performance of an individual case worker. There are a number of factors that influence outcomes for an individual client, and many of these are not in the case worker's control (see section on interpreting results below).

Data gathering tools – an overview

The diagram below shows all the tools that are used as part of the PCM process and indicates which tools will be used to gather data on each of the three PCM outcomes. Data for each outcome area will be collected at least twice in the PCM process – once at the beginning of the PCM response and once at the end. Comparing the result at the beginning to the result at the end makes it possible to measure change for each individual client.

- Intake form and informed consent
- Protection risk assessment - *Includes questions for gathering data on **protection risk reduction outcome** ('baseline')*
- Psychosocial wellbeing scale - *Data gathering tool for the **psychosocial wellbeing outcome** ('baseline')*
- Basic MHPSS assessment - *Data gathering tool for the **psychological distress outcome** ('baseline')*
- Action Plan
- Psychosocial wellbeing scale - *Data gathering tool for the **psychosocial wellbeing outcome** ('endline')*
- Basic MHPSS assessment - *Data gathering tool for the **psychological distress outcome** ('endline')*
- Case closure - *Includes questions for gathering data on **protection risk reduction outcome** ('endline')*

The baseline psychosocial wellbeing scale (WEMWBS) and basic MHPSS assessment may be completed at the same session as the protection risk assessment. They may also be completed during a separate session if the case worker feels it is too much to fit all three activities into one session (e.g. because the client is tired or due to concerns about time). It is recommended to complete both scales in a single section, ideally before the action plan is developed, so the results can inform the action plan. Similarly, for establishing the endline, the tools can be used during the case closure or as a separate session. This is a decision for the caseworker and can be made on a case-by-case basis.

Reminders:

- **Confidentiality:** Before leading the client through the data gathering tools, it is good practice to remind the client about the principles in the confidentiality agreement, particularly that the case worker will keep their information confidential at all times and any exceptions to this.
- **Informed consent:** As set out in the scripts below, the case worker must always ensure they have informed consent from the client **before completing** either the psychosocial wellbeing scale or the basic MHPSS assessment. It is also good practice to get informed consent to use data from the surveys for MEAL purposes, reminding the client that data will be completely anonymised and with no identifiable information included, and will be combined with data from other clients in the analysis. For instance, after you have introduced the tool to the client, you might say something like:

"In order to make sure that the case management services we provide are truly supporting clients like you, it's important to us to regularly review our case management services and programming. With your permission, I would like to use some of the information you share with us today in order to learn about whether and how case management is helping our clients. All data will be anonymised – this means we will never include any information that would allow you to be personally identified. In fact, the data will be combined with data from other clients and analysed together in number form, so there is no way your personal responses could be connected to you. Learning about the outcomes of case management for clients can help us improve our services in the future. Do I have your permission to include your responses in our review? Please know that your response does not impact your ability to receive services in any way."

Gathering data on the psychosocial wellbeing outcome

The psychosocial wellbeing scale is a questionnaire with 14 statements about feelings and thoughts.3 For each statement the client will select a response which best describes their own experience over the past two weeks. The client will select from the following five options: (1) none of the time, (2) rarely, (3) some of the time, (4) often, or (5) all of the time.

Begin by **explaining the tool to the client and asking for their consent to participate in this activity.** You might say something like the following:

"As part of our meeting today, I want to ask if you would be willing to take part in an activity to help us both better understand how you are doing in different aspects of your life. First, I will ask you some questions about your thoughts, feelings, day to day life and relationships. Then, we will work together to develop an action plan to address some of the problems that are concerning you. If you are willing to do so, we can return to these questions in the future to see if things have improved. Is it okay with you if we complete this activity together?"

If the client agrees, **lead the client through the tool**. You might say something like the following:

"I am going to read out a statement about feelings and thoughts. I want you to think about your own experiences over the past two weeks and then choose the response that best describes your experience. For each statement you will choose a response from these five options: (1) none of the time, (2) rarely, (3) some of the time, (4) often, or (5) all of the time. There are no right or wrong, or good or bad answers to any of the questions – just choose the answer that feels the most right to you. If you decide you do not want to go any further or you want to skip any question, that's always okay, you are welcome to stop at any time. Do you have any questions for me before we begin?"

- Go through the statements one by one with the client;
- If the client is struggling to choose a response, feel free to prompt or guide them – but try not to influence their response;
- Remind the client that if they wish to stop at any time that is fine – they just need to let you know;
- Try your best to cover all 14 statements, unless the client declines to answer;
- Once the client has finished, thank them for sharing their answers with you.

Action point! The psychosocial wellbeing scale uses a tool called the 'Warwick Edinburgh Mental Wellbeing Scale' (WEMWBS) developed by academics at Warwick University and Edinburgh University. The tool is available to use freely for public sector organisations (including social services, NGOs and charities), but because the tool is protected by copyright, it is necessary to register with Warwick University before using the tool. IRC has

registered for a license. If you are from another organisation and are planning to use the psychosocial wellbeing scale (WEMWBS) it is necessary to register before doing so. The registration process is very short and straightforward. You can complete your registration here: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/non-commercial-licence-registration/

Gathering data on the psychological distress outcome

The basic mental health and psychosocial support (MHPSS) assessment[4] is a questionnaire with 9 statements about experiences, feelings and thoughts. For each statement the client will select a response which best describes how often the statement was true over the past two weeks. The client will select from the following four options: (0) not at all, (1) several days, (2) more than half the days, or (3) nearly every day.

Begin by **explaining the tool to the client and asking for their consent to participate in this activity**.[5] You might say something like the following:

"*Today, I'll be asking you some additional questions so that we can understand more about how you are feeling and how your feelings, thoughts and emotions are impacting your life. The information you share will help us work together to create a plan to provide you with the best possible support services. If you decide you do not want to go any further or do not want to answer a question, that's always okay, you are welcome to stop at any time."*

During previous sessions together, we've talked about the confidentiality and how the information you share with me will be kept confidential.

There is an important exception to confidentiality, for your safety and the safety of others, that I want to share with you. In situations where there is a serious threat to your safety or the safety of others (for example you are at risk of being hurt or hurting yourself or others) it may be necessary for me to share some information about the safety risk with specific colleagues or specialized service providers so that you (or the person at risk) can be protected from harm. The goal is to keep you safe. In cases where I need to break confidentiality, I will always inform you first and consult with my supervisor. Do you have any questions for me before we continue?"

If the client agrees, **lead the client through the tool.** You might say something like the following:

"I am going to read to you a statement about experiences, feelings and thoughts. I want you to think about the past two weeks and choose the response that best describes how often the statement has been true for you. For each statement you will choose a response from these four options: (0) not at all, (1) several days, (2) more than half the days, or (3) nearly every day. Remember, there are no right or wrong, or good or bad answers to any of the questions – just be as honest as you can and choose the answer that feels the most right to you. You can stop me to ask questions or clarification at any time. And if you decide you do not want to go any further, you can stop at any time. is it okay with you if we complete this activity together? Do you have any questions before we begin? "

- Go through the statements one by one with the client;
- If the client is struggling to choose a response, feel free to prompt or guide them, but try not to influence their response;
- Remind the client that if they wish to stop at any time that is fine – they just need to let you know;
- Try your best to cover all 9 statements, unless the client declines to answer;
- Once the client has finished, thank them for sharing their answers with you.

Gathering data on the protection risk reduction outcome

Questions designed to gather data for the protection risk reduction outcome have been integrated into the protection risk assessment form and the case closure form. You can gather this information from the client as part of these processes. The relevant questions are set out below.

From: 'Protection risk assessment, Part G: Summary for Client'

"From what we have discussed, what do you feel is the thing which is worrying you most?"

"You mention (...) as the main problem(s) you worry about. How much would you say the problem(s) we discussed are affecting you and your life right now?"

Not at all; Some; A moderate amount; A lot; Severely

"How would you rate your ability to address this problem? "

No ability; Low ability; Moderate; High; Very high

When asking about the 'main problem', refer back to the problem (or problems) the client highlighted in the original question. If the client struggles to understand the question or rank the impact of the problem you can provide some explanation or guidance. For example, you might illustrate the way the problem is affecting the clients life, by adding the phrase: "For example, by impacting your safety and security, your health, your mood and stress levels, your ability to do daily tasks, your ability to access what you need, your family life, your personal dignity, etc."

Case closure form (question 3)

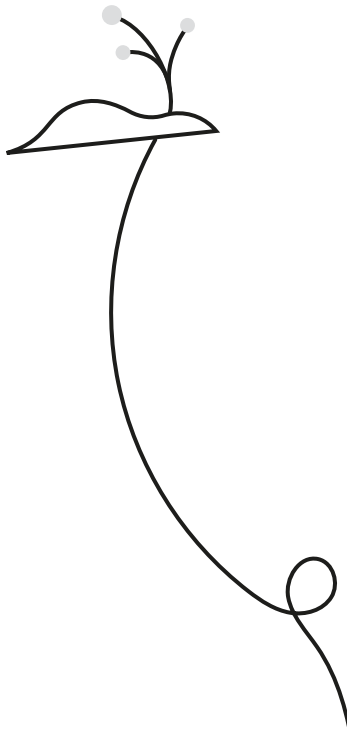
"When we first discussed your case, you mentioned (...) as the main problem(s) you worried about. How much would you say this problem is (these problems are) affecting you and your life right now? "

Not at all; Some; A moderate amount; A lot; Severely

"Now that we are closing the case, how would you rate your ability to address this problem? "

No ability; Low ability; Moderate; High; Very high

Again, provide some guidance to the client if needed.



Gathering qualitative data on protection outcomes

Qualitative data can help us understand and interpret quantitative results by providing important context and explanation: the **'why'** and *'how'* behind the client's response to a standardised question. For this reason, we have added a number of open-ended questions to the case closure form. The responses to these questions will not be used to calculate indicators or measure outcomes.

Qualitative questions included in the case closure form:

- What about the PCM support you received was most valuable to you personally? Why?

- Were there any changes you were hoping PCM could help you to achieve that didn't happen in practice? How could PCM have supported you better?
- What were the most important changes that you experienced in your life as a result of your participation in PCM?
- Were there any changes you were hoping PCM could help you to achieve that didn't happen in practice? How could PCM have supported you better?

A note on contextualisation

Both the psychosocial wellbeing scale and the basic MHPSS assessment are based on tools that have been validated in a range of diverse contexts. Given this, we would recommend using the tools as they are without making significant changes. This is particularly the case for the psychosocial wellbeing scale. The statements in the scale refer to concepts that are abstract, and likely to be broadly relevant across contexts. Furthermore, as part of its licensing agreement the University of Warwick asks users to agree not to: "adapt, alter or modify the content of the WEMWBS or the resources in any way."

That said, it is important to ensure that the statements in the scales are meaningful and appropriate in the context where they are being used. For instance, when piloting the use of the Basic MHPSS Assessment with PCM teams, case workers gave feedback that not all statements were relevant to clients' lives. For example, the assessment asks respondents if they have had "trouble concentrating on things, such as reading, listening to the radio or watching television". In a context where television isn't available or accessible this question may need to be adapted – for instance by replacing 'watching television' with another, more relevant activity that requires concentration.

As part of the initial planning process, it is important to review the statements in the psychosocial wellbeing scale and Basic MHPSS Assessment to ensure that they are clear, relevant and meaningful in the context where you are working. In particular, it may be helpful to consider:

- Whether local terminology could be used to communicate concepts more clearly and meaningfully;
- Whether examples are contextually relevant.

This will help ensure that tools are valid and results are meaningful.

For additional information on contextualization of MHPSS MEAL materials and beyond, please refer to the MHPSS Minimum Service Package (MSP) key considerations, relevant guidelines, standards and tools on contextualization and/or reach out to the MHPSS MSP HelpDesk. The MHPSS MSP builds on existing MHPSS standards and tools to create a single, easy-to-follow intersectoral package inclusive of core activities, an orientiation guide, costing tool, gap analysis tool, and seminal guidelines. For additional support in MHPSS M&E, please reach out to the MHPSS M&E HelpDesk. The IASC MHPSS Reference Group introduced the MHPSS M&E Helpdesk in 2021 to support uptake and use of the IASC Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings: With means of verification (Version 2.0).

Part III: Compiling and Analyzing Results

Psychosocial Wellbeing

Scoring the psychosocial wellbeing scale

Each of the 14 items on the psychosocial wellbeing scale has a scoring range of 1 – 5, with the following values:

- None of the time (1)
- Rarely (2)
- Some of the time (3)
- Often (4)
- All of the time (5)

To calculate the total score for each individual client, simply add up the scores across all 5 items. Total scores will range from 14 – 70.

A note on missing values:
If you are using a digital system for scoring: do not calculate a score for a client with **more than two** missing values – these responses should not be included when the indicator is calculated. For clients missing **one or two** values, calculate the 'average' response to each statement (total score / number of statements with a response), and fill in the missing value with the average.

If you are scoring the surveys manually: do not calculate a score for a client with **any** missing values.

Data from incomplete surveys can be entered into your database for further analysis, indicating missing values, but the score should not be used when calculating the psychosocial wellbeing indicator (see below).

Interpreting scores[6]

The following thresholds can provide some guidance on how to interpret clients' psychosocial wellbeing scores. Please note that these thresholds are based on analysis of data from UK populations – while we assume these are also relevant and appropriate for clients using PCM services, contextual differences should be taken into account.

14-40	**Very low psychosocial wellbeing:** The client's score is in the very low range, indicating that they are facing significant difficulties and would likely benefit from MHPSS services and may also require additional support from a specialized mental health professional. It is likely useful to administer the basic MHPSS assessment for clients that score in this range to further inform the PCM response, including potential referals for specialized MHPSS services.
41-44	**Low psychosocial wellbeing:** The client's score is in the low range, indicating that they would likely benefit from receiving MHPSS services to support their mental health and psychosocial wellbeing. It may be useful to administer the basic MHPSS assessment for clients that score in this range to further inform the PCM response, including potential referrals for non-specialized and specialized MHPSS services.
45-59	**Moderate psychosocial wellbeing:** The client's score is in the moderate range, indicating that they are doing ok. But they could still benefit from MHPSS services to support their mental health and psychosocial wellbeing. Activities centred around improving resilience and addressing or reducing risk factors, may be beneficial to prioritize activities that support coping strategies.
60-70	**High psychosocial wellbeing:** The client's score is in the high range, suggesting they are doing well. It is still important to incorporate MHPSS services in PCM activities for the client to take steps to improve resilience and develop coping strategies in order to maintain high wellbeing, particular in light of emerging risks, threats and challenges.

If case management is effective in supporting clients to address protection risks, recover from harm and access their rights and entitlements you can expect wellbeing scores to rise. **For each PCM client it is useful to record the following data: the client's psychosocial wellbeing score at intake, the client's psychosocial wellbeing score at case closure and the change in the client's score (see below).**

Interpreting change over time for an individual client

In order to measure change in a client's psychosocial wellbeing, you need to have at least two scores for the client over time (meaning they need to have completed the psychosocial wellbeing survey at least twice during the PCM process).

Subtract the baseline score from the endline score to calculate the level of change. If the clients' score has decreased the level of change may be a negative number.

[Endline score] – [Baselinet score] = change in psychosocial wellbeing

An increase (or decrease) of three or more constitutes a significant change in psychosocial wellbeing.7 This means that the change reflects more than random differences in the way the client answered the questions: it reflects an **actual improvement (or decline) in psychosocial wellbeing.**

A change in psychosocial wellbeing may result from the case management intervention and it may also result from a change in external factors that affect an individual's psychosocial wellbeing.

- Qualitative data provided by clients on the case closure form can also help you understand the reasons behind changes for individual clients;
- Contextual information, such as information contained in protection analyses, can help you identify external factors that may have influenced psychosocial wellbeing;
- Finally, by analysing data across many clients, you can begin to identify trends in how PCM interventions affect psychosocial wellbeing.

Interpreting change across many clients: calculating the psychosocial wellbeing indicator

The psychosocial wellbeing indicator was developed to capture whether protection case management contributes to improved psychosocial wellbeing for clients. The indicator and its two parts are set out below.

> **Psychosocial wellbeing indicator:** % of PCM clients who demonstrate improved psychosocial wellbeing after receiving PCM support.
>
> **Numerator:** # of clients surveyed whose psychosocial wellbeing scores improve by at least 3.
>
> **Denominator:** # of clients who participate in the psychosocial wellbeing survey at both baseline and endline.

In order to calculate the indicator you need to:

Step 1: Calculate the total number of clients who participated in both baseline and endline of the Psychosocial Wellbeing Assessment during the designated time period;

Step 2: Calculate the number of PCM clients whose psychosocial wellbeing scores improved by at least 3 between baseline and endline;

Step 3: Divide the second number (Step 2) by the first number (Step 1) and multiply the result by 100: this is your indicator value.

In addition to calculating the proportion of clients with improved psychosocial wellbeing, it may be useful to calculate:

- The average psychosocial wellbeing score across all clients at intake and case closure;
- The distribution of psychosocial wellbeing scores across clients at intake (how many clients fell into the very low, low, moderate, and high categories), and characteristics of clients within these categories.
- The distribution of psychosocial wellbeing scores across clients at case closure (how many clients fell into the very low, low, moderate, and high categories);
- The average change in psychosocial wellbeing score across all clients;

- The distribution of the change in psychosocial wellbeing scores across all clients.8

It can be useful to disaggregate these results by other relevant variables in order to understand and explain them. You may consider the following questions:

- How do psychosocial wellbeing outcomes differ according to the client's gender, age, disability status, displacement status, risk level and/or type of protection risk?
- How do psychosocial wellbeing outcomes differ between different geographic areas? What are the possible explanations for these differences (e.g. availability of referral services, external risks and conditions, etc)?
- Do outcomes differ in relation to how the case management service was implemented, or the quality or process of PCM (consider process and quality indicators for relevant variables)?
- How have psychosocial wellbeing outcomes changed since the previous review period? What might explain this (e.g. differences in practice, capacity, availability of referral services, external risks and conditions, etc)?

More information about how to analyse and interpret results can be found in the Monitoring, Evaluation, Accountability and Learning (MEAL) Guidelines for Protection Case Management.

Psychological Distress

Scoring the Basic MHPSS Assessment

Each of the nine (9) core questions on the Basic MHPSS Assessment has a scoring range of 0 – 3, with the following values:

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

To calculate the total score for each individual client, add up the score for each of the nine (9) items. Total scores will range from 0 – 27. A tenth question on the Basic MHPSS Assessment asks about the extent to which the previously mentioned symptoms make functioning in daily life difficult. The response to the tenth question is not factored into the final

score; however, case workers may use the response to help gauge the impact of the reported symptoms on their daily life.

A note on missing values:
If you are using a digital system for scoring: do not calculate a score for a client with **more than two** missing values – these responses should not be included when the indicator is calculated. For clients missing **one or two** values, calculate the 'average' response to each statement (total score / number of statements with a response), and fill in the missing value with the average.

If you are scoring the surveys manually: do not calculate a score for a client with **any** missing values.

Data from incomplete surveys can be entered into your database for further analysis, indicating missing values, but the score should not be used when calculating the psychosocial wellbeing indicator (see below).

Interpreting Basic MHPSS Assessment scores

In order to understand what the client's score tells us about a client's psychological distress and depression levels, determine which category the score falls into:

0-04	**Minimal:** Individuals in this category experience few or no symptoms. They may occasionally feel down, but these feelings are infrequent and fleeting. Daily functioning is generally unaffected. They continue to perform well in their work, social interactions, and other daily activities without significant issues. They might not require any specific treatment but should maintain healthy lifestyle habits to prevent escalation
5-9	**Mild:** Experience more frequent feelings of sadness or lack of interest, but these symptoms are still manageable. There is a minor impact on daily life. Tasks may feel a bit more challenging, and there might be a slight drop in productivity or social engagement. It might be beneficial to incorporate lifestyle changes such as exercise, better sleep to address these mild symptoms.

10-14	**Moderate:** Symptoms are more pronounced and persistent, such as frequent sadness, significant loss of interest in activities and, fatigue Daily functioning is moderately affected. Work performance, relationships, and social activities may suffer. Individuals might struggle with maintaining their usual level of productivity and could benefit from a structured support plan
15-19	**Moderately** severe: Individuals experience symptoms, such as intense sadness, persistent fatigue, and feelings of worthlessness or excessive guilt. There is a considerable impact on daily functioning. Individuals may find it hard to perform at work, maintain relationships, or take care of daily responsibilities. Focused intervention is typically necessary at this stage.
20-27	**Severe:** Symptoms are severe and debilitating. Individuals may experience extreme sadness, hopelessness, lack of energy, and thoughts of death or suicide. It becomes difficult to carry out even simple daily tasks, and there is a high risk of self-harm or suicide. Referrals to focused specialized MHPSS assistance is necessary.

As set out in the Basic MHPSS Assessment Guidance document, if a client falls into the 'severe' category (score of 20-27), they should be referred to a specialised MHPSS service provider. If they are classified as 'moderately severe', the caseworker should discuss available support services with the client and get input from a supervisor and client on how they can best support the client.

Interpreting change over time for an individual client

Undertaking the Basic MHPSS Assessment once, at the start of the process, can provide useful information on the specialised services the clients requires as part of the case management process. However, this form can only be used to measure protection outcomes if it is used at least twice during the PCM process: in order to measure change in a client's level of psychological distress, you need to have at least two scores for the client over time.

Subtract the baseline from the endline score to calculate the level of change. If the clients' score has decreased (*which we would expect to see!*) the level of change will be a negative number.

[Endline score] – [Baseline score] = change in psychological distress

A change of five or more constitutes a significant improvement (or decline) in levels of psychological distress.9

This means that the change reflects more than random differences in the way the client answered the questions: it reflects an **actual reduction (or increase) in psychological distress.**

Interpreting change across many clients will help you calculate the psychological distress indicator

The reduced psychological distress indicator was developed to capture whether protection case management contributes to reduced psychological distress for clients with more serious mental health needs. The indicator and its two parts are set out below.

Psychological distress indicator: % of PCM clients with mental health needs who demonstrate a reduction in symptoms of psychological distress over the course of the PCM process.

Numerator: # of clients with an initial score of 15 or higher (indicating moderately severe or severe levels of disabling distress) whose final score was 5 or more points **lower** than the initial score.

Denominator: # of clients who completed the Basic MHPSS Assessment at both baseline and endline and scored 15 or higher at intake.

In order to calculate the indicator you need to:

Step 1: Of the PCM clients who completed the MHPSS Basic at both baseline and endline, determine the number of PCM clients who scored 15 or higher on their initial score;

Step 2: Of these, count the number whose final score on the Basic MHPSS Assessment was 5 or more points lower than the initial score;

Step 3: Divide the second number (Step 2) by the first number (Step 1) and multiply the result by 100: this is your indicator value!

In addition to calculating the proportion of clients with improved psychosocial wellbeing, it may be useful to calculate:

- The average psychological distress score across all clients at intake and case closure;
- The distribution of psychological distress scores across clients at intake (how many clients fell into the minimal, mild, moderate, moderately severe and severe categories);
- The distribution of psychological distress scores across clients at case closure (how many clients fell into the minimal, mild, moderate, moderately severe and severe categories);
- The average change in psychological distress scores across all clients.
- The distribution of levels of change in psychological distress scores across all clients.

It can be useful to disaggregate these results by other relevant variables in order to understand and explain them. You may consider the following questions:

- How do psychological distress outcomes differ according to the client's gender, age, disability status, displacement status, risk level and/or type of protection risk?
- How do psychological distress outcomes vary between clients who received an MHPSS referral (and subsequent services) and those who did not?
- Do outcomes differ in relation to how the case management service was implemented, or the quality or process of PCM (consider process and quality indicators for relevant variables)?
- How have psychosocial wellbeing outcomes changed since the previous review period? What might explain this (e.g. differences in practice, capacity, availability of referral services, external risks and conditions, etc)?

More information about how to analyse and interpret results can be found in the Monitoring, Evaluation, Accountability and Learning (MEAL) Guidelines for Protection Case Management.

Protection Risk Reduction

Interpreting protection risk reduction results

In order to understand how effective the case management response has been in responding to clients' protection concerns, we have asked

clients to rank how much they are impacted by their priority protection risks at the beginning and end of the case management process.

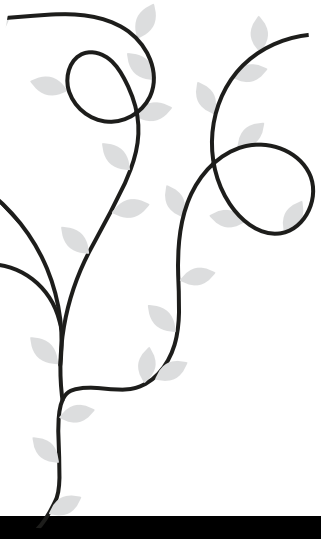
Clients respond by selecting from the five options set out below, with their corresponding values (0 – 4).

- Not at all (4)
- Some (3)
- A moderate amount (2)
- A lot (1)
- Severely (0)

We also request them to rank their ability to address this problem. Clients respond by selecting from the five options set out below, with their corresponding values (0 – 4).

- Very high (4)
- High (3)
- Moderate (2)
- Low ability (1)
- No ability (0)

By comparing a client's response at the risk assessment stage to their response at case closure, we can understand how their perception of the severity of their protection risk, and their ability to address this problem, has changed. We hope to see an improvement in both scores, which means they are less affected by the problem and have increased ability to manage it. This change may reflect external factors, such as an increase or decrease in the protection risk of concern. But it may also reflect a reduction in the clients' vulnerability to the risk and/or an increase in their ability to cope with the risk, as a result of the case management response.



Again, a change in the impact of a protection risk on a client may result from the case management intervention and it may also result from a change in external factors – particularly, the nature of the protection threat that creates the risk for the client.

- Qualitative data provided by clients on the case closure form can also help you understand the reasons behind changes for individual clients;
- Contextual information, such as information contained in protection analyses, can help you identify external factors that may have influenced protection risk;

- Finally, by analysing data across many clients, you can begin to identify trends in how PCM interventions affect protection risk.

Interpreting change across many clients: calculating the protection risk reduction indicator

The protection risk reduction indicator was developed to capture whether protection case management support reduces clients' vulnerability to protection risks and increases their ability to cope with protection risks, thereby reducing the impact of these risks on the client. The indicator and its two parts are set out below.

Protection risk reduction indicator: % of PCM clients who report to be less impacted by protection risks after receiving case management support.
Numerator: # of clients who report to be less impacted by the protection risk of concern at case closure than they did at the risk assessment stage
Denominator: # of clients who shared how much a protection risk is impacting their life at both the risk assessment and case closure stage.
Protection risk reduction indicator: % of PCM clients who report that they are better equipped to reduce or mitigate the protection risk after receiving PCM support.
Numerator: # of clients who report to be better able to address the problem at case closure than they did at the risk assessment stage
Denominator: # of clients who shared their ability to cope at both the risk assessment and case closure stage.

Using results

The MEAL guidelines provide a comprehensive overview of how data on PCM outcomes (and other PCM data) can be used to report to donors and support funding requests, to inform context analysis and strategic planning, and to support external evaluation.

Endnotes

1 Outcomes data can provide helpful insight into how PCM services can be delivered effectively when analysed together with monitoring data on PCM process and quality.

2 The PCM Theory of Change, included in 'Your Guide to Protection Case Management', sets out how the PCM response is expected to contribute to each outcome area.

3 The psychosocial wellbeing scale is based on a validated tool called the Warwick Edinburgh Mental Wellbeing Scale designed to measure psychosocial wellbeing.

4 The basic MHPSS assessment draws on a mental health assessment tool called the PHQ9.

5 See the basic MHPSS assessment Guidance for more detail

6 Thresholds were taken from the 'User Guide to the Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS and SWEMWBS)', version 4, June 2020.

7 This change threshold is recommended by Warwick Medical School based on statistical analysis of existing data. For more detail, see: https://hqlo.biomedcentral.com/counter/pdf/10.1186/1477-7525-10-156.pdf

8 When interpreting data keep in mind that three is the threshold for a significant change in WEMWBS.

9 A 5-point change on the Patient Health Questionnaire (which the Basic MHPSS Assessment is based on) is considered to be the threshold for clinically significant change.

Annex 3.14
Indicator Interpretation

PROTECTION OUTCOME INDICATORS

PO-01: % of clients who demonstrate improved psychosocial wellbeing after receiving protection case management support

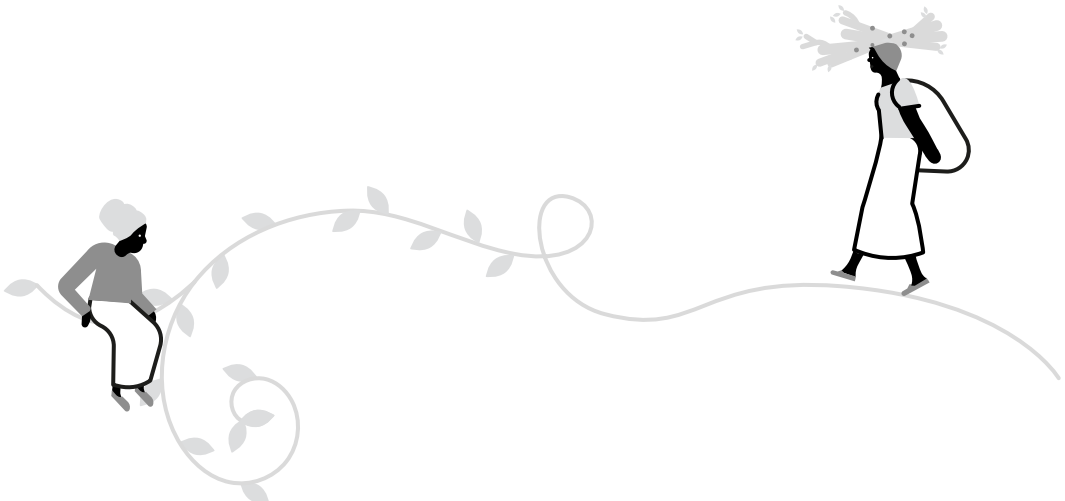
Indicator ID	**PO-01**
Category	Protection Outcome
Objective(s)	To measure the impact of case management on individual clients' lives
Calculating the score for individual clients	Each of the 14 items on the psychosocial wellbeing scale has a scoring range of 1 – 5, with the following values: • None of the time (1) • Rarely (2) • Some of the time (3) • Often (4) • All of the time (5) To calculate the total score for each individual client, add up the scores across all 5 items. Total scores will range from 14 – 70.
Interpreting the score for individual clients	**Score: 14-40** Very low psychosocial wellbeing: The client's score is in the very low range, indicating that they are facing significant difficulties and would likely benefit from MHPSS services and may also require additional support from specialised mental health professionals. It is likely useful to administer the basic MHPSS assessment for clients that score in this range to further inform the PCM response, including potential referrals for specialized MHPSS services. **Score 41-44** Low psychosocial wellbeing: The client's score is in the low range, indicating that they would likely benefit from receiving MHPSS services to support their mental health and psychosocial wellbeing. It may be useful to administer the basic MHPSS assessment for clients that score in this range to further inform the PCM response, including potential referrals for non-specialized and specialized MHPSS services.

	Score 45-59 Moderate psychosocial wellbeing: The client's score is in the moderate range, indicating that they are doing ok. But they could still benefit from MHPSS services to support their mental health and psychosocial wellbeing. Activities centered around improving resilience and addressing or reducing risk factors, may be beneficial to prioritize activities that support coping strategies. **Score 60-70** High psychosocial wellbeing: The client's score is in the high range, suggesting they are doing well. It is still important to incorporate MHPSS services in PCM activities for the client to take steps to improve resilience and develop coping strategies in order to maintain high wellbeing, particular in light of emerging risks, threats and challenges.
Calculating and interpreting change over time for individual clients and across many clients	In order to measure change in a client's psychosocial wellbeing, you need to have at least two scores for the client over time (meaning they need to have completed the psychosocial wellbeing survey at least twice during the PCM process). Subtract the baseline score from the endline score to calculate the level of change. If the clients' score has decreased the level of change may be a negative number. *[Endline score] – [Baseline score] = change in psychosocial wellbeing* **An increase of three or more constitutes a significant improvement in psychosocial wellbeing.** This means that the change reflects more than random differences in the way the client answered the questions: it reflects an actual improvement in psychosocial wellbeing. **Calculating change across many clients:** **Numerator:** # of clients surveyed whose psychosocial wellbeing scores improved by at least 3. **Denominator:** # of clients who participate in both stages of the psychosocial wellbeing survey at both baseline and endline.

What could this mean?	• **Data quality:** If all surveyed clients are reporting high (or low) distress, or there are many questions without a response, the assessment may not be understood by the client/case worker, or they may not be comfortable using the assessment **A HIGH proportion of clients could mean:** • Caseworker(s) possess the capacity, knowledge and skills to deliver effective and client-centered PCM services; • PCM support is delivered in line with quality standards and protocols; • Case worker(s) establish strong, supportive and trusting relationships with clients; • Relevant referral services are available and accessible; • There is a change in external or contextual factors which have reduced risks or threats to clients' wellbeing or reduced clients' vulnerability to these. **A LOW proportion of clients could mean:** • Critical referral services are unavailable or not accessible; • There are gaps in case worker(s) or supervisor capacity, knowledge, and skills; • A strong, trusting and supportive relationship between the client and caseworker has not been achieved; • There is a change in external or contextual factors which have further undermined clients' wellbeing.
What else do we need to know to strengthen interpretation?	• Other information provided by client: response to protection risk reduction questions on protection risk assessment and case closure forms; responses to qualitative questions on case closure form; client feedback and satisfaction surveys. • Measurement of quality and process indicators – analysis of how wellbeing outcomes differ in relation to indicators on the quality and process of PCM. • Relevant contextual information on threats, shocks and risks affecting clients, including information contained in protection analyses.

PO-02: % of clients who report being less impacted by protection risks after receiving protection case management support

Indicator ID	**PO-02**
Category	Protection Outcome
Calculating and interpreting change over time for individual clients and across many clients	Calculating and interpreting change over time for individual clients and across many clients Clients respond by selecting from the five options set out below, with their corresponding values (0 – 4). • Not at all (4) • Some (3) • A moderate amount (2) • A lot (1) • Severely (0) By comparing a client's response at the risk assessment stage to their response at case closure, we can understand how their perception of the severity of their protection risk has changed. We hope to see the value of the clients' response value increase over the course of the case management process, as this indicates that they are less impacted by the protection risk. **Calculating change across many clients** **Numerator:** # of clients who report to be less impacted by the protection risk of concern at case closure than they did at the start of the process. **Denominator:** # of clients who shared how much a protection risk is impacting their life at the start of the process and case closure stage.
Objective(s)	To measure the impact of case management on individual clients' lives



What could this mean?	**A HIGH proportion of clients could mean:** • Caseworker(s) possess the capacity, knowledge and skills to deliver effective and client-centered PCM services; • PCM support is delivered in line with quality standards and protocols; • Case worker(s) establish strong, supportive and trusting relationships with clients; • Relevant referral services are available and accessible; • There is a change in external or contextual factors which have reduced the impact of the problem(s) of concern (protection risk(s)) on clients or clients' vulnerability to these. **A LOW proportion of clients could mean:** • Critical referral services are unavailable or not accessible; • There are gaps in case worker(s) or supervisor capacity, knowledge, and skills; • A strong, trusting and supportive relationship between the client and caseworker has not been achieved; • There is a change in external or contextual factors which has increased the impact of the problem(s) of concern (protection risk(s)) on clients or clients' vulnerability to these.
What else do we need to know to strengthen interpretation?	• Other information provided by client: wellbeing score; responses to qualitative questions on case closure form; client feedback and satisfaction surveys. • Measurement of quality and process indicators – analysis of how wellbeing outcomes differ in relation to indicators on the quality and process of PCM. • Relevant contextual information on threats, shocks and risks affecting clients, including information contained in protection analyses.

PO-03: % of clients with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving protection case management support

Indicator ID	**PO-03**
Category	Protection Outcome
Objective(s)	To measure the impact of case management on individual clients' lives
Calculating the score for individual clients	To understand what the client's score tells us about a client's psychological distress and depression levels, determine which category the score falls into: • 0-4: Minimal • 5-9: Mild • 10-14: Moderate • 15-19: Moderately • 20-27: Severe
Interpreting the score for individual clients	As set out in the Basic MHPSS Assessment Guidance document, if a client falls into the 'severe' category (score of 20-27), they should be referred to a specialised MHPSS service provider. If they are classified as 'moderately severe', the caseworker should discuss available support services with the client and get input from a supervisor and client on how they can best support the client.
Calculating and interpreting change over time for individual clients and across many clients	In order to measure change in a client's level of psychological distress, you need to have at least two scores for the client over time (meaning they need to have completed the Basic MHPSS Assessment at least twice during the PCM process). Subtract the baseline from the endline score to calculate the level of change. If the clients' score has decreased (which we would expect to see!) the level of change will be a negative number. *[Endline score] – [Baseline score] = change in psychological distress* **A decrease of five or more constitutes a significant improvement** in levels of psychological distress. This means that the change reflects more than random differences in the way the client answered the questions: it reflects an **actual reduction in psychological distress.** **Calculating change across many clients:** **Numerator:** # of clients with an initial score of 15 or higher whose final score was 5 or more points **lower** than the initial score. **Denominator:** # of clients who completed the assessment at both baseline and endlineand scored 15 or higher at intake.

What could this mean?	• **Data quality:** If all surveyed clients are reporting high (or low) distress, or there are many questions without a response, the Basic MHPSS Assessment may not be understood by the client or the case worker or the caseworker may not be comfortable using the assessment **A HIGH proportion of clients could mean:** • Caseworker(s) possess the capacity, knowledge and skills to deliver effective and client-centered PCM services; • Caseworker(s) have strong knowledge of and skills in MHPSS service delivery; • PCM support is delivered in line with quality standards and protocols; • MHPSS problems are prioritized in the case management action plan; • Case worker(s) establish strong, supportive and trusting relationships with clients; • Relevant referral services are available and accessible, particularly specialized MHPSS services; • There is a change in external or contextual factors which have reduced risks or threats to clients' wellbeing or reduced clients' vulnerability to these. **A LOW proportion of clients could mean:** • Critical referral services are unavailable or not accessible, particularly specialized MHPSS services; • There are gaps in case worker(s) or supervisor capacity, knowledge, and skills; • Case worker(s) lack the confidence or skills to address clients' MHPSS concerns; • MHPSS problems have not been identified, or sufficiently addressed in the action plan; • A strong, trusting and supportive relationship between the client and caseworker has not been achieved; • There is a change in external or contextual factors (e.g. an increase in risks or threats or the emergence of new risks or threats) which have further undermined the clients' mental health and psychosocial wellbeing.

What else do we need to know to strengthen interpretation?	• Other information provided by client: wellbeing score; response to protection risk reduction questions on protection risk assessment and case closure forms; responses to qualitative questions on case closure form; client feedback and satisfaction surveys. • Measurement of quality and process indicators – analysis of how wellbeing outcomes differ in relation to indicators on the quality and process of PCM. • Relevant contextual information on threats, shocks and risks affecting clients, including information contained in protection analyses.

PO-04: % of clients who report that they are better equipped to reduce or mitigate the protection risk after receiving protection case management support

Indicator ID	**PO-04**
Category	Protection Outcome
Objective(s)	Clients respond by selecting from the five options set out below, with their corresponding values (0 – 4). • Very high (4) • High (3) • Moderate (2) • Low ability (1) • No ability (0) By comparing a client's response at the risk assessment stage to their response at case closure, we can understand how their perception of their ability to cope with a protection risk has changed. We hope to see the value of the clients' response value increase over the course of the case management process, as this indicates that they are better equipped. **Calculating change across many clients** **Numerator:** # of clients who report to be less impacted by the protection risk of concern at case closure than they did at the start of the process. **Denominator:** # of clients who shared how much a protection risk is impacting their life at the start of the process and case closure stage.
Objective(s)	To measure the impact of case management on individual clients' lives

What could this mean?	**A HIGH proportion of clients could mean:** • Caseworker(s) possess the capacity, knowledge and skills to deliver effective and client-centered PCM services; • PCM support is delivered in line with quality standards and protocols; • Case worker(s) establish strong, supportive and trusting relationships with clients; • Relevant referral services are available and accessible; • There is a change in external or contextual factors which have reduced the impact of the problem(s) of concern (protection risk(s)) on clients or clients' ability to cope. **A LOW proportion of clients could mean:** • Critical referral services are unavailable or not accessible; • There are gaps in case worker(s) or supervisor capacity, knowledge, and skills; • A strong, trusting and supportive relationship between the client and caseworker has not been achieved; • There is a change in external or contextual factors which have reduced the impact of the problem(s) of concern (protection risk(s)) on clients or clients' ability to cope.
What else do we need to know to strengthen interpretation?	• Other information provided by client: wellbeing score; responses to qualitative questions on case closure form; client feedback and satisfaction surveys. • Measurement of quality and process indicators – analysis of how wellbeing outcomes differ in relation to indicators on the quality and process of PCM. • Relevant contextual information on threats, shocks and risks affecting clients, including information contained in protection analyses.

PROCESS & QUALITY INDICATORS

PQ-01: % of intakes eligible for PCM

Indicator ID	**PQ-01**
Category	Process and Quality
Objective(s)	Measure outreach and quality of intake
What could this mean?	**A HIGH proportion of intakes could mean:** • Strong understanding of case management among community in catchment areas • Strong understanding of case management within the humanitarian system. • Contextually relevant eligibility criteria. • High quality protection analysis. • Case management/Intake team understand case management criteria and process. **A LOW proportion of intakes could mean:** • Limited understanding of protection case management among (potential) clients and humanitarian actors. • Gaps in training/coaching • Low quality protection analysis. • Eligibility criteria are inappropriate. • PCM is not a priority within the context.
What else do we need to know to strengthen interpretation?	• What are the needs of those arriving who are not eligible for PCM? • What are the gaps in outreach and dissemination?

PQ-02: # of total protection case management clients

Indicator ID	**PQ-02**
Category	Process and Quality
Objective(s)	To understand total caseload, overall project reach and resource requirements.
What could this mean?	**An HIGH in the number of cases could mean:** • Ability access to case management • Increased trust in programming or service provision • There is awareness of how to accessPCM and what PCM is • High concentration of protection risks covered by protection case management. • Other actors providing PCM have reduced or closed services. • Strong referral to case management system • Strong staff capacity • Population movement into the catchment area. • An increase in cases can have implications for the case workers, such as a decrease in quality due to increased load and a high workload of case workers. **A Low in the number of cases could mean:** • Barriers to access case management • Limited trust in programming or service provision • Presence of other actors providing similar services • Limited concerns covered by protection case management. • Insufficient staffing of case workers • Gaps in referral to case management system • Population movement away from the catchment area.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by risks (e.g., are certain profiles more represented among certain risk levels)

PQ-03: # of new cases registered for protection case management

Indicator ID	**PQ-03**
Category	Process and Quality
Objective(s)	To understand current caseload and resource requirements.
What could this mean?	**An INCREASE in the number of new cases could mean:** • Increased access to case management process • Increased trust in programming or service provision • Increases awareness of the case management process. • Increase in concerns covered by protection case management. • Other actors providing PCM have reduced or closed services. • Improved referral to case management system • Increased staff capacity • Population movement into the catchment area. • An increase in cases can have implications for the case workers, such as a decrease in quality due to increased load and a high workload of case workers. **A REDUCTION in the number of new cases could mean:** • Reduced access to the case management process • Decreased trust in programming or service provision • Presence of other actors providing similar services • Decrease in concerns covered by protection case management. • Gaps in referral to case management system • High workload case workers, unable to serve additional clients. • Population movement away from the catchment area.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by risks (e.g., are certain profiles more represented among certain risk levels)

PQ-04: % of cases closed due to meeting objectives of the action plan

Indicator ID	**PQ-04**
Category	Process and Quality
Objective(s)	• Measure quality of overall case management process • Measure appropriateness of the goals
What could this mean?	**A HIGH proportion of case plans closed could mean:** • Goals in case action plan are SMART[1] • Goals are not sufficiently ambitious • Required services are available and accessible. • Client has trust in the process and action plan. • High case worker(s) capacity, knowledge, and skills **A LOW proportion of case plans closed could mean:** • Case plan goals are not SMART, for instance when the goals set are unrealistic. • Several key services are unavailable or not accessible. • Outdated service mapping. • Gaps in case worker(s) or supervisor capacity, knowledge, and skills • High staff turnover • sudden change in operational context, for instance displacement of a number of clients.
What else do we need to know to strengthen interpretation?	• Duration of cases (CC-03) • Client satisfaction (PQ-11) • Case worker knowledge assessment (PQ-07) • Contextual analysis of shocks

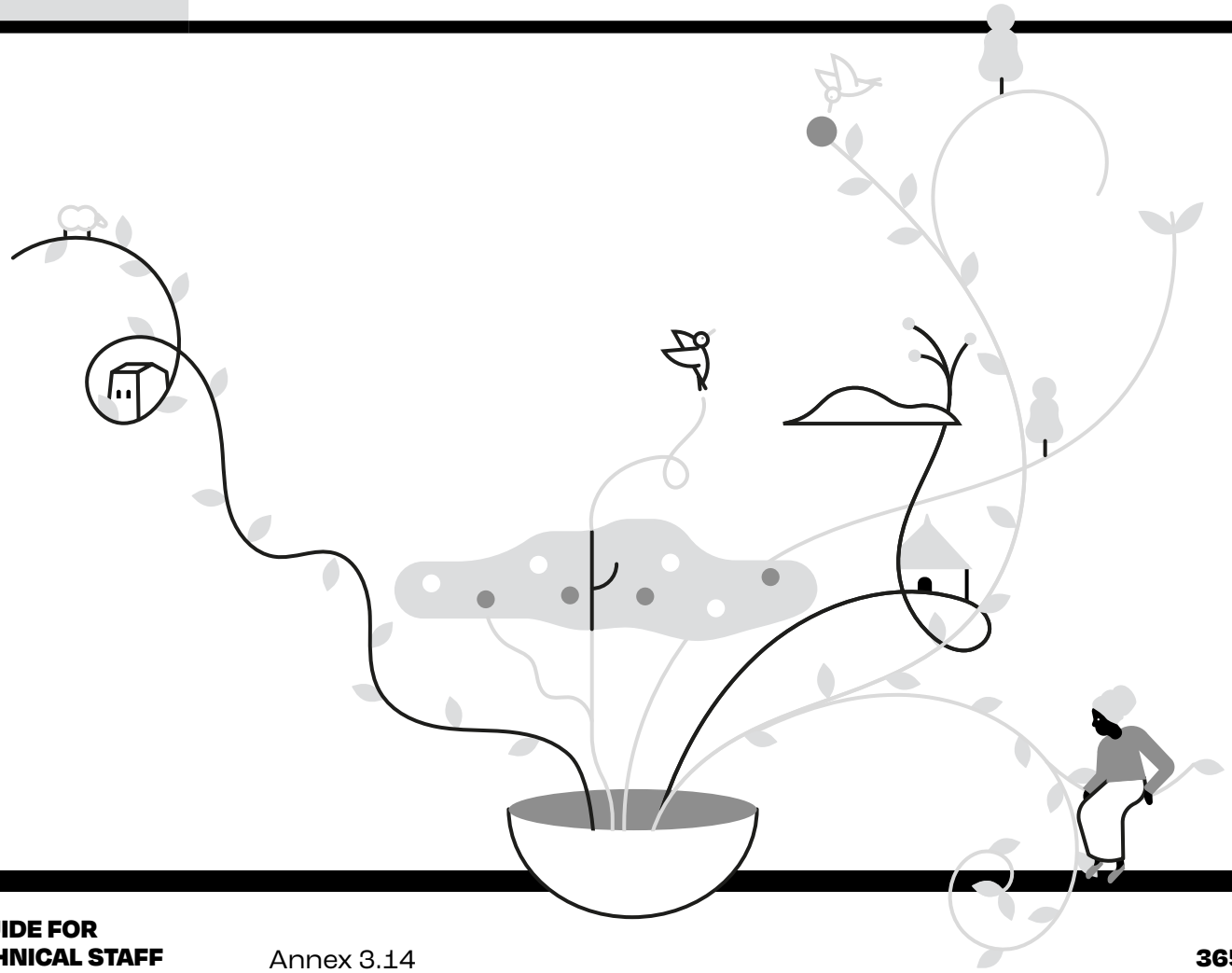
1 SMART objectives are articulated in a way that is Specific, Measurable, Achievable, Realistic, and Time-based

PQ-05: % of clients who received cash assistance through protection case management

Indicator ID	**PQ-05**
Category	Process and Quality
Objective(s)	Understand who has received cash assistance
What could this mean?	**A very LOW proportion cases receive cash assistance** • Cash might not be an appropriate for the types of protection risks addressed by case management • Case workers are unaware of how to provide cash or the process is burdensome and challenging for the case worker **Cash could be creating additional protection risks** • A very HIGH proportion of that receive cash assistance • Case workers could be providing cash assistance based on basic needs rather than addressing a protection risk • A high number of complex cases
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic and type of risk

PQ-06: Average # of cases per case worker per month

Indicator ID	**PQ-06**
Category	Process and Quality
Objective(s)	Understand caseworker workload
What could this mean?	**A HIGH number of cases per caseworker could mean:** • High workload caseworker • High ratio of complex cases to caseworkers • High number of inactive vs active case • Case workers do not use case closure procedures, or these are unclear. **A LOW number of cases per caseworker could mean:** • Capacity is available to take on additional cases.
What else do we need to know to strengthen interpretation?	• # of high-risk cases by case worker, to reduce concentration of high-risk cases. • Duration of cases (CC-03)



PQ-07: % of case workers whose knowledge assessment score is at least 70%

Indicator ID	**PQ-07**
Category	Process and Quality
Objective(s)	Identify gaps case worker knowledge
What could this mean?	**A HIGH proportion of caseworkers could mean:** • High quality training • Strong supervision structures • Low staff turnover. • High case worker(s) capacity and knowledge • Knowledge assessment has been successfully contextualized. • Data limitations: if the proportion is too high, this might indicate a limitation in how the survey is administered. **A LOW proportion of caseworkers could mean:** • Deficiencies in the training • Weak supervision structures • High staff turnover. • Difficulties in recruiting the right profile. • Low case worker(s) capacity and knowledge • Lack of contextualized tools and guidance. • Data limitations: deficiencies in how the survey is administered.
What else do we need to know to strengthen interpretation?	• Starting date case workers • Caseworker attitude score (PQ-08) • Caseworker learning path, e.g. number of training sessions, coaching opportunities, pre-post tests etc.

PQ-08: % of case workers whose attitudes score is at least 80%

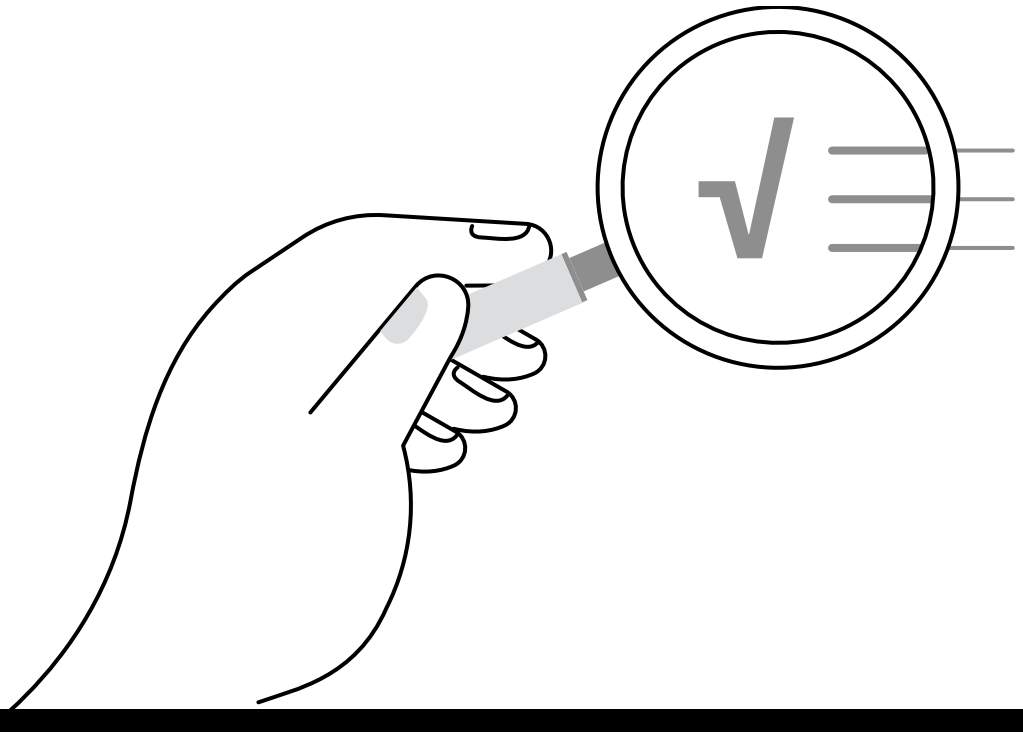
Indicator ID	**PQ-08**
Category	Process and Quality
Objective(s)	Measure case worker attitudes towards clients
What could this mean?	**A HIGH proportion of caseworkers could mean:** • High quality training related to caseworker attitude • Strong supervision structures • Low staff turnover. • High case worker(s) capacity and knowledge • Knowledge and attitude assessment has been successfully contextualized. • Data limitations: if the proportion is too high, this might indicate a limitation in how the survey is administered. **A LOW proportion of caseworkers could mean:** • Safe space for case manager to express limitations. • Deficiencies in the training • Weak supervision structures • Difficulties in recruiting the right profile. • Biases and stereotypes engrained in PCM process. • Data limitations: deficiencies in how the survey is administered.
What else do we need to know to strengthen interpretation?	• Case worker experience • Caseworker knowledge score (PQ-07)

PQ-09: % of case files reviewed that meet 80% of criteria of a case file checklist

Indicator ID	**PQ-09**
Category	Process and Quality
Objective(s)	Measure quality of documentation and identify priority gaps.
What could this mean?	**A HIGH proportion of casefiles could mean:** • High quality training • Strong supervision structures • High case worker(s) capacity and knowledge • Forms are appropriate for and endorsed by case workers. • Strong information management system • Guidance and tools adapted to context. **A LOW proportion of casefiles could mean:** • Gaps in case worker(s) capacity and knowledge • Weak supervision structures • Information management system is unsuitable for the context.
What else do we need to know to strengthen interpretation?	• Which components score high or low? What is the proportion of cases with: Informed consent/assent to collect, store and share information. A risk assessment carried out within 1 week of the identification. A developed case plan?

PQ-10: # of case workers trained on protection case management

Indicator ID	**PQ-10**
Category	Process and Quality
Objective(s)	Understand caseworker capacity
What could this mean?	**A HIGH number caseworkers trained could mean:** • Case workers have a basic understanding of protection case management • Low turn over of case workers and effective supervision **A LOW number of case workers trained could mean:** • Lack of capacity of case workers that have not been trained on protection case management • A high turnover of case workers • Lack of a structured supervision
What else do we need to know to strengthen interpretation?	• % of case files reviewed that meet 80% of criteria of a case file checklist (PQ-09)



PQ-11: % of clients that felt they were involved in decisions during their case management

Indicator ID	**PQ-11**
Category	Process and Quality
Objective(s)	Measure client centered nature of process
What could this mean?	**A HIGH proportion of clients could mean:** • Service provision is client-centered • Use of reasonable adaptations when needed to ensure the accessibility of language and information (in response to barriers) • High quality training • High caseworker(s) capacity and knowledge **A LOW proportion of clients could mean:** • Gaps in case worker(s) capacity, attitudes, and knowledge. • Lack of explanation of case management to client. • Existing communication barriers are not addressed, making it difficult for the client to engage. • Cultural or individual barriers to participation in decision making, including power dynamics between client and case manager.
What else do we need to know to strengthen interpretation?	• Client feedback for specific supervisors • Was the action plan signed off? • Were strengths identified and used to develop the action plan? • Did the action plan include barriers identification and in response reasonable adaptations for persons with disabilities? • Case worker attitude score (PQ-08)

PQ-12: % of clients that are satisfied with the case management services

Indicator ID	**PQ-12**
Category	Process and Quality
Objective(s)	• Measure quality of overall case management process • Measure client satisfaction with the process
What could this mean?	**A HIGH proportion of clients satisfied could mean:** • The case management process is effective. • Client has trust in the process and case worker capacity. • The process is client centered approach and reasonable adaptations are implemented as required. • High caseworker(s) capacity, knowledge, and skills • Data quality: If all surveyed clients are satisfied with the process, the measurement instrument might be biased, or clients do not feel safe reporting concerns. **A LOW proportion of clients satisfied could mean:** • Unrealistic expectations of case management process • Lack of a client centered approach • Lack of identification of barriers or measures to address barriers. • Required services are not available or accessible.
What else do we need to know to strengthen interpretation?	• Average number of cases per case worker per month (PQ-06) • Success of referrals (PQ-13) • Analysis of barriers/accessibility audit per case (particularly for those identified with a disabilities)

PQ-13: % of successful referrals

Indicator ID	**PQ-13**
Category	Process and Quality
Objective(s)	• Measure quality of overall case management process • Identify gaps in service delivery
What could this mean?	**A HIGH proportion of successful referrals could mean:** • Up-to-date and quality service mapping • Required services are available and accessible. • Client trusts the service provider and is able/willing to follow up. • High caseworker(s) capacity, knowledge, and skills • Data limitations: The measurement of ¨successful¨ does not capture all barriers and as such underreports existing constraints to access. **A LOW proportion of successful referrals could mean:** • Outdated service mapping. • Client unwilling or unable • Several key services are unavailable, overwhelmed or not accessible. • Lack of (implementation of) clear SOPs with service providers.
What else do we need to know to strengthen interpretation?	• What are the barriers to access, are there physical access issues, information gaps or language/attitude constraints? • Has there been accompaniment from the case worker or supervisor during referral? If yes, what has been their experience? (by type of service)

CASE CHARACTERISTICS INDICATORS

CC-01: % of cases by protection risk

Indicator ID	**CC-01**
Category	Case characteristics
Objective(s)	Measure characteristics of cases and relevant changes over time.
What could this mean?	**The breakdown by type of cases increases understanding of:** • Protection risks not covered by the case management process, due to a lack of trust, outreach, or prevalence of the concern. • The key concerns faced by clients. • Appropriateness of the eligibility criteria. • Specific barriers for certain groups facing specific protection risks (people with disabilities, older people… etc.) **A change in time of in protection concerns can reflect a change in:** • Overall context • Barriers to access for clients with a specific profile. • Outreach activities and related understanding of case management among the community.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by risks (e.g., are certain profiles more represented among certain risks)

CC-02: % of cases by risk level

Indicator ID	**CC-02**
Category	Case characteristics
Objective(s)	Measure characteristics of cases and relevant changes over time.
What could this mean?	In a well-functioning case management system, the majority of cases will be at medium risk, with a small number identified as high risk. **A low or high % of cases identified as high risk can mean:** • Gaps in understanding of the risks levels and how to apply these. • Lack of outreach to high-risk cases. **A change over time in risk levels among clients can reflect a change in:** • Understanding of risk levels by case managers. • Changes in the overall context • Barriers to access for clients with a specific profile. • Outreach activities and related understanding of case management among the community.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by risks (e.g., are certain profiles more represented among certain risk levels)

CC-03: % of cases by duration

Indicator ID	**CC-03**
Category	Case characteristics
Objective(s)	Measure the quality of the process and understand the team's ability to close cases.
What could this mean?	**A HIGH proportion of cases with a specific protection risk showing delays could mean:** • Case closure process is unclear or not used. • Gaps in case worker(s) capacity and knowledge • Specific protection risks are difficult to address within the operational context. • Gaps in service provision (accessibility or availability) • Barriers remain unidentified or not addressed. **A LOW proportion of cases with a specific protection risk showing delays could mean:** • Strong case worker capacity • Eligibility criteria are up to date in the context. • Complex cases are excluded from the process. • Goals are not sufficiently ambitious. • Key services required are available and accessible.
What else do we need to know to strengthen interpretation?	• Are the goals within the action plans SMART? • Are the eligibility criteria appropriate within the context? • Is the service map up to date?

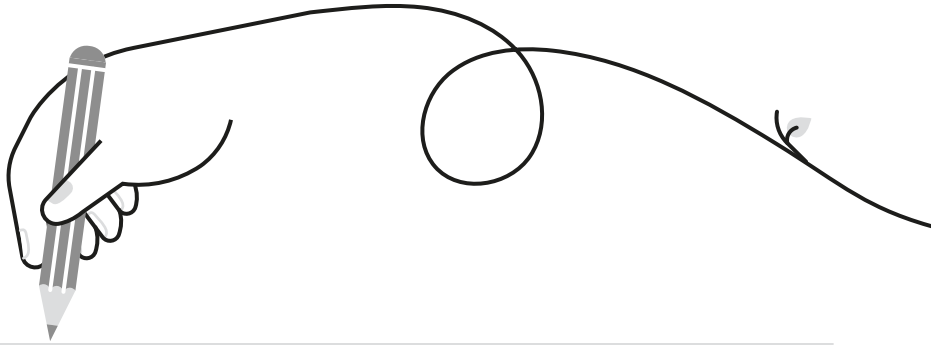
CC-04: % of clients that have a disability

Indicator ID	**CC-04**
Category	Case characteristics
Objective(s)	To determine the profile of clients and any barriers to accessing PCM specifically affecting those with a disability.
What could this mean?	**A HIGH proportion of clients with a disability** • A high proportion of the population has a disability • Specific context crisis results in increase risks/violence for people with disabilities (requiring immediate case management response) • Protection case management is perceived as a useful service for those with a disability. • Effective identification and reduction of access barriers. • Case workers are comfortable with working with people with disabilities (extensive inclusion training/coaching or extensive experience) • Data quality concern: Misuse or misinterpretation of the module administered to measure disability among clients (Washington Short Group of Questions) **A LOW proportion of clients with a disability** • Gaps in inclusion training/coaching resulting in knowledge gaps for the case workers • Negative attitudes of case workers toward persons with disabilities • Lack of barriers identification for accessibility leading to proper outreach for persons with disabilities • Outreach process not prioritizing persons with disabilities • Key services are unavailable or inaccessible • Data quality concern: Misuse or misinterpretation of WGSS
What else do we need to know to strengthen interpretation?	• Feedback case managers on use WGSS • Case workers attitudes on inclusion and inclusive practices in case management • Contextual analysis related to barriers identification for persons with disabilities (physical, attitudes, information/communication barriers) • Main barriers identified as part of the PCM process (seeing, hearing, walking, remembering, self-care and communicating)

CC-05: % of cases with a finalized safety plan

Indicator ID	**CC-05**
Category	Case characteristics
Objective(s)	Understand profile of cases managed
What could this mean?	**A very LOW proportion of safety plans can indicate:** • Misunderstanding among case workers on the value and use of safety plan. • Safety plan format and process is not considered appropriate within the context. • Clients do not share safety concerns, for instance due to a lack of trust. • Lack of outreach to high-risk cases. **A very HIGH proportion of safety plans can indicate:** • Overuse of the safety plan, including for clients who do not face immediate threats to their safety and security. • Case workers are comfortable with safety planning.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by safety plan (e.g., are certain profiles more represented among those with a safety plan)

Form 1
Intake



Initial informed consent to undertake intake

I _____ (client/service user name), hereby give permission to the (name service provider) to collect information in order to determine whether the provision of case management services may be of benefit to me.

I understand that my information will be treated with confidentiality and respect and that I have the right to:

- Decide what information I share with the caseworker. They will not pressure me to share information.
- Request for my information not to be documented or written down.
- Refuse to answer any questions that I don't want to and ask for the caseworker to stop or slow down at any time.
- Ask questions at any time to the caseworker; if I feel that I could work better and talk more easily to someone else than the assigned caseworker or work with another organization I can request this.

The caseworker will keep my information confidential. The only exceptions to this are;

1. The caseworker may seek guidance from a supervisor in relation to my case. The caseworker would only share information as needed to support me.
2. If I express thoughts or plans that involve causing physical harm to myself or others, the caseworker will take action to protect my safety and the safety of those around me, without seeking my consent, although they would do their best to inform me of actions taken.

By signing this form, I give permission to the (name service provider) to collect my personal information for the specific purpose of determining whether the (name service provider) is in a position to support me and whether the provision of case management services may be of benefit to me.

If we agree that case management services are of benefit, the caseworker will explain in more detail how information is used and shared throughout the case management process. At that point, I can adjust or review my permission to collect information, before continuing with case management services.

_____	_____	_____
Signature of client (or caregiver)	Caseworker code	Date

Part A | Preliminary intake information

Complete these details before your intake with the client. The client should have provided permission for an interpreter or anyone else to be present.

Date intake*

Client code*

Case code

Caseworker code*

Geographic location intake*

Interpreter code

Has the client provided consent for this intake?

- ☐ Yes
- ☐ No (Do not continue until the client has provided consent)

Who referred/identified the person?

- ☐ Family, friend, neighbour or community member
- ☐ Internal referral
- ☐ Referral from other organisation
- ☐ Self-referral
- ☐ Government
- ☐ Other (specify):

Does the client need any support to take part in this intake?

- ☐ No
- ☐ Yes. Note down what support has been put in place:

Part B | Intake

Sex assigned at birth	• Female • Male • Intersex • Prefer not to say • I do not understand the question
Gender*	• Woman • Man • Non-binary • Prefer not to say • I use another term – please specify: _____ _____
Age or date of birth?*	
Is the client already receiving case management from another organisation or actor, or have they in the past?	☐ Yes ☐ No If yes: from whom?

Part C | Protection Case Management eligibility

Main protection risk or problem shared by client, and impact on the client's well-being and safety	
Social support network (e.g. family and community support)	
Protection risks (match with Form 0)* Select all that apply	• (Forced) family separation • Abduction, kidnapping or enforced disappearance • Arbitrary or unlawful arrest and/or detention • Death or injury through deliberate or non-deliberate attack by armed groups • Extortion • Forced labour or slavery • Forced recruitment into armed forces/groups • Maiming or mutilation • Physical assault or abuse (not related to sexual and gender-based violence) • Psychological/emotional abuse • Torture or inhuman, cruel or degrading treatment • Trafficking in persons • Other, please specify:
Risk Level*	• HIGH (Serious and imminent risk requiring immediate action in max 48 hours) • MEDIUM (Probability of a serious risk, requiring intervention within a week) • LOW (Low probability of a serious risk)

Based on the client's responses, what are the next steps? Select all that apply	• A. Continue with Protection Case Management Protection Risk Assessment • B. Do not proceed with case and refer to GBV Case Management • C. Do not proceed with case and refer to Child Protection Case Management • D. Referral to Legal Aid • E. Referral required, Protection Case Management is not necessary
Urgent follow-up actions based on intake:	
Case manager observations:	

Client code: _____

Form 1a

Interpreter Non-Disclosure Agreement

Date*

Name of interpreter*

Phone number / email of interpreter*

Organisation(s)

Language*

- ☐ Language 1
- ☐ Language 2
- ☐ Language 3
- ☐ Sign language

Gender of interpreter

- Woman
- Man
- Non-binary
- Prefer not to say
- I use another term – please specify:_____

NON-DISCLOSURE

I _____(interpreter name) understand that the sole purpose of my presence is for translation. I am not here to judge or reformulate the client's statements and should translate as close as possible to the original language used by the client. I understand that everything that will be said during that interview will be kept confidential and that I am not authorised to share information. I understand that by signing that statement I am making myself contractually reliable to the _____(organisation name) in the way that _____(organisation name) could engage legal proceedings against me if I am breaching the confidentiality principle.

_____ _____

Signature of client. *Please sign or mark to show understanding.* Date

Form 2
Informed Consent

Part A | Consent

Explain informed consent and the Protection Case Management process, see Module 4, page 156

INFORMED CONSENT to release information

I_____ (client name), acknowledge that the _____ (service provider name) has clearly explained the case management process to me. I understand that I will guide the case management process to identify my needs and goals, and that the primary purpose of this service is to ensure my safety, dignity, and well-being.

I understand that my information will be treated with confidentiality and respect, and that through the case management process I have the right to:

- Decide what information I share with the caseworker without pressure to share information
- Request for my information not to be documented or written down
- Not to answer questions that I don't want to
- Ask for the caseworker to stop or slow down at any time or ask questions at any time to the caseworker
- Request another organisation or caseworker if it would make me feel more comfortable and/or easier to communicate
- Understand why the referral is taking place, how it will be done, what information will be shared.
- Ask for the caseworker to accompany me or refuse referrals to services if I don't want them
- Stop the case management process at any time
- Request to see my case files or other documents, as well as asking for any changes to them

My caseworker will keep my information confidential, except in situations with the following exceptions:

1. When a caseworker may seek guidance from a supervisor or from other case managers in relation to my case. My caseworker would only share information as needed to support me and it will not include information that could identify me.
2. If I express thoughts or plans of committing physical harm to myself, or others, my caseworker will take action to protect my safety and the safety of those around me. If there is a risk of immediate danger, my caseworker would not need to seek my consent in such cases but would do their best to inform me of actions taken.

3. If there are situations where non-identifiable information may be used for purposes of humanitarian reporting and analysis only.

By signing this form, I authorise this exchange of information to the specified service provider/s for the specific purpose of providing assistance.

Signature/thumbprint of client

Caseworker code

Date

Part B | Contact information & other identifying information

To be kept separate from the rest of the Protection Case Management forms

What is your preferred mode of communication?*

Select all that apply

- ☐ Phone
- ☐ Whatsapp
- ☐ Email
- ☐ In-person at home
- ☐ In-person at other agreed to location
- ☐ Through community focal point
- ☐ Another designated individual
- ☐ Other

Explain:

If preferred contact is by phone, who owns the phone? *Check whether it is safe for you to contact and get authorisation to identify yourself to the contact provided*	☐ Owned by client ☐ Borrowed/shared
Preferred time and day to be contacted	
Contact number	
Email address	
UNHCR registration number	
Physical address	
If preferred contact is through a community focal point, what are the name contact details of the community focal point?	
Preferred meeting location	☐ In person at home ☐ In person at our community space ☐ In person in a different location ☐ Other: please specify

Part C | Client consent to engage an interpreter

INFORMED CONSENT to engage an interpreter

I_____ (client name), acknowledge that the_____ (interpreter name) will be present during the case management process/session for the sole purpose of translation to facilitate understanding and communication. To the best of their abilities, they will not change the meaning of my words. I understand that they will keep my information during the case management process/session confidential and that they are not authorised to share any of my information. I understand I can request for them to stop attending at any time.

By signing this form, I authorise the presence of the interpreter during case management sessions.

_____

Signature/thumbprint of client

_____ _____

Caseworker code Date

Form 3

Protection Risk Assessment Form

Part A | Preliminary information

To be kept separate from the rest of the Protection Case Management forms

Date assessment *

Client code*

Case code

Caseworker code*

Interpreter code

Has the client provided consent for the Protection Case Management process?*	☐ Yes ☐ No (Do not continue until the client has provided consent)
Does the client need any support to take part in this meeting?	☐ No ☐ Yes: Note down what support has been put in place:

Client code: _____

Part B | Clients bio-data

Civil/marital status	☐ Single ☐ Married/co-habitating ☐ Divorced/separated ☐ Widowed
Displacement status	☐ IDP ☐ Returnees ☐ Local community ☐ Other
If displaced, where is the place of origin?	
Languages the client can communicate in	

Washington group set of questions
Read out loud: "The next questions ask about difficulties you may have doing certain activities."

1. Do you have difficulty seeing, even if wearing glasses?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
2. Do you have difficulty hearing, even if using a hearing aid?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know

3. Do you have difficulty walking or climbing steps?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
4. Do you have difficulty remembering or concentrating?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
5. Do you have difficulty with self-care, such as washing your whole body or getting dressed?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
6. Using your usual customary language, do you have difficulty communicating, for example understanding or being understood?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
Disability Status (case worker only): Yes / No *(Yes = one or more questions where the client has responded with yes to "a lot of difficulty/cannot do at all")*	☐ No ☐ Yes

Client code: _____

Part C | For people who require a caregiver

A caregiver is a person who provides direct care for an adult. This can be a parent, or any adult person who by law or custom is responsible for doing so.

Is there a caregiver?

☐ No
☐ Yes

If yes, what is the name of the caregiver/s?

If there is a caregiver, what is the relationship between the client and the caregiver?

Client's living environment

Describe your client's housing/ shelter situation

How many people are you living with? For each, note down their age and gender.

Number	Age	Gender

Who is the client living with and what are the relationships between the household members?

Client code: _____

Specific risk(s) to safety	
Describe your client's safety concerns and resulting needs	☐ No ☐ Yes
Is a safety plan needed for this case? *If yes, close this form and fill out the safety plan with the client.*	

Basic needs, services and legal status	
Describe your client's access to basic needs, services, and government assistance.Note any related gaps.	
Describe the client's physical and mental health and needs	
Describe the client's access to education and vocational training. Note any related gaps.	
Describe any documentation and legal challenges	
Does your client have legal status within the country?	☐ Yes ☐ No ☐ Do not know

Client code: _____

Part E | Exploring strengths

Summarise what the client is already doing to address any issues identified, or planning to do in the future (protective factors/coping capacities).

Part G | Summary for client

From what we have discussed, what do you feel are things which are worrying you most?

If you think about the problems that worry you most right now, how much would you say they are affecting you and your life?

- Not at all (0))
- Some (1)
- A lot (2)
- Severely (3)
- Do not understand the question
- Do not want to respond

How would you rate your ability to address noted problems?

- No ability (0)
- Low ability (1)
- High (2)
- Very high (3)
- Do not understand the question
- Do not want to respond

What do you see as the way forward?

Thank the client and finalise the form

Client code: _____

Part H | Summary for caseworker

Protection risks (match with Form 0)*
Select all that apply

- (Forced) family separation
- Abduction, kidnapping or enforced disappearance
- Arbitrary or unlawful arrest and/or detention
- Death or injury through deliberate or non-deliberate attack by armed groups
- Extortion
- Forced labour or slavery
- Forced recruitment into armed forces/ groups
- Maiming or mutilation
- Physical assault or abuse (not related to sexual and gender-based violence)
- Psychological/emotional abuse
- Torture or inhuman, cruel or degrading treatment
- Trafficking in persons
- Other, please specify:

Did the client self-report identifying as being part of the diverse SOGIESC community?
Do not ask the client directly

- ☐ Yes
- ☐ No
- ☐ Do not know

Are there characteristics which may increase the client's exposure or affect their ability to cope?
Select all that apply

- Chronic Illness
- Older person
- Person with a disability
- Legal status
- Lack of documentation
- Religious or ethnic minority
- Minority language speaker
- Other, please specify:

Any additional comments or observations about your client, and their appearance or behaviour, which could indicate their level of distress and mental health and psychosocial wellbeing? (e.g., a client appears distracted, distant or confused, is crying or angry and cannot calm down, and is acting differently from previous interactions.)	
Review the risk Level	• HIGH (Serious and imminent risk requiring immediate action in max 48 hours) • MEDIUM (Probability of a serious risk, requiring intervention within a week) • LOW (Low probability of a serious risk)
Urgent follow-up actions based on risk assessment	
Caseworker observations	

Client code: _____

Form 4

Psychosocial Wellbeing Assessment Tool[1]

Date*

Client code*

Case code

Caseworker code*

Interpreter code

Does the client need any support to take part in this meeting?

- ☐ No
- ☐ Yes: Note down what support has been put in place:

I am going to read you some statements about feelings and thoughts. Think about the last two weeks and please tell me how often the statement has been true for you in your life. Tell me if the statement has described your experience:

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

1. I've been feeling optimistic about the future

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

2. I've been feeling useful

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

3. I've been feeling relaxed

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

4. I've been feeling interested in other people

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

5. I've had energy to spare

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

6. I've been dealing with problems well

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

7. I've been thinking clearly

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

8. I've been feeling good about myself

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

9. I've been feeling close to other people

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

10. I've been feeling confident

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

11. I've been able to make up my own mind about things

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

12. I've been feeling loved

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

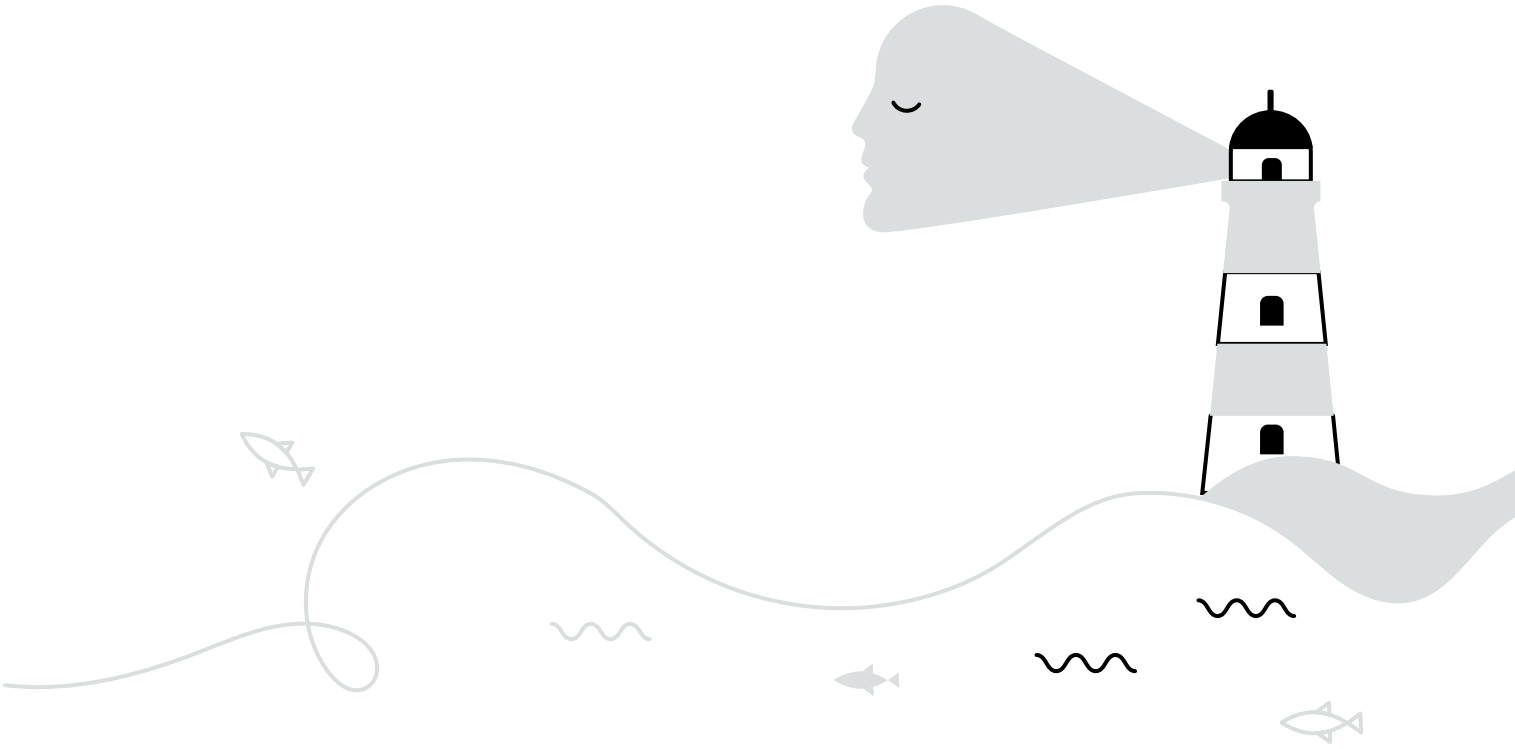
13. I've been interested in new things

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

14. I've been feeling cheerful	☐ None of the time (1) ☐ Rarely (2) ☐ Some of the time (3) ☐ Often (4) ☐ All of the time (5)
Total combined score (14-70)	

Endnotes

1 This tool applies an (adapted) version of the Warwick-Edinburgh Mental Wellbeing Scales



Client code: _____

Form 5

Basic Mental Health and Psychosocial Support (MHPSS) Assessment

Date*

Client code*

Case code

Caseworker code*

Interpreter code

Does the client need any support to take part in this meeting?

- ☐ No
- ☐ Yes: Note down what support has been put in place:

Over the past two weeks, how often have you been bothered by any of the following problems...

1. Little interest or pleasure in doing things?*

- ☐ Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

2. Feeling down, depressed or hopeless?*

- ☐ Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

3. Trouble falling or staying asleep? Or the opposite – sleeping too much?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
4. Feeling tired or having little energy?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
5. Poor appetite and not wanting to eat, even when food was available? Or the opposite –overeating?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
6. Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
7. Trouble concentrating on things, such as reading or watching television?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
8. Moving or speaking so slowly that other people notice? Or the opposite, such as being fidgety or restless and moving around a lot more than usual?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
9. Had thoughts that you would be better off dead, or thoughts of hurting yourself in some way?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

If you are experiencing any of these problems, how difficult have these problems made it for you to take care of yourself, manage things at home, do your work, and/or get along with other people?*

☐ Not difficult ☐ Difficult ☐ Very difficult ☐ Impossible

Suicidal ideation assessment

To be used if a client has had any suicidal thoughts (answered in question 9)

A. In the past month, have you had serious thoughts or plans to end your own life?

If the client responded 'no' to Question A, thank them for answering your questions and you can end this section of the assessment.

☐ Yes
☐ No

B. If yes to question A: What plans have you made or actions have you taken to end your life?

Write response here:

C. Do you have plans to end your life in the next two weeks?

If 'yes' or 'unsure', ask the client to describe their plan to you.

☐ Yes
☐ No
☐ Unsure

Write response here:

Referrals:

If the client responds 'no', and declines to complete the suicidal ideation assessment, complete a referral to MHPSS services for further assessment and MHPSS service provision. Without more information from the client at this time, the client should be categorised as a high-risk client and should receive a referral.

If the client answers 'yes' to question C, they have a plan to end their life in the near future and you must contact your supervisor immediately. Stay with the person while you do this. If you are unsure whether the client will end their life in the near future, tell them you would like to contact your supervisor to ask them follow-up questions.

For the caseworker:

Total combined score (0-27), to be filled after the assessment

***Include any additional comments or observations about your client, and their appearance or behaviour, which could indicate their level of distress and mental health and psychosocial wellbeing*.**

Client code: _____

Form 6
Case Action Plan

Part A | Preliminary intake information
Complete these details before your meeting with the client. The client should have provided permission for an interpreter or anyone else to be present.

Date*

Client code*

Case code

Caseworker code*

Date of last meeting*

Is a safety plan required?

☐ No
☐ Yes

Does the client need any support to take part in this meeting?

☐ No
☐ Yes: Note down what support has been put in place:

Client code: _____

Part B | Action plan

Specific risk: **Goal (s):**

Actions	By who	When	Status
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*

Specific risk: **Goal (s):**

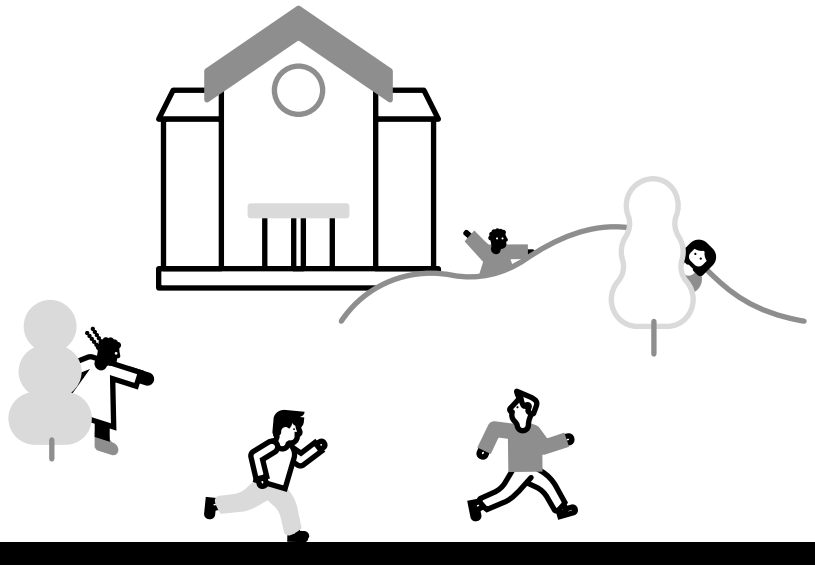
Actions	By who	When	Status
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*

Specific risk: **Goal (s):**

Actions	By who	When	Status
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*

Specific risk: **Goal (s):**

Actions	By who	When	Status
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*



Client code: _____

Referrals made
Select all that apply

- ☐ Psychosocial support
- ☐ Legal Aid services
- ☐ Livelihoods
- ☐ Family reunification
- ☐ Education
- ☐ NFI
- ☐ Health
- ☐ Cash
- ☐ Registration
- ☐ Water/sanitation
- ☐ Food services
- ☐ Shelter (including rehabilitation)
- ☐ Transport
- ☐ Documentation
- ☐ Safehouse
- ☐ Other, specify:

Are there any referrals that the client requires but are not available? If yes, which ones?
Select all that apply

- ☐ Psychosocial support
- ☐ Legal Aid services
- ☐ Livelihoods
- ☐ Family reunification
- ☐ Education
- ☐ NFI
- ☐ Health
- ☐ Cash
- ☐ Registration
- ☐ Water/sanitation
- ☐ Food services
- ☐ Shelter (including rehabilitation)
- ☐ Transport
- ☐ Documentation
- ☐ Safehouse
- ☐ Other, specify:

Is cash provided as part of an action plan? ☐ Yes ☐ No

If yes, How much?

Client signature	Caseworker code
Date	Date
Client signature	Caseworker code
Date	Date
Client signature	Caseworker code
Date	Date
Client signature	Caseworker code
Date	Date

Form 7
Referral Form

Priority*	Date of identification*	Referral date*
Indicate the priority of the case so the receiving agency knows the timeframe to respond. Consider if there are indications of immediate risk to personal safety.		
☐ High risk (48 hours) ☐ Medium risk (1-7 days) ☐ Low risk		

Referred by*	Referred to*
Insert the contact information of referring agency	***Insert the contact information of receiving agency***
Sector: Agency: Location: Focal point name: Email: Phone:	Sector: Agency: Location: Focal point name: Email: Phone:

Client code: _____

Client information* (only include if consent has been obtained)

Insert the person's individual bio data and contact. Check your service mapping to see whether additional information requirements are needed to access the service. Only include the identifying information required for the receiving agency to provide the service.

Name:
Address:
Phone:
Phone belongs to whom:
Preferred method of contact:
Preferred date/time for contact:

UNHCR registration # (if applicable)
Age:
Sex:
Disability status *(based on the outcome of your Washington group questions in the identification & intake form)*: Y/N

Caregiver information

Name:
Affiliation/organisation:
Relationship to the client:
Address:
Phone:
Caregiver informed of referral: Y/N
Explain if no:

Referral for which specific service and assistance*

Indicate the service(s) you are referring for. Please refer to the service mapping to ensure the service is available and the case meets the eligibility requirements for the service. Update explanations of services available in your context. See examples for CP, GBV, and MHPSS.

- ☐ **Child protection:** *This can include children at risk of exploitation, violence and abuse, children engaged in the worst forms of child labour, unaccompanied and separated children*
- ☐ **Gender-based violence:** *Women-at-risk of gender-based violence who can benefit from prevention and response services, including case management, safe spaces, early marriage cases*
- ☐ **Health**
- ☐ **Mental health and psychosocial support (MHPSS) services:** *This can include service providers in health, protection, and beyond; depending on the referral needs of the client and available MHPSS services providers in the area.*
- ☐ **Legal:**
- ☐ **Basic needs (food, nutrition)**
- ☐ **Shelter**
- ☐ **Water, sanitation and hygiene**
- ☐ **Education**
- ☐ **Livelihood**
- ☐ **Other**

Case narrative*

Describe the minimum information required for the receiving agency to respond. For example, problem description, whether the client receives other assistance, number in the household. Also include what accessibility/reasonable accommodation measures should be in place/put in place by the receiving organisation to support access to the service. For example, a temporary ramp or an interpreter. Remember for referrals to SGBV, CP and legal case management services do not provide details of the incident or case.

Consent *to release information**

Read the disclosure with the individual. Inform the individual how the service provider will use their data and answer any questions they might have before they sign the disclosure. For children under 18 years where the caregiver may be implicated in the abuse, informed assent should be sought instead.

Explain to the individual that they have the right to request that their information not be documented and can request retrieval of the information at any time. They have the right to refuse to answer any questions they prefer not to and the right to ask questions or for explanations about the referral process at any time.

I _____ (clients name), acknowledge that the service provider, _____ (service provider name) has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. I understand that my information will be treated with confidentiality and respect, and will only be shared as needed to provide assistance. I understand the information may be used for humanitarian analysis. By signing this form, I authorise this exchange of information to the specified service provider/s for the specific purpose of providing assistance.

_____ _____

Signature of client Date

Form 8
Safety Plan

Part A | Preliminary intake information

Complete these details before your meeting with the client. The client should have provided permission for an interpreter or anyone else to be present.

Client code*

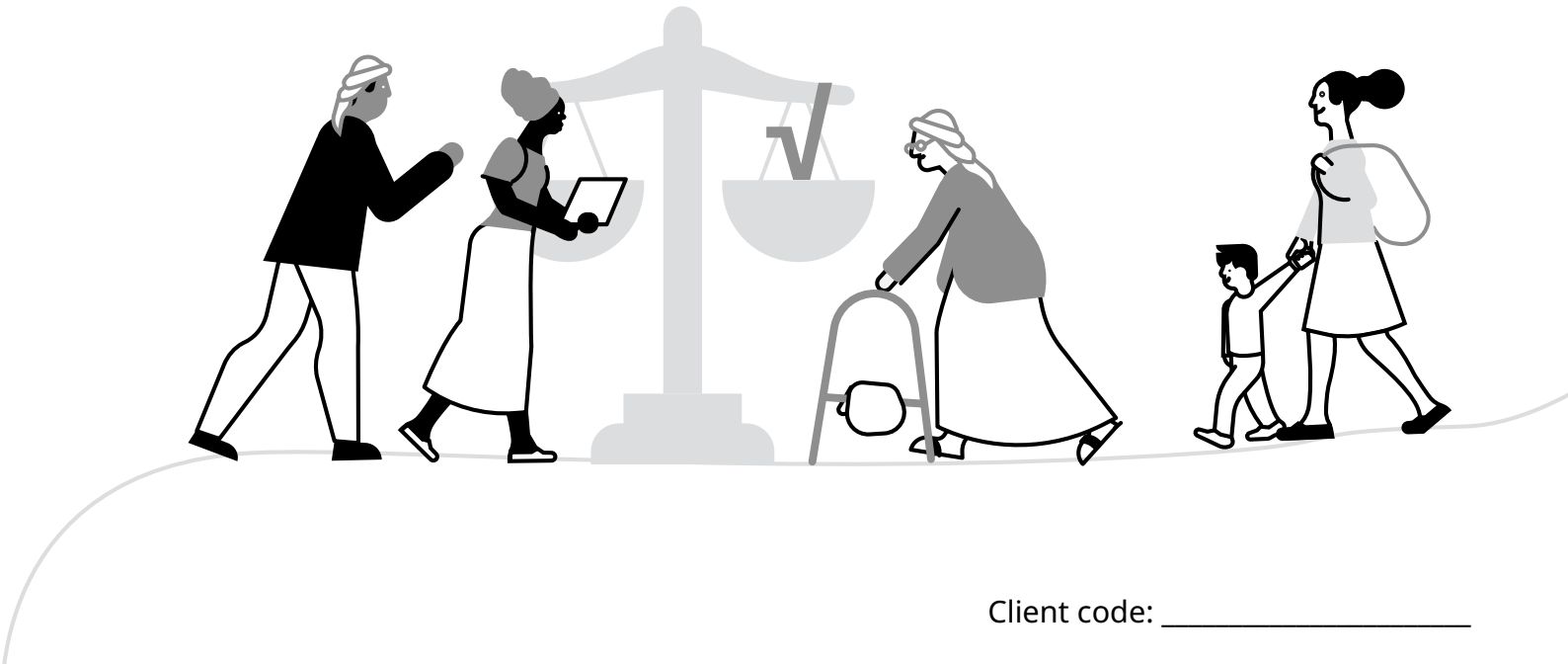
Case code

Caseworker code*

Date*

Does the client need any support to take part in this meeting?

☐ No
☐ Yes: Note down what support has been put in place:



Client code: _____

Part B | Safety

Risk or event that the client is planning for*

Current plans

What is the client's plan to protect themselves? *

Explore potential safety strategies

Whom do they trust? Is there anyone who can intervene or influence the perpetrator? What local authorities or prominent members of the community might they involve? what circumstances would they involve them?

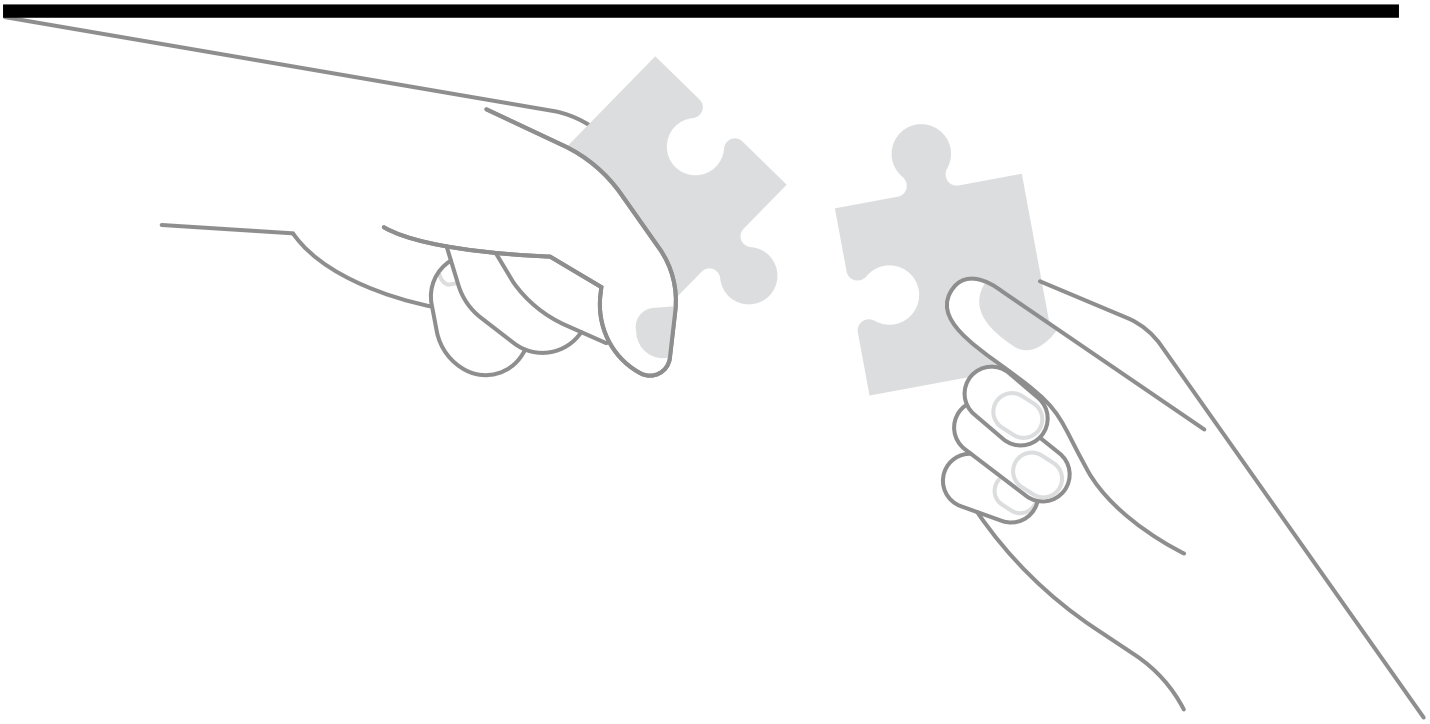
If the client has to leave, where could the client go, what financial resources do they have and/or what materials resources do they have?

If the client has to leave, or if the risk/ incident occurs, what will happen to their family or other responsibilities that they normally have? Who else might be in danger? Have they been made aware of this danger?

What will they bring, for themselves and their families? What financial and material resources and documents do they have?

Client code: _____

Preparatory action to be taken by the client	Preparatory action to be taken by the caseworker



Client code: _____

Form 9
Follow-up & Monitoring

Part A | Preliminary information

Date*	
Client code*	
Case code	
Caseworker code*	
Risk-level at intake*	☐ High ☐ Medium ☐ Low
Risk-level* *Update the risk-level based on progress of the case action plan*	☐ High ☐ Medium ☐ Low
Does the client need any support to take part in this meeting?	☐ No ☐ Yes: Note down what support has been put in place:

Client code: _____

Part B | Re-assess safety and mental health and psychosocial wellbeing

Part C | Progress made towards goals

These goals are linked to the goals laid out in the action plan. You will need to update them accordingly and insert any needed details about actions to achieve them.

1. ***Update the client on developments you have with regards to their action plan since the last time you met.***
2. ***Where appropriate, also ask the client to update you on developments regarding their action plan.***
3. ***Agree on how you are progressing towards goals including any challenges.***
4. ***Agree on changes you need to make to the action plan and next step.***

Goal 1*	Progress towards goal:
Goal 2	Progress towards goal:
Goal 3	Progress towards goal:

Client code: _____

Part D | Progress made towards goals

Consult the case action plan to see the referrals made. Discuss with the client the successfulness of the referrals. Have the referral(s) been successful? If not, why?

Agree on any revisions you need to make to the case action plan.
Update the case action plan with the client. Note down any justification for changes made to the Case Plan

Part E | Follow-up

Agree on the need for the next follow-up visit, including the location, time and day.
Check whether you need to make any adjustments to ensure the clients full participation in the next meeting. (i.e. organising for interpretation, meeting in a more accessible place)

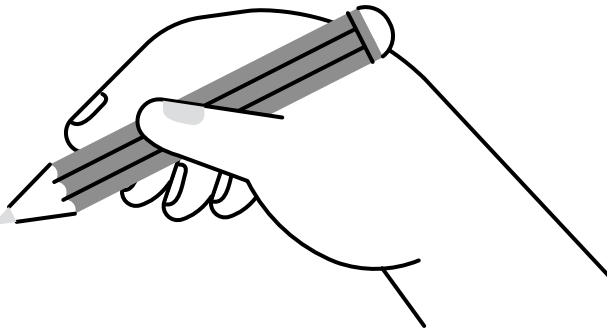
Follow-up meeting:
☐ Yes
☐ No

Location:
Date:
Time:
Adjustments for full participation needed:

Agree on what you each want to achieve by the next visit
On your next visit you can start by checking in with each other on whether you met these goals

Client code: _____

Form 10
Casefile Notes



Date*

Client code*

Caseworker code*

Select the action(s) taken by the caseworker

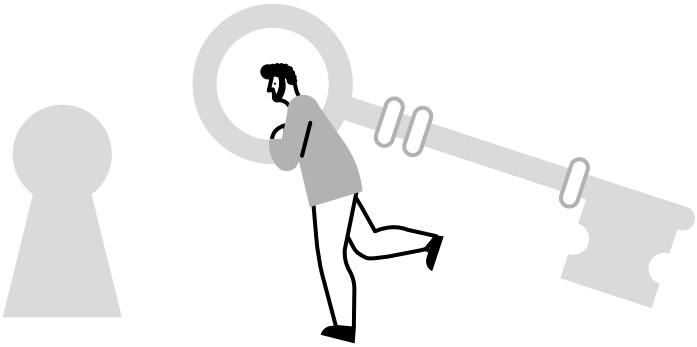
- ☐ Home visit
- ☐ Meeting/contact/phone cal
- ☐ Referral made
- ☐ Changes to case plan
- ☐ Update any new information received
- ☐ Other (explain)

Briefly describe any actions taken and updates regarding the beneficiary and her/his situation

Recommendations/actions required (if relevant):

Client code: _____

Form 11
Case Closure



Date*

Client code*

Case code

Caseworker code*

Case Closure	
Were the goals of the action plan met?* Summarise *progress towards goals in the action plan*	☐ Completely ☐ Mostly ☐ Few elements ☐ No
Explain the reasons for closing the case.*	☐ Client's needs have been met to the extent possible ☐ No contact with the client for more than _____ ☐ Client requested to close the case ☐ Client left the area ☐ Case Transfer ☐ Death of client ☐ Other

Client code: _____

If there was a case transfer, what are the reasons for transferring the case?	☐ Another organisation is better placed to manage the case due to specialised services required by the beneficiary ☐ Client moving to a new location; the case will be transferred to another case management organisation in that location ☐ There are organisational reasons for transferring this beneficiary's case ☐ The Client has requested a different organisation to provide PCM services ☐ Other
Impact of the service provided	
When we first discussed your case, you mentioned (...) as the main problem(s) you worried about. How much would you say this problem is (these problems are) affecting you and your life right now?	☐ Not at all (0)) ☐ Some (1) ☐ A lot (2) ☐ Severely (3) ☐ Do not understand the question ☐ Do not want to respond
How would you rate your ability to address this problem?	☐ No ability (0) ☐ Low ability (1) ☐ High (2) ☐ Very high (3) ☐ Do not understand the question ☐ Do not want to respond
What about the Protection Case Management support you received was most valuable to you personally? Why?	
Were there any changes you were hoping PCM could help you to achieve that didn't happen in practice? How could Protection Case Management have supported you better?	

Client code: _____

Closure checklist for caseworker	
If the client requires future services, the client has been informed of information on available services, how to access them, and how to contact your organisation, other agencies or community support structures.*	☐ Yes ☐ No
The client is actively involved in decisions regarding case closure or transfer, and, whenever possible, has given their informed consent for the case to be closed or transferred.*	☐ Yes ☐ No If no, explain:
The client has given consent to participate in the client feedback survey.*	☐ Yes ☐ No

Signature of client _____ Date _____

Signature of caseworker _____ Date _____

Signature of supervisor _____ Date _____

Form 12
Service User Feedback Survey

Instructions

This form should be completed at the end of the Protection Case Management process, or after the case action plan has been (partly) implemented with the client. Allow for the client to self-administer the form where possible. If this is not possible, the survey should be administered by someone who is not the assigned caseworker to the case. Either, another caseworker, the supervisor, MEAL staff, or others appropriately trained in protection principles, psychological first aid, and data protection principles.

Step by step:

1. Identify who on your team is going to administer the feedback form. In case of self-administration by the client, adjust the questions to ensure the client fully understands what is being asked, contextualise the questions where required, and translate the form to the local language(s).
2. Ask for informed consent following these steps:
   - Explain the purpose of the survey. Inform the client that you will ask them some questions but will not write their name on the form, and that the survey will remain anonymous.
   - Remind the client that you will not ask them any questions about their actual case, but are just interested in the services they received throughout the Protection Case Management process.
   - Ask for their permission to proceed. **The client consent section** aloud to the person, as noted below. If the client declines, tell the person that it is ok and if they change their minds, they can contact you.

To be read to the client:

We would like to know how you feel about the Protection Case Management and counselling services you received or are receiving. In order to understand your experience, we would like to ask you a few questions about your experiences. This survey is voluntary. Its purpose is to collect information about the services that have been provided to you, assisting us to make improvements in the quality of care that our clients receive in this community. Please let us know whether you require any support to participate in the survey. For example, whether it is easier for me to read the questions to you, whether you understand me well, or if you require an interpreter.

These questions are only to help us improve our services and in no way are related to your actual case. ***Your name and responses will remain anonymous and will not affect your services or support in any way.***

Do you agree to provide us with feedback through this questionnaire?

☐ Yes ☐ No

If consent is given, continue on to the survey.

_____

Date survey conducted

Survey administered by	
Gender	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say ☐ I use another term – please specify:
Age	
Displacement status	☐ IDP ☐ Returnee ☐ Local community ☐ Other
Preferred spoken language	[Context-specific list]
Has your case been closed?	☐ Yes ☐ No ☐ Do not know
How did you find out about our service(s)?	☐ Family, friend, neighbour, or community member ☐ Referral from another organisation ☐ Community discussion ☐ Flyer or pamphlet you saw or received ☐ Government referral ☐ Other (specify):

Disability status-WG-SS: The next questions will ask if you have difficulties doing certain activities

1. Do you have difficulty seeing, even if wearing glasses?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know
2. Do you have difficulty hearing, even if using a hearing aid?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know
3. Do you have difficulty walking or climbing steps?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know
4. Do you have difficulty remembering or concentrating?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know
5. Do you have difficulty (with self-care such as) washing all over or dressing?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know

6. Using your usual customary language, do you have difficulty communicating, for example understanding or being understood?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know

Access and safety	
How many times have you met with the caseworker since you started services with us? This includes meetings by phone that you have had with the caseworker to discuss your case in detail.	
Did you ever have any difficulties reaching, entering, circulating or using our services?	☐ Yes ☐ No
If yes, please Explain	
If yes, did you share this information with your caseworker?	☐ Yes ☐ No
If yes, was there any measure put in place to facilitate your access?	☐ Yes ☐ No
If yes, were any measures effective?	☐ Yes ☐ No If no, please explain why not:

How long did you have to travel (in minutes) to receive Protection Case Management services?	☐ Less than 15 minutes ☐ 16-30 minutes ☐ 31 minutes – 1 hour ☐ More than 1 hour ☐ No travel, phone-based services Please explain:
Did you pay for travel to cProtection Case Management services?	☐ Yes ☐ No
If yes, did it seem affordable?	☐ Yes ☐ No ☐ Not Applicable – did not pay for travel
If you have been referred to other services, did you feel safe accessing the Protection Case Management services?	☐ No, not at all ☐ Not really ☐ Somewhat /neutral ☐ Mostly yes ☐ Yes, completely
If "no, not at all", "not really" or "somewhat/neutral", please explain why not	
Have you been referred to other services during the case management process?	☐ Yes ☐ No ☐ Do not know
If yes, did you ever have any difficulties reaching or using any services you were referred to?	☐ Yes ☐ No Please explain:

If yes, which services?	☐ Health ☐ Legal assistance ☐ Education ☐ MHPSS ☐ Cash/asic needs ☐ Shelter ☐ WASH ☐ Other (Pleases specify)
If yes, did you share this information with your caseworker?	☐ Yes ☐ No
If yes, did the caseworker support you to put any measure in place to facilitate your access?	☐ Yes ☐ No
If yes, were any measures effective?	☐ Yes ☐ No If no, please explain why not:
If you have been referred to other services, did you feel safe accessing the services?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely
If "no, not at all", "not really" or "somewhat/neutral", please explain why not	

Respectful and dignified treatment	
Did you feel comfortable talking to the caseworker?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely
Did you feel pressured at any time by your caseworker?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely

Voice and empowerment	
How satisfied were you with your social worker's communication skills?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely
Do you feel the case manager has sufficiently involved you when decisions were made during the Protection Case Management process?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely
If "no, not at all", "not really" or "somewhat/neutral", please explain why not.	
Was there any issue in your caseworkers' attitude towards you that you would like to share?	

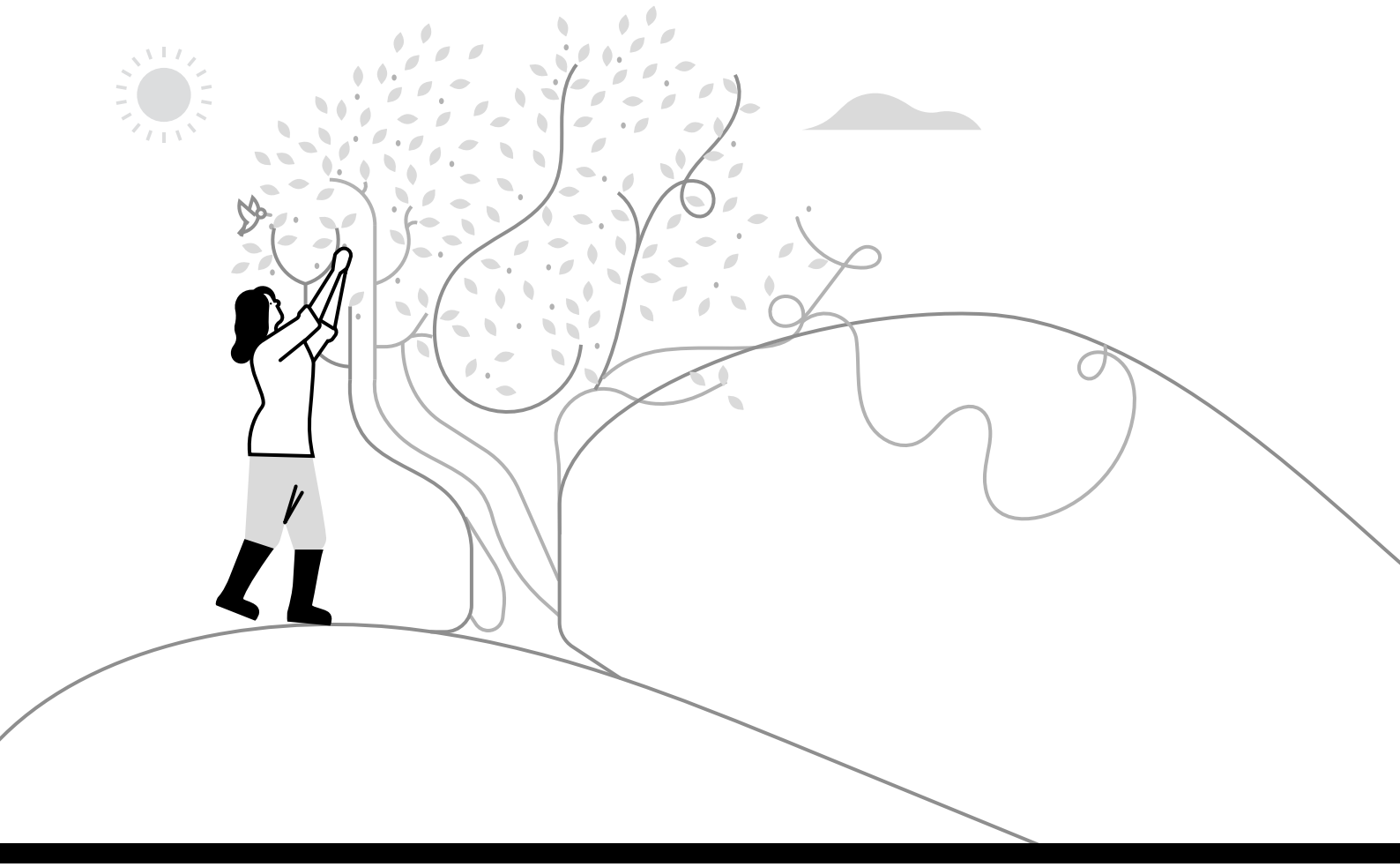
Accountability	
Did the caseworker explain to you how to provide a complaint or feedback if you wanted to?	☐ Yes ☐ No ☐ Do not know
Did the caseworker explain your rights at the beginning?	☐ Yes ☐ No ☐ Do not know

Relevance and satisfaction

Has your problem been addressed?	☐ No, not at all ☐ Not really ☐ Somewhat ☐ Mostly ☐ Yes, completely
If "no, not at all", "not really" or "somewhat/neutral", were there any changes you were hoping the Protection Case Management services could help you to achieve that didn't happen?	
Overall, how satisfied were you with the services that you received during your Protection Case Management	☐ Not at all satisfied ☐ Not really satisfied ☐ Somewhat/neutral ☐ Somewhat satisfied ☐ Completely satisfied Please explain:
What improvements could we make to our services for other clients?	

Would the client recommend a friend who has experienced something similar to come here for support?	☐ Yes ☐ No If no, please explain why not:

Thank the client for taking the time to take the survey.



***CC-06: % of clients reporting symptoms of moderate to severe distress or indicated suicidal ideation in the 14 days prior to Basic MHPSS Assessment at Protection Risk Assessment**

Indicator ID	**CC-06**
Category	Case characteristics
Objective(s)	• To determine the profile of clients and their level of distress • To identify clients requiring referrals for additional MHPSS services, inclusive of but not limited to specialized MHPSS services
What could this mean?	**A HIGH proportion of clients with moderate and severe disabling distress could mean:** • Limited accessible and quality MHPSS services and referrals • The context has deteriorated and/or the client has experienced complex or compounding risks • Limited family and/or community support structures • Limited individual self-regulation skills including the ability to understand, express and regulate emotions **A LOW proportion of clients with moderate and severe disabling distress could mean:** • Accessible and quality MHPSS services • The context is stable or has stabilized or the client has experienced minimal exposure to complex or compounding risks • Strong family and/or community support structures for clients • Strong individual self-regulation skills including the ability to understand, express and regulate emotions **Data quality:** If all surveyed clients are reporting high (or low) distress, the Basic MHPSS Assessment may not be understood by the client or the caseworker or the caseworker may not be comfortable using the assessment
What else do we need to know to strengthen interpretation?	• Caseworker has been trained on MHPSS service provision, including how to conduct the Basic MHPSS Assessment • Access to quality MHPSS services, including but not limited to specialized MHPSS services • Analysis of the context (e.g. to identify sudden changes such as increased generalized violence) • Assessment or knowledge on community and individual support structures

Annex 4.1
Inclusive Communication Tip Sheet

Communicating with People with Disabilities and Older People - Tip Sheet[1]

Inclusive Language

To guarantee inclusion and respect of the human rights-based approach of disability, it is essential to use appropriate vocabulary. To know what terminology to use, the best option is just asking the person what words they prefer/identify with. This can be different in different contexts and languages.

If this is not possible, as per the table below, it is recommended the use of **"person-first language",** which puts the person before their impairment. For example, we will say "person with disabilities" instead of "disabled".

Labels NOT to use	**Person first terminology.**
Handicapped, Disabled, PWD	Person(s) with disability/ies
Mental patient Mental handicap, Mentally defective	Person with psychosocial disabilities Person with intellectual disabilities, Person with learning disability Person with cognitive disability
Blind Visually impaired	Person who is blind, Person with visual impairment, partially sighted person
Hearing impaired Deaf	Person with hearing impairment, Person who is hard of hearing, Persons who is deaf Person who experiences communication difficulties.

Labels NOT to use	Person first terminology.
Invalid, handicapped person Wheelchair bound, confined or restricted to a wheelchair	Person with a physical disability Person who uses a wheelchair, Wheelchair-user
Old person, Oldies	Older person

Communication tips

There are some general recommendations2 to improve communication and interaction skills when interacting with older people and persons with disabilities:

- ✔ Do not make assumptions about the skills and capacities of persons with disabilities and older people – this can affect the way we communicate and interact with them. Remember that persons with disabilities are people, first and foremost. Just like all people, they have different opinions, skills and capacities.
- ✔ Address older people and persons with disabilities in the same way as you talk to everyone else, speak directly to them, even if there is an interpreter or a caregiver.
- ✔ Use a normal tone of voice, do not patronize, or talk down.
- ✔ Look at what they can do. This can often give insight into how they can communicate and participate in your activities.
- ✔ Ask first when offering assistance, wait until your offer is accepted before you help, and follow the instructions of the person.
- ✔ Be patient and let the person set the pace in talking and doing things.

- ✔ Greet persons with disabilities in the same way you would greet other people. For example, offer to shake hands (if culturally appropriate), even if they have an arm impairment or artificial limb.
- ✔ Be close to the person but keep an appropriate distance.
- ✔ Ask for advice. If you have a question about what to do, how to do it, what language to use or the assistance you should offer – ask them. The person you are trying to work with is always your best resource.

You should always support older people and persons with disabilities to participate in a survey, an interview or submit feedback and complaints on their own behalf and if required you must provide reasonable accommodation. Alternatively, if an older person or a person with a disability requires and authorizes someone else (such as a caregiver, personal assistant, or family member) to participate, allow them to do so3. However, you must always check with the person that their advocate has conveyed the correct message on their behalf and that you have understood it correctly.

In addition to these general recommendations, below are some tips when relating with specific difficulties:

People with difficulties seeing

- ✔ Always identify yourself and others who may be with you.
- ✔ Indicate when you move from one place to another and if you leave or return to a room.
- ✔ When conversing in a group, remember to say the name of the person to whom you are speaking to give vocal cues.
- ✔ Speak in a normal tone of voice.
- ✔ Avoid vague language, such as “that way” or “over there” when directing or describing a location.
- ✔ Let the person know when the conversation is at an end.
- ✔ Do not touch the person without asking.
- ✔ When you offer to assist someone with a vision loss, allow the person to take your arm to better guide this person.
- ✔ Use specifics such as “left at 2 meters” when directing.
- ✔ When offering seating, place the person’s hand on the back or arm of the seat.

People with difficulties seeing	**Example of reasonable accommodation:** Ask persons with vision impairments if they would like documents in alternative formats, such as Braille or large print. In some contexts where people have access to computers, persons with vision impairments may prefer electronic documents that are accessible through screen reader software (e.g., Word documents).
People with difficulties hearing	✔ Find out how the person prefers to communicate. People with hearing impairments may use a combination of writing, lip reading and/or sign language. This can be done by following the person's cues to find out if they prefer and use sign language, gesturing, writing, or speaking or other alternative communication methods. ✔ Get the person's attention before speaking, by raising your hand or waving politely. ✔ Face and talk directly to a person who is deaf, not to the interpreter (as they are only facilitating the communication). ✔ Look directly at the person and speak clearly, slowly and expressively without overreacting/overemoting to establish if the person can read your lips. ✔ Speak in a normal tone of voice, do not shout. ✔ Keep your hands and food away from your mouth when speaking. Avoid communicating while smoking or chewing gum. ✔ Try not to sit or stand with your back to the light – this can put your face in the dark and make it difficult to lip read. ✔ Try to eliminate background noise. ✔ Written notes can often facilitate communication. ✔ Encourage feedback to assess clear understanding. ✔ f you have trouble understanding the speech of a person who is deaf or hard of hearing, let him/her know and offer to try again or use alternative communication methods. **Example of reasonable accommodation:** Provide sign language interpretation

People with difficulties communicating (understanding or being understood)	✔ Ask the person (or if appropriate the persons accompanying them) about how best to communicate with them. ✔ Encourage the person to communicate in whatever way/s work for them and encourage them to ask questions. ✔ Check how the person indicates yes and no. ✔ Keep your manner encouraging rather than correcting. ✔ Allow extra time for communication and check understanding regularly. Do not attempt to finish a person's sentences – let them speak for themselves. ✔ Formulate simple sentences and use precise language incorporating simple words. Do not give too much information at one time. If necessary, ask short questions that require short answers or a nod or shake of the head. ✔ Use hand gestures, notes, easy-to-read forms, pictures/photographs. ✔ Be patient, do not speak for the person. Take the time necessary to ensure clear understanding and give time to put the thoughts into words, especially when responding to a question. ✔ Give the person time to respond to your question or instruction before you repeat it. If you need to repeat a question or point, then repeat it once. If this does not work, then try again using different words. ✔ Give whole, unhurried attention when talking to a person who has difficulty speaking. It is OK to say "I don't understand." Ask the individual to repeat their point, and then say it back to them to check that you have understood it correctly. ✔ Always check If the person has understood and if you have understood him/ her correctly. Verify responses to questions by repeating each question in a different way. ✔ Revisit any areas of misunderstanding and try to articulate more clearly and simply. ✔ Use real life examples to explain and illustrate points. For example, if discussing an upcoming medical visit, talk the person through the steps they are likely to go through both before and during the appointment. ✔ Give exact instructions: for example, "Be back from lunch at 12:30," not "Be back in 30 minutes" **Example of reasonable accommodation:** Provide Easy-to-Read consent form and formats, if required ensure a support person is part of the process if needed

People with difficulties walking (including wheelchair users)	✔ When speaking with someone in a wheelchair, talk directly to the person and try to be at their eye level, but do not kneel. If you must stand, step back slightly so the person does not have to strain his/her neck to see you. ✔ When giving directions to people with mobility limitations, consider distance, weather conditions and physical obstacles such as stairs, curbs and steep hills. ✔ Arrange the interview space to provide for movement in a wheelchair or other assistive devices. ✔ Do not lean on or move someone's wheelchair or assistive device without their permission. ✔ If a person transfers from a wheelchair to a car, toilet, etc., leave the wheelchair within easy reach. Always make sure that a chair is locked before helping a person transfer. ✔ Move at their speed. Do not walk ahead of them if they are moving slower than you. ✔ Discuss transportation options for activities and events. Consider what is going to be safest, most affordable and the least amount of effort for the individual and family. **Example of reasonable accommodation:** Provide transport cost if the location is not accessible.

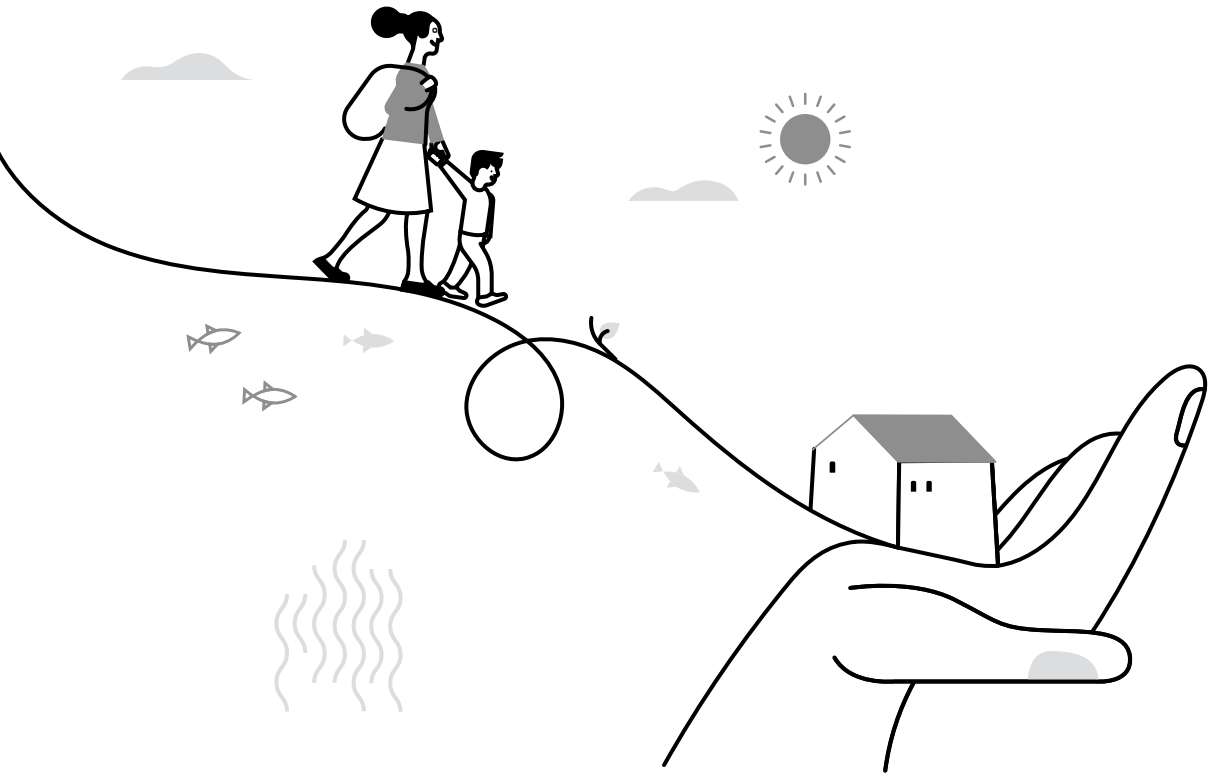
More information on accessible communication product, meeting and events, check this guidance from the Bridging the Gaps initiative: https://bridgingthegap-project.eu/wp-content/uploads/BtG_Inclusive-and-accessible-Communication-Guidelines.pdf and the Listen Include Respect Guidance for persons with intellectual disabilities: https://www.listenincluderespect.com/

Endnotes

1 This guidance paper was adapted from the IRC Inclusive Client Responsiveness Toolkit – May 2021 https://www.rescue.org/resource/inclusive-client-responsiveness-focus-people-disabilities-and-older-people

2 https://bridgingthegap-project.eu/wp-content/uploads/BtG_Inclusive-and-accessible-Communication-Guidelines.pdf

3 https://humanity-inclusion.org.uk/sn_uploads/document/humanitarian-inclusion-standards-for-older-people-and-people-with-disabilities-ADCAP.pdf



Annex 4.2

Guidance on Washington Group Short Set Use[1]

The Washington Group Questions are recommended for collecting data on disability status during quantitative data collection (and qualitative under certain circumstances). The most commonly used tool is the short set (six questions) which have been developed and tested extensively by the Washington Group, and are considered the most reliable tool to disaggregate data by disability status, allowing for comparability across a range of international contexts. These questions are designed to identify people who have difficulties in performing basic, universal activities and are at greater risk than persons without such difficulties of restricted social participation and access to services in an unaccommodating environment. The short set is aligned to the rights-based understanding on disability [2].

Six questions on short set

					
Do you have **difficulty seeing**, even if wearing glasses	Do you have **difficulty hearing** even if using a hearing aid?	Do you have **difficulty walking** or climbing steps?	Do you have **difficulty remembering** or concentrating?	Do you have **difficulty (with self-care** such as) washing all over or dressing	Using your usual language, do you have **difficulty communicating** or being understood?

For each question, the respondent selects one of four possible answer categories:

- ☐ No, no difficulties
- ☐ Yes, some difficulties
- ☐ Yes, a lot of difficulties
- ☐ Cannot do it at all

In addition to providing information on who faces each type of difficulty and what is the level of difficulties, responses to the six questions can be combined into **one binary answer** (disability status = "yes"/"no") determining whether an individual has a disability, regardless of the total number of difficulties.

The cut-off recommended by the Washington Group to determine disability status is:

At least one answer to the six question is either "a lot of difficulties" or "cannot do it at all."

Using the Washington Group Short Set of Questions has the following **advantages:**

- ☐ They are designed expressly as an **add-on** to existing censuses and surveys.
- ☐ They are **short**, and on average take only one to two minutes to administer.
- ☐ They are **internationally standardized** as they use universal activities (seeing, hearing, walking, remembering, or concentrating, self-care and communicating) that can be analyzed and compared across global contexts.
- ☐ They identify persons with disabilities as per the **human-rights based** approach to disability.
- ☐ They **do not stigmatize** the respondent as they do not use the word disability or discriminatory language.
- ☐ They rely on **self-reporting** as only the person experiencing a disability will be able to report accurately the level of difficulties, they are facing.

Depending on the context, other Washington Group questionnaire may be more appropriate:

- ☐ The Enhanced Short Set (extra 4 questions) which adds extra questions on anxiety and depression to the short set to better identify psychosocial disability which can be essential is some contexts.
- ☐ The Child Functioning Module, developed with UNICEF for children aged 2-4 and 5-17.
- ☐ The Extended Set where more details information about disability is required

The Washington Group Questions set was designed to be used at individual level (as individuals are best placed to report accurately the level of difficulties they are experiencing in their environment).

REMEMBER: DO NOT link the question domain (seeing, hearing walking etc.) to an impairment or type of disability (e.g. difficulty seeing =visual impairment/disability). **This will not lead to correct or reliable data,** as multiple difficulties could be present in all impairments e.g. persons who cannot see also often report difficulties to walk.

Guidance for Data Collection

When collecting data to answer the Washington Group Questions, keep in mind the following advice:

Preparing for Data Collection

- ☐ **DO** always add the questions in the demographic section of your tool (along with age and sex)
- ☐ **DON'T** change the questions and answer categories, **EXCEPT** for the following minor adaptations (which you can **DO** if needed):
  - Remove references to "glasses" in question 1 when they are not available in your context.
  - Remove references to "hearing aids" in question 2 when they are not available in your context.
  - Replace the reference to "stairs" in question 3 if they are not present in your context, and either remove or replace them with "short hill" or "small ladder"
  - Remove question 5 on "self-care" if this is perceived as offensive or disrespectful in your context.
  - Move question 6 on "communication" to the start if you want to begin with a more common question on the language barriers.
- ☐ **USE** the available translated questions on the website.
- ☐ **DO** specifically train the enumerators on how to ask the Washington Group Questions *(using the guidance below)*

During Data Collection	☐ **DO** use respect and patience when conducting the interview. ☐ **DON'T** use the word "disability" when asking or introducing questions. ☐ **DO** ask questions directly to each respondent/person, and **ONLY** use a proxy/caregiver in situations where this is not possible. ☐ **DO** ask the questions and answer categories using the exact language given. ☐ **DON'T** provide any examples. ☐ **DON'T** translate the questions during the data collection/interview. ☐ **DO** record the answer given to you by the respondent, and **DON'T** challenge or question the respondent's answer. ☐ **DO** remember that these questions are **NOT** a diagnosis tool and **DON'T** use the respondent's answers for referral to health services.

Analysis of the data

Once you have collected information on disability status and the Washington Group Questions as part of your data collection, there are many new and nuanced questions you can ask and answer!

Cleaning the Data	Prior to analysis, all data should be cleaned (e.g. checked for consistency, accuracy, and useability). Depending on the specific information being analyzed, this could include: ☐ No redundancy in the unit of analysis (e.g. the same person does not appear twice in the database unless for a particular reason). ☐ Ensuring no entry errors and conducting spot checks if manually entered data. ☐ Confirming that all quantitative values fall within a reasonable range. ☐ Read across all the data for a few individuals. Do their "stories" (e.g. flow of data) make sense?
Calculating Overall Disability Status	For each client or respondent, the six Washington Group Questions will provide answers to six distinct difficult questions. These should be combined into a single overall disability status ("yes/no"), indicating whether a given person has a disability ("lot of difficult" or "cannot do it at all") in at least one domain. This overall status can be calculated in Microsoft Excel using simple formulas (see an example below).

Looking at type of difficulties	**Note:** While a single overall disability status ("yes"/"no") will be calculated for each respondent, depending on how this information will be used or acted upon, program staff may find it useful to **further disaggregate key questions by specific type of difficulty.** For example, program staff may want to know if people with a certain type of difficulty (e.g. seeing or walking) have more or less access to services (due to specific barriers) or are more or less satisfied with IRC's response. **But, DO NOT** link the question domain (seeing, hearing walking etc.) to an impairment or type of disability (e.g. difficulty seeing=visual impairment/ disability) in your analysis. **This will not lead to correct or reliable data,** as multiple difficulties could be present in all impairments e.g. persons who cannot see also often report difficulties to walk. **DO NOT** add all the people who report one type of difficulties as you will double count people who reported difficulties in more than one domain.
Disaggregating Disability with Sex and Age	Disability data should **always** be presented disaggregated by **sex** and **age**. Avoid presenting groups such as "persons with disabilities" as a separated group with no sex and age disaggregation.

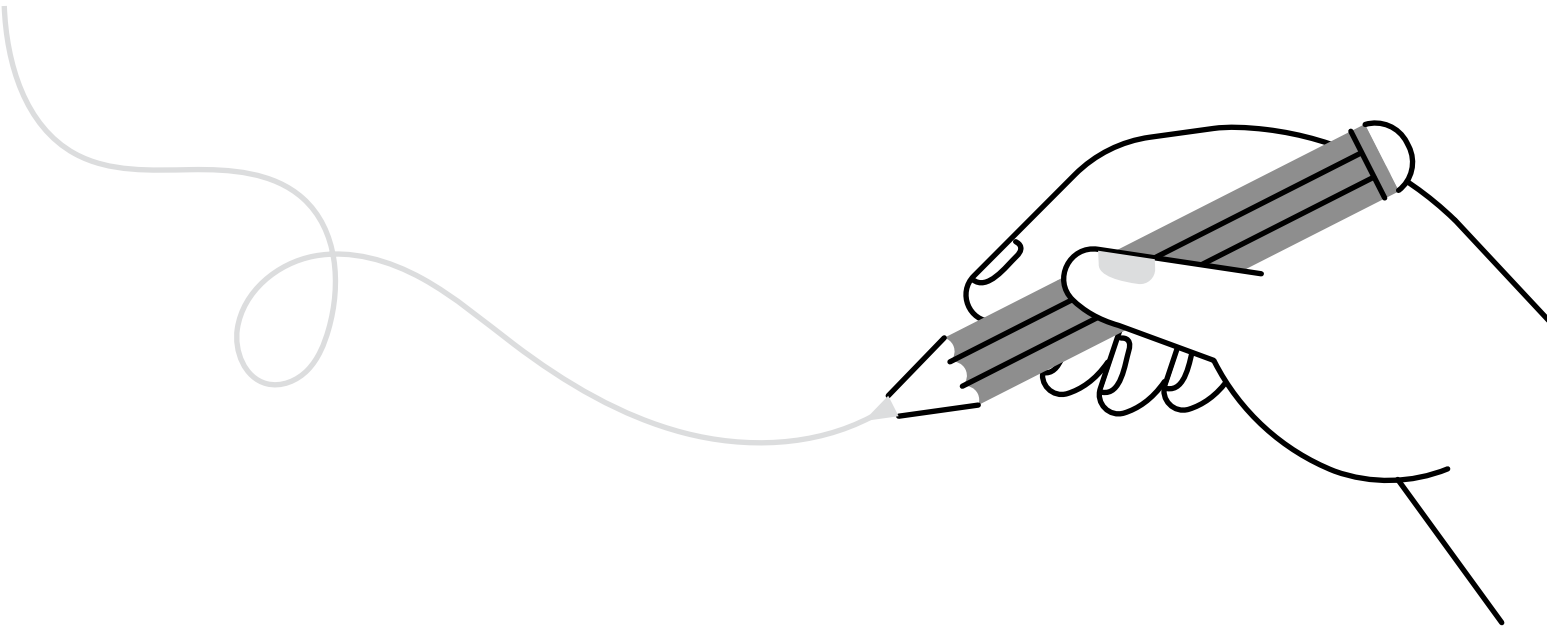


Table 1: Sample Washington Group Question responses and overall disability status

Person #		Person 1	Person 2	Person 3
Washington Group Question *(asked)*	**1. Do you have difficulty seeing, even if wearing glasses?**			
	2. Do you have difficulty hearing, even if using a hearing aid?			
	3. Do you have difficulty walking or climbing steps?			
	4. Do you have difficulty remembering or concentrating?			
	5. Do you have difficulty (with self-care such as) washing all over or dressing?			
	6. Using your usual language, do you have difficulty communicating, (for example understanding or being understood by others)?			
Disability Status? (1=yes, the person rates "a lot of difficulty" or "cannot do it at all" on at least one item OR 0=no, the person ranks "no difficulty" or "some difficulty" on all items) (calculated)				

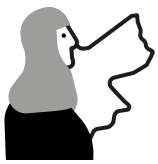
Common challenges or mistakes include:

- ☐ "Double counting" an individual who reports having a lot of difficulties or cannot do it at all in more than one domain (e.g. both visual and mobility difficulties)
- ☐ Disaggregating disability data without an accompanying sex/age disaggregation
- ☐ Linking the level of difficulties to impairments or medical conditions

REMEMBER: While age may be reported in groups, the **actual age** of an individual should always be collected where possible. This can be done by collecting the individual's date of birth where appropriate (e.g. case management services) or asking the individual directly for their age.

Highlights from analysis can be visualized in different ways to draw attention to key trends or takeaways. Some good examples of data visualization from a study[3] carried out by Humanity & Inclusion and IMMAP can be seen below.

Jordan



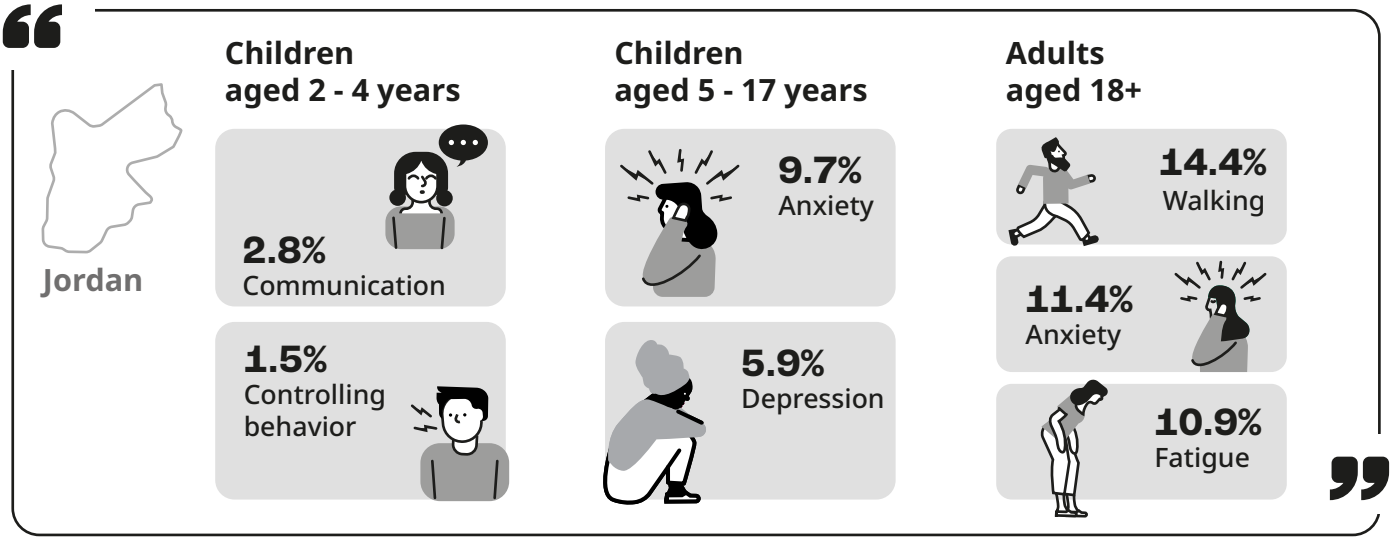
23.9%

21.9%

Age distribution in the surveyed population aged 2+

(18.1%) 13	(81.9%) 59	2.4%	65+	2.2%	(68.2%) 45	(31.8%) 21
(31.2%) 54	(68.8%) 119	5.7%	51-64	5.0%	(43.8%) 64	(56.2%) 82
(56.9%) 285	(43.1%) 216	16.4%	35-50	13.1%	(30.2%) 117	(69.8%) 270
(81.6%) 628	(18.4%) 142	25.2%	18-34	20.8%	(23.9%) 147	(76.1%) 467
(85.2%) 1038	(14.8%) 180	39.9%	5-17	46.7%	(18.2%) 250	(81.8%) 1125
(96.0%) 309	(4.0%) 13	10.5%	2-4	12.2%	(6.1%) 22	(93.9%) 337

Without disabilities With disabilities



Common Analysis Q&A

- **What population is my program serving, and what disability considerations should I keep in mind?** One of the simplest analyses is to calculate the proportion of the clients you serve who have disabilities using the Washington Group recommended cut-off. You can also calculate the proportion of clients who have each type of difficulties. For example, knowing that a large proportion of your clients have difficulty walking may affect the extent to which you conduct home outreach or provide transportation assistance. You can also keep these differences in mind as you conduct further data collection and data analysis moving forward (e.g. how might the needs of people with these different disabilities be similar to or different from those of people without disabilities?).

  Note: Some individuals may have multiple types of disabilities, so it is important to separately calculate (i) the proportion of clients with disabilities and (ii) the breakdown of clients with each type of disability. You cannot simply sum the number of people with difficulties in one domain to get the total number of people with disabilities. You will be double counting people who report difficulties in more than one domain.

- **Do I need to disaggregate every single question and response category by disability?** While collecting and analyzing this information may lead you to results you were not expecting, it can also be a way to capture trends and stories you and your team are

already aware of through your work but do not have evidence for. Some questions you could ask yourselves include:
    - To what extent are people with disabilities accessing the organization's services?
    - Where might it be important to understand differences in lived experience between people with different types of difficulties? (i.e. seeing vs. communicating difficulties)
    - Given our own experience and stories we hear, what do we suspect may be affecting the access of people with disabilities to important resources? What information do we need to effectively address these gaps?
    - What information would help us best understand the lived experience of people with disabilities? How might we make decisions differently with this knowledge?
- **There are too many numbers! How could I better understand what this means?** As noted above, looking at this information through visuals and charts may help us see trends and patterns more clearly, particularly when we are trying to understand how the lived experience of people with disabilities may differ from that of people without disabilities.
- **Okay, we made our tables with disability disaggregates. We're done with analysis, right?** No, you're just getting to the interesting pieces! While these tables and charts may look pretty, you're now at the stage where you get to remind yourself, "Why does this matter? What story do we see?" It may be helpful to sit with a colleague, and your team and go table-by-table or chart-by-chart and ask yourself:
    - What makes sense to you or aligns with your own experience?
    - What surprised you or confused you?
    - How might this affect what decisions you make? What other information might you need to do so?
    - What do we need to do next? Which next steps are necessary?

Limitations on the Use of Washington Group Questions- Short Set[4]:

The Washington Group Short Set of Questions on Disability (WG-SS) is widely used to identify persons with disabilities in surveys and censuses. However, it does have several limitations:

- **Severity Thresholds:** The questions use a severity threshold (e.g., "a lot of difficulty" or "cannot do at all"), which might not capture milder forms of disability that still significantly impact an individual's life.

- **Less effective for psychosocial disabilities:** Although many individuals with psychosocial disabilities are identified through questions about cognition (remembering/concentrating) and communication, some are still overlooked. Additionally, those identified with disabilities are not specifically recognized as having psychosocial issues.
- **Omitting aspects of disability:** The questions do not capture critical information such as the age of onset, cause of the disability, use and impact of assistive devices, or environmental barriers. it may not provide enough detailed information to design and implement specific policies or programs tailored to the needs of people with disabilities
- **Limited Range of Disabilities:** The WG-SS focuses on functional limitations in six domains (seeing, hearing, walking, cognition, self-care, and communication). It does not cover all types of disabilities, such as mental health conditions or chronic pain

Additional Washington Group data collection resources:

There are numerous resources available on the Washington Group website and developed by Humanity & Inclusion regarding the use of these questions in humanitarian action:

- ☐ **E-learning:** https://kayaconnect.org/course/view.php?id=1221
- ☐ **FAQs:** https://humanity-inclusion.org.uk/sn_uploads/document/2019-01-WGQs-Frequently-Asked-Questions-final.pdf
- ☐ **UNICEF Resources on Child Functioning Module:** https://data.unicef.org/topic/child-disability/module-on-child-functioning/

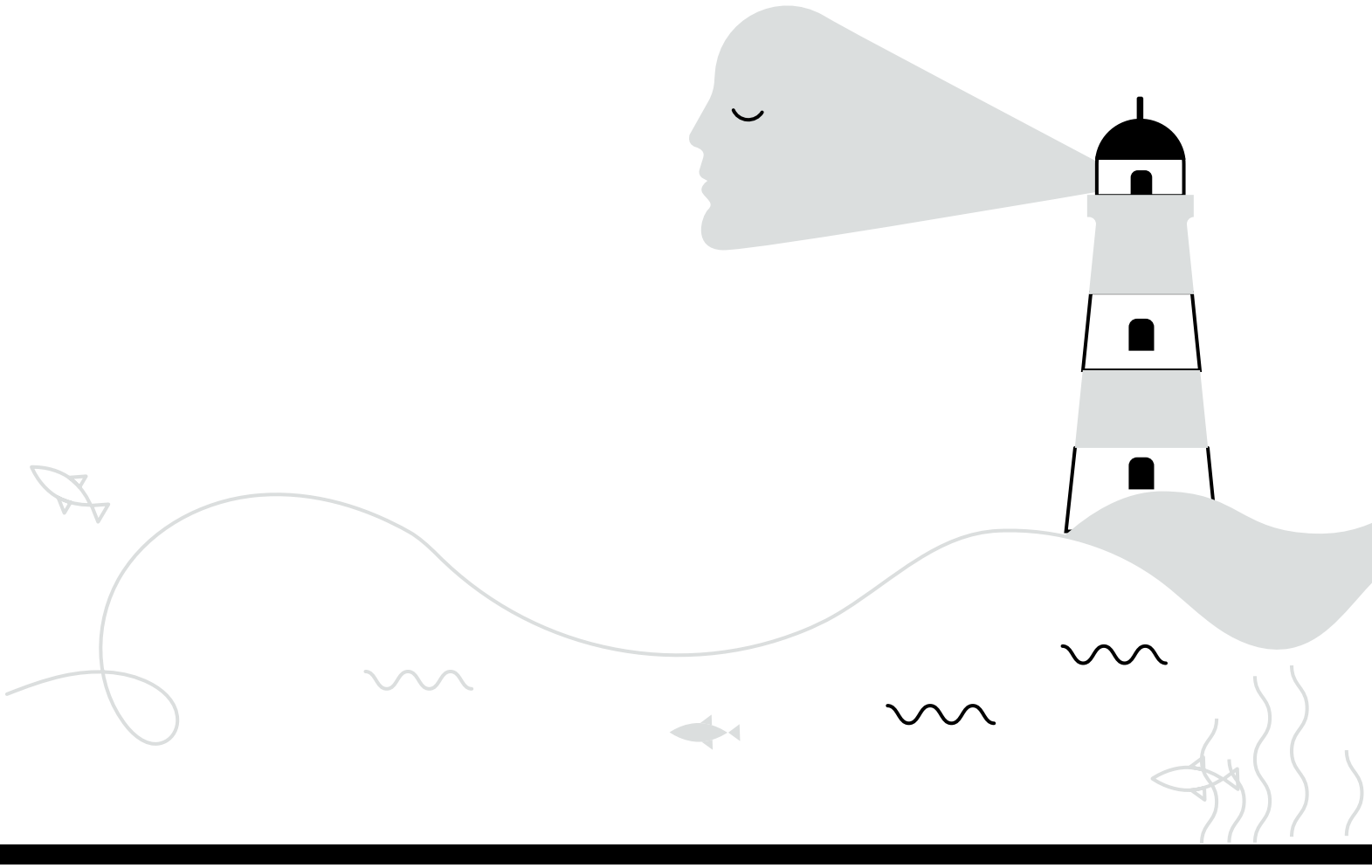
Endnotes

1 This guidance paper was adapted from the IRC Inclusive Client Responsiveness Toolkit – May 2021 https://www.rescue.org/resource/inclusive-client-responsiveness-focus-people-disabilities-and-older-people

2 https://sites.unicef.org/disabilities/index_70434.html

3 https://humanity-inclusion.org.uk/en/news/1-in-5-syrian-refugees-has-a-disability-new-survey-reveals

4 https://e-inclusion.unescwa.org/node/1358



Annex 4.3

Suicide Safety Plan[1]

Introduce the Suicide Safety Plan for those at risk of suicide plan (i.e., optional script): *"A safety plan helps us to understand the warning signs that you may not be safe, and helps us to come up with a plan to help you to feel safe when needed. You will bring a copy of this home with you and you can look at it and use the tools anytime you feel the warning signs."*

1. What are thoughts that make me feel like hurting myself and/or ending my own life?

   _____

   Feelings?_____

   Situations?_____
2. What activities can I do to help myself feel calm? What has worked in the past?

   _____
3. What are my reasons for living?

   _____ _____ _____ _____
4. Who can I talk to when I am upset and feeling like hurting myself or ending my own life? (include more than one person)

   _____ Phone number_____

   _____ Phone number_____

   _____ Phone number_____

5. Is there anything I can remove from my environment to make me safer? (e.g., lethal means)_____
6. Things I can do when I am not feeling safe:

   Places I can go:_____

   Professional I can call:_____

   Hotline number:_____

   If I am in danger of hurting myself or fear for my safety, I must call emergency response or go to nearest hospital.

   Emergency number:_____

   Closest hospital (address and phone number): _____

   _____

1 Adapted from IFRC Reference Centre for Psychosocial Support and Suicide Prevention, and Suicide Prevention during Covid-19

Annex 4.4
MHPSS Activities and Resources

Annex 4.4.1: Guidance on MHPSS Interventions and Activities

Introduction

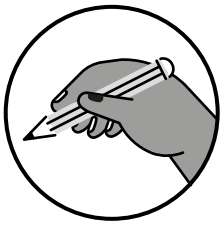
The purpose of this annex is to equip caseworkers with essential information for implementing focused mental health and psychosocial support (MHPSS) services to meet the needs of their clients. It is important to note that while this annex specifically focuses on the role of protection caseworkers in delivering focused MHPSS interventions, caseworkers should employ basic psychosocial support skills that promote mental health and psychosocial well-being throughout the case management process and in every interaction with their clients. Key content related to basic psychosocial support skills is integrated across the Protection Case Management (PCM) Guidance (see particularly Module 4). Prior to implementing services, it is important for organizations to consider and adhere to any local and national regulatory requirements for providing MHPSS interventions

Focused MHPSS Activities

There are many different types of focused MHPSS services that caseworkers can provide to support the unique MHPSS needs of their clients. While not an exhaustive list, this annex highlights four categories of activities and equips caseworkers with crucial information on how to select and implement different focused MHPSS activities with clients. The Annex 4.4: MHPSS Activities and Resources includes 25 activities and step-by-step instructions for implementation.

Categories of Focused MHPSS Activities

Category	About	Goal	Example(s)
 **Psychoeducation**	The provision of information from caseworkers to clients (and family members) to help them understand their experience of distress and connect signs and symptoms to MHPSS activities that can help them cope.	• To educate the client (and family) about key topics related to their distress. • To provide information that can help build practical life skills, normalize reactions, encourage help-seeking behaviors, and ensure clients have basic knowledge about key issues affecting them.	• Psychoeducation on the impact of stress • Psychoeducation on identifying emotions • Psychoeducation on grief and loss
 **Emotion Regulation**	Intentional practices and strategies aimed at managing and modifying one's emotional responses to various stimuli. These activities help individuals maintain mental health and psychosocial well-being by promoting emotional stability, reducing stress, and enhancing coping mechanisms.	• To give clients the tools to recognize and regulate their own emotional state.	• Belly breathing • Progressive muscle relaxation • Five senses

Category	About	Goal	Example(s)
 **Creative Expression**	Forms of expression such as art, dance or music in a supported setting to help clients explore different emotions and situations in which they arise, and transform or modify their emotional reactions.	• To help clients explore, feel, express, and manage their emotions. • To help clients share and process feelings and memories that may be difficult to verbalize.	• Traditional song and dance • Drawing the past, present, and future • Affirmation cards
 **Solution-Focused**	Goal-focused activities where caseworkers co-construct with clients practical and sustainable solutions to address challenges rather than focus solely on problems.	• To highlight the client's ability to solve problems rather than focus on why or how the problem was created.	• Mapping supports • Circles of control • Exception questions

Each category is indicated by a symbol within the Annex 4.4.

Psychoeducation

Emotion Regulation

Creative Expression

Solution-Focused

It is important to note that some MHPSS activities may fall into more than one category, offering versatility in use to address various goals with clients. For example, the activity 'Affirmation Cards' can be categorized as both creative expression and emotion regulation because the caseworker supports the client in creative expression as

they come up with the affirmations and draw the affirmation cards, and then helps the client regulate their emotions as they practice repeating the affirmations to move through difficult moments and ultimately transform negative self-perception to a focus on personal strengths and self-worth.

Within the Annex 4.4: MHPSS Activities and Resources, activities are categorized by the four categories noted above and identified based on the common issues they help address. This categorization and identification ensures flexibility to meet the client's needs while also providing structure and guidance for utilization. It allows for caseworkers and their supervisors to either:

- Select a stand-alone activity to address an immediate need or issue with the client (e.g., emotional regulation activity) or
- Follow standard pathways for addressing specific problems raised by the client (e.g ***Identifying and Regulating Overwhelming Emotions****).*

Pathways for Focused MHPSS Activities

Five unique pathways for use are provided for caseworkers to follow with clients. The pathways correspond with common issues (i.e., challenges) that protection case management clients may experience. These include:

1. Identifying and regulating overwhelming emotions
2. Engaging in difficult conversations
3. Enhancing self-esteem and self-worth
4. Building and maintaining healthy relationships
5. Managing acute distress

Each pathway is designed for caseworkers to achieve specific objectives in collaboration with the client. Caseworkers work with their clients to select and prioritize the appropriate pathway(s) to meet the clients' needs. The information gathered during the Form 3 Protection Assessment and Form 5 Basic MHPSS Assessment should inform these discussions and help the caseworker and client to select the most relevant pathway(s).

All five pathways include a range of activities from across the four different focused MHPSS activity categories: psychoeducation, emotion

regulation, creative expression, and **solution-focused.** The activities are purposefully sequenced along the pathways, typically beginning with one or more psychoeducation activity to lay a foundation of understanding, followed by a range of activities designed to foster emotion regulation, inspire creative expression, and cultivate solution-focused skills.

Each pathway provides a recommended sequence of focused MHPSS activities for caseworkers and clients to follow. The activities in each pathway are sequenced and color-coded to help caseworkers identify which of the four activity categories it belongs to. The sequencing may be particularly beneficial for less experienced caseworkers or caseworkers who are new to implementing MHPSS services.

> For example, under Pathway #1, ***Identifying and Regulating Overwhelming Emotions*** , the sequence begins with a psychoeducation activity that explains the differences between helpful and harmful stress. Once clients have an understanding of the types of stress and their impact, the next activity helps clients identify and manage overwhelming emotions that arise in stressful situations. The sequence is designed to facilitate an effective process for helping clients to understand and manage their stress.

Experienced caseworkers or those who have a professional background in MHPSS services (e.g., social workers, licensed counselors and therapists, psychologists, etc.) may customize the sequence of activities or integrate additional ones to further meet the specific, and evolving needs of the client. If the caseworker and client identify multiple relevant pathways, it is important to select the pathway the client would like to begin with. Moreover, experienced caseworkers are encouraged to use multiple pathways at the same time to address multiple issues concurrently, when deemed beneficial. Since some of the pathways use the same focused MHPSS activities, when using multiple pathways simultaneously it is important to customize repeated activities to avoid redundancy and ensure relevance to the client's specific issue and how it has evolved over the course of case management.

For example, the activity Identifying Sources of Support is included in all pathways. Rather than complete this activity in the same manner multiple times, caseworkers should customize this activity and facilitate it in a sequence that meets the overall needs of the client.

Each pathway also includes a prompt to incorporate decisions and key actions into the client's Coping Plan) as relevant and necessary. The caseworker and client can add focused MHPSS activities to the client's Coping Plan after each session and/or at the conclusion of a pathway according to what the client feels is most helpful. The caseworker and client should also include goals related to MHPSS into the Form 6 Case Action Plan. Each of the five pathways are described in more detail below.

Pathway 1: Identifying and Regulating Overwhelming Emotions

This pathway focuses on assisting clients in managing stress and coping with grief. It emphasizes identifying disruptive emotions that hinder daily functioning, which often drive them to seek help. Effectively identifying and regulating overwhelming emotions is vital for the client's mental health and psychosocial wellbeing.

Identifying and regulating overwhelming emotions is achieved in two ways:

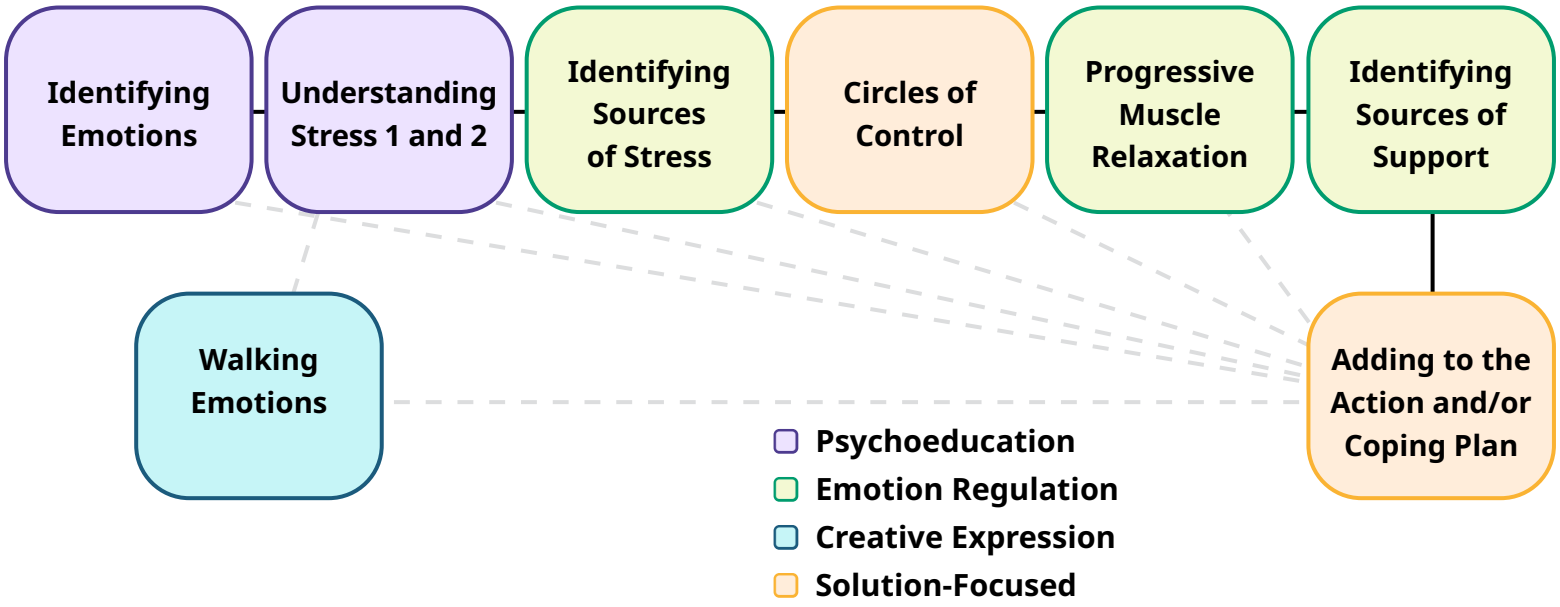
1. By addressing different types of stress stemming from experiences such as displacement, natural disasters, or living in environments with limited resources and supports; and/or
2. By identifying specific support(s) for clients navigating grief due to different types of loss.

When focusing on addressing different types of stress, this pathway aims to help the client:

- Understand stress and its impact on physical and mental health and wellbeing;
- Identify primary sources of stress and resultant emotional reactions;
- Distinguish what is within and outside of their control;
- Explore and select emotion regulation activities to address overwhelming emotions; and
- Identify sources of support to help manage the impact of stress.

It is important to contextualize the pathway to each client's unique needs, especially when exploring overwhelming emotions. The process of engaging in these exercises and reflections can be difficult for clients. Therefore, it is crucial to take the necessary time to adjust and use emotion regulation exercises whenever needed along this pathway.

[Image 1] Pathway 1: Identifying and Regulating Overwhelming Emotions - Stress Management

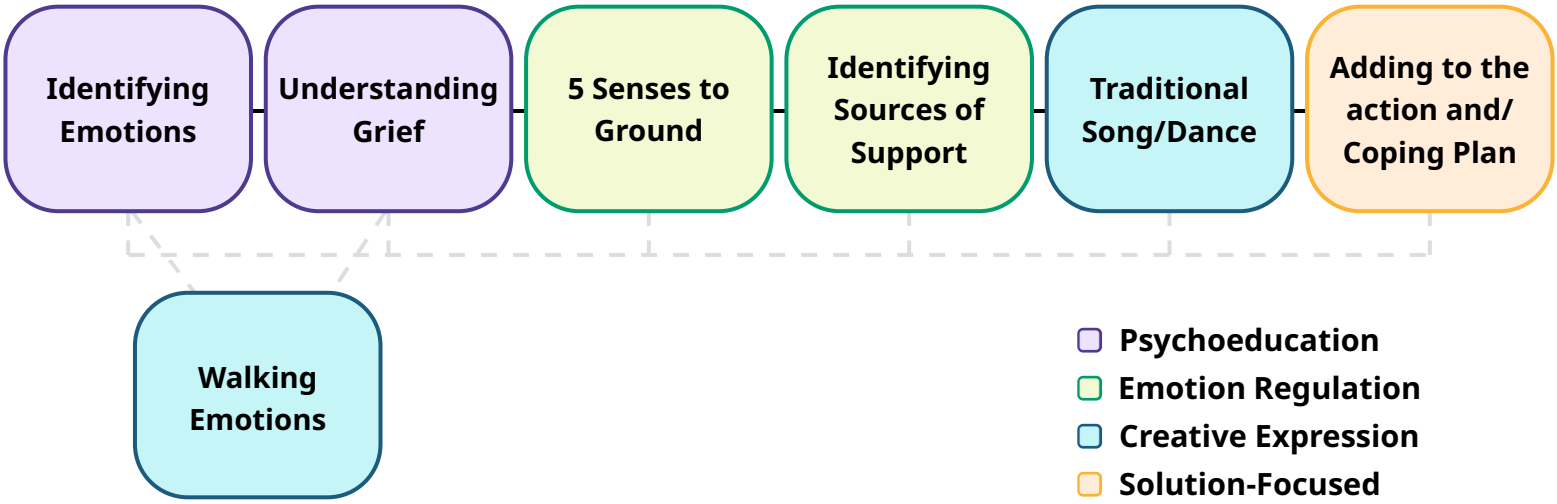


When focusing on navigating grief due different types of loss, the pathway aims to help the client:

- Recognize emotions they are experiencing and/or struggling to move through;
- Understand grief and loss are including causes and impact;
- Develop skills to help manage the emotions that arise with grief;
- Explore what it is like to navigate the different components of grief; and
- Identify supports for the grieving process.

It is important to remember and acknowledge that processing grief is a non-linear journey and requires time and support. The focused MHPSS activities are designed to support this understanding. Moreover, since grief and loss can affect other areas of a client's life, additional pathways may be necessary to comprehensively address their needs and concerns.

[Image 2] Pathway 1: Identifying and Regulating Overwhelming Emotions - Navigating Grief



It is important to note that while clients may experience a wide range of overwhelming emotions, this pathway specifically focuses on stress and grief, as these are commonly associated with clients' needs. The MHPSS Activities within this pathway assist clients in identifying various emotions they may be experiencing, including but not limited to stress and grief.

Pathway 2: Engaging in Difficult Conversations

This pathway is designed to assist clients in identifying sources of stress within their families, workplace, friendships, and communities, and develop strategies for navigating difficult conversations that may emerge from these stressors.

This pathway aims to help the client:

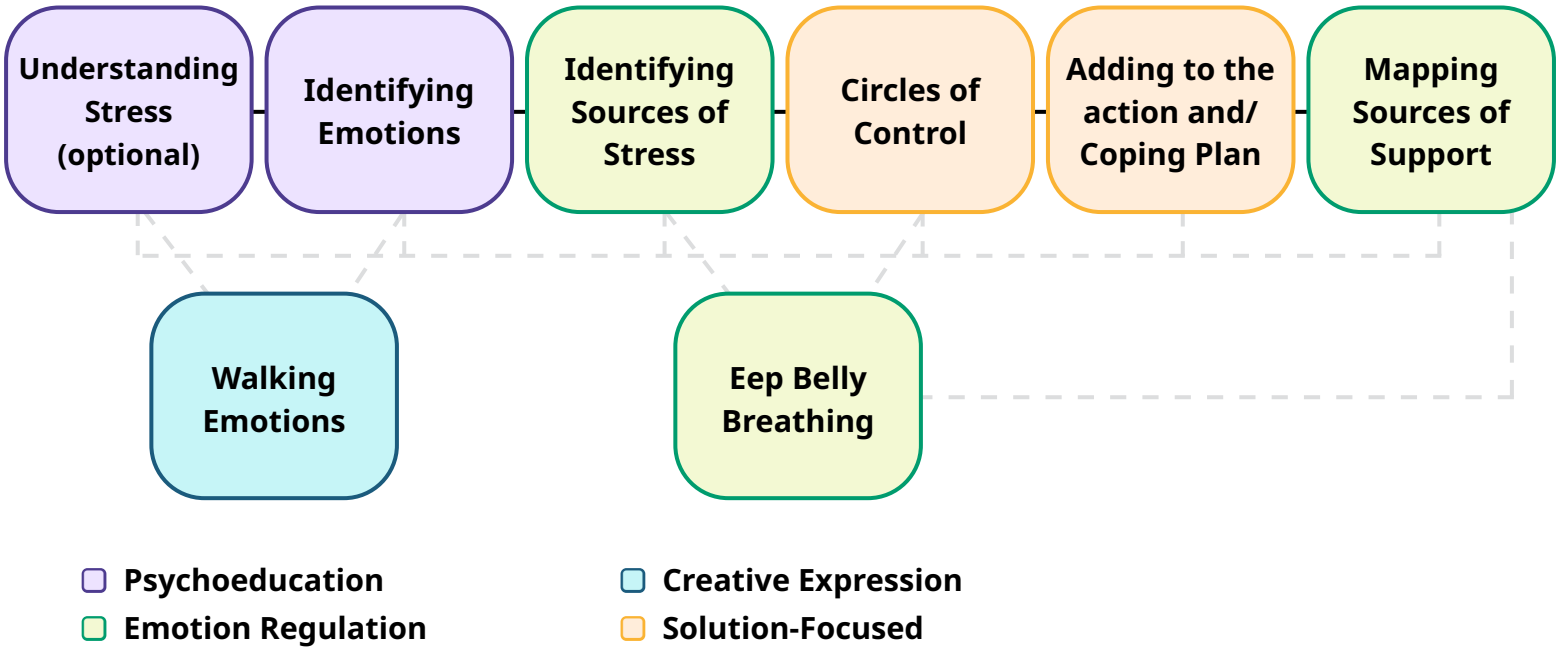
- Recognize the origins and sources of their stress;
- Differentiate between what is within their control and what is beyond their control;
- Learn and utilize emotion regulation techniques to aid in navigating difficult conversations; and
- Identify and understand how to leverage sources of support effectively.

If the client is struggling to understand what stress is and how it impacts them, it is recommended to start this pathway with the psychoeducation

activity *Understanding Stress 1* (refer to Annex 4.4: MHPSS Activities and Resources). If the client already has an understanding of stress but is having trouble identifying the emotions or feelings they are experiencing when engaging with family, friends, and/or their community, begin with the psychoeducation activity *Identifying Emotions* (refer to Annex 4.4: MHPSS Activities and Resources).

It is crucial to recognize the complexity of engaging in difficult conversations. The MHPSS activities provided in this pathway are specifically designed to support clients in reducing stress associated with these challenges.

[Image 3] Pathway 2: Engaging in Difficult Conversations



Pathway 3: Enhancing Self-Esteem and Self-Worth

This pathway aims to deepen the client's self-understanding, foster positive self esteem, and emphasize their strengths. The primary goal of the pathway is to enhance self-worth through introspective and personal development exercises.

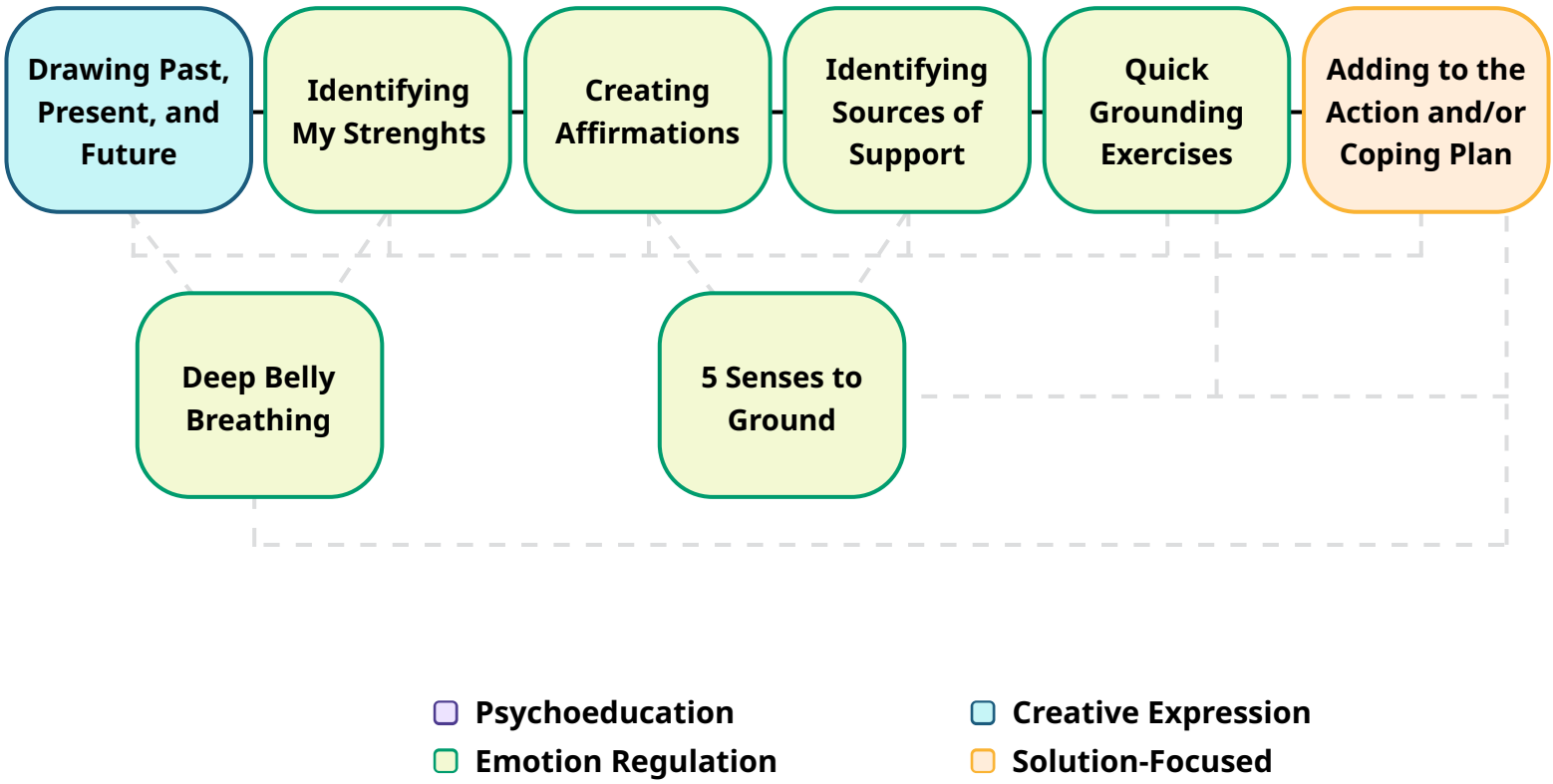
This pathway aims to help the client:

- Reflect on their life journey;
- Recognize their strengths;

- Create and use affirmations to increase awareness of their strengths;
- Identify, understand the value of, and activate the supports in their lives; and
- Develop additional coping strategies to navigate and overcome feelings of worthlessness, shame, and self-doubt.

This pathway begins with the creative expression activity Drawing past, present and future to assist clients in reflecting on past and present experiences, envisioning their desired future, and setting goals to achieve their vision. The caseworker can use the information discussed during this activity to support the next activity in the sequence, Identifying the client's strengths. Once the caseworker has supported the client to identify their internal and external strengths, the caseworker engages the client in additional activities to help the client increase awareness of and utilize these strengths and celebrate achievements. Over time, these activities will support the client to increase their self-esteem and enhance their sense of self-worth.

[Image 4] Pathway 3: Enhancing Self-Esteem and Self-Worth



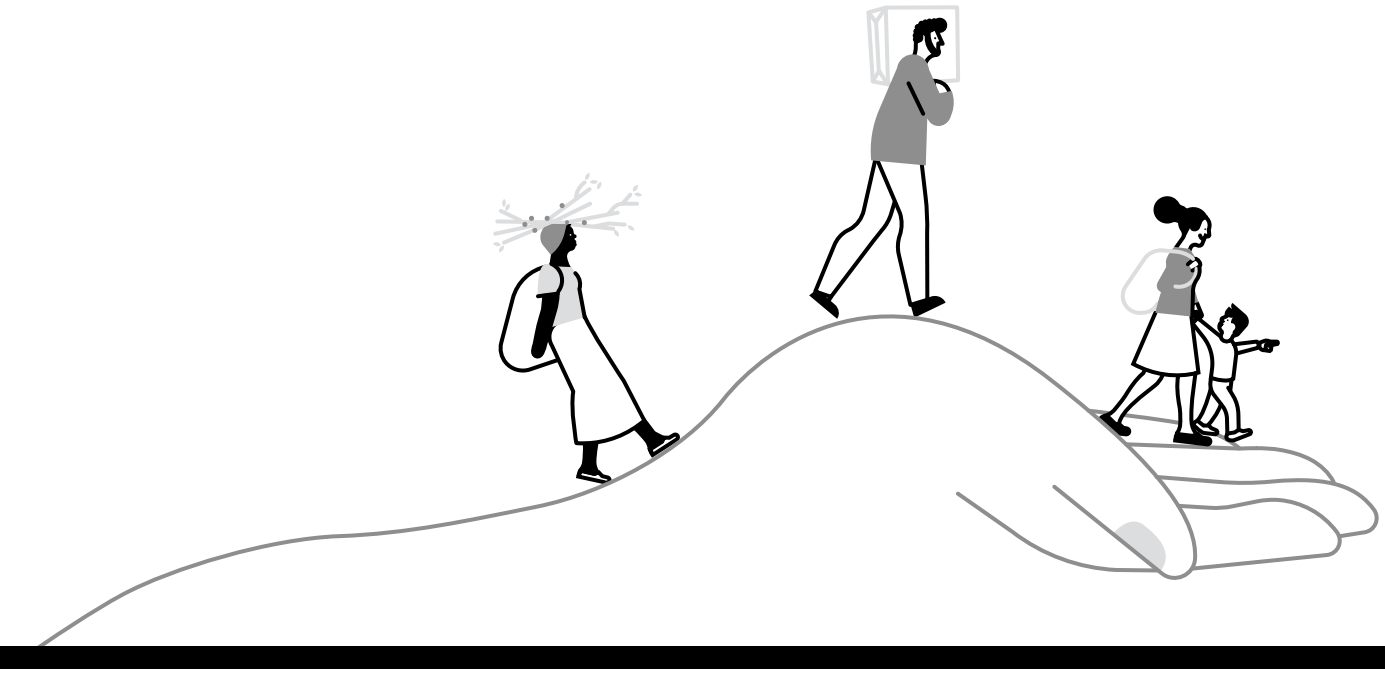
Pathway 4: Building and Maintaining Healthy Relationships

This pathway is designed to enhance the client's relationship-building skills and clarify what they can and cannot control in their relationships with others. The pathway aims to foster increased trust and support, whether in strengthening existing bonds or nurturing new ones.

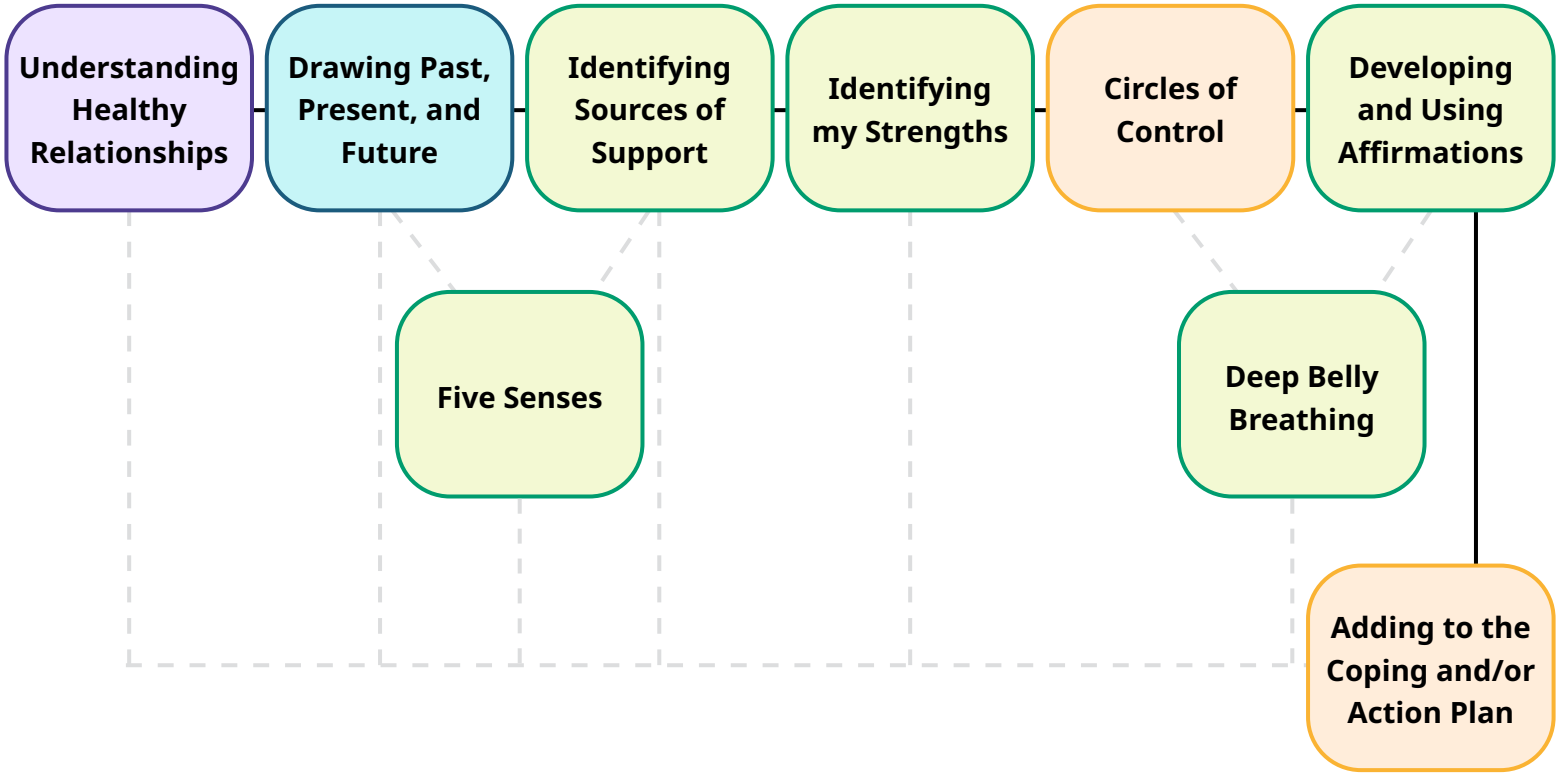
This pathway aims to help the client:

- Understand the characteristics of a healthy relationship;
- Reflect on the characteristics of healthy relationships in their past and envision qualities they desire in future relationships;
- Recognize existing support systems that are examples of healthy relationships;
- Identify internal strengths;
- Gain insight into what they can and cannot control in relationships; and
- Learn and use emotion regulation techniques to support their efforts to build and maintain healthy relationships/

This pathway uses psychoeducation to explain the traits of a healthy relationship, creative expression to reflect on past relationships and envision future ones, and emotion regulation activities to develop skills for fostering healthy relationships based on trust. Since the development of healthy relationships is not only dependent on the client but also on the other person's reactions, receptivity, and willingness to engage, this pathway also uses solution-focused activities to help the client determine the actions they can take towards a healthy relationship as well as identify what is outside the locus of their control.



[Image 5] Pathway 4: Building and Maintaining Healthy Relationships



Pathway 5: Managing Acute Distress

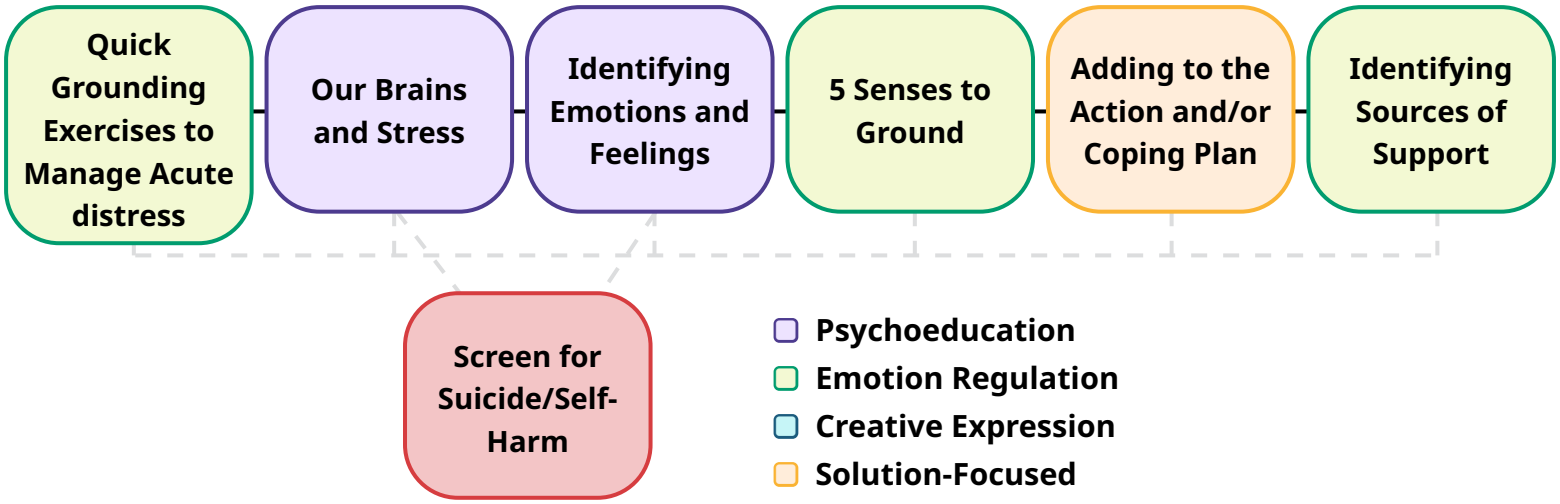
Acute distress refers to when a client is overwhelmed and unable to regain a sense of calm. Examples of acute distress include but are not limited to when the client is: angry and in "fight" mode, upset and unable to stop crying, afraid or anxious and unable to stay focused, or numb or zoned out and "frozen". This pathway and the activities included in this pathway can be selected as a priority pathway during initial discussions between the caseworker and client, or used at any time that the client is presenting with signs of acute distress.

This pathway aims to help the client:

- Return to a state of calm through grounding exercises;
- Understand how stress impacts the brain and body;
- Identify their emotional and physical reactions and what may have caused them; and
- Learn coping skills and understand when to utilize them.

Because this pathway is specifically for use when clients are in acute distress, the sequence begins with an emotion regulation activity - specifically a grounding exercise - to help the client regain a sense of calm. At some point, but not always immediately after the client has regained calm, focus can shift to the next activity in the sequence, psychoeducation. It is recommended that the caseworker integrate the client's experience of acute distress into the psychoeducation activity to normalize the client's experience and ground them in the reality that they can learn to manage these overwhelming reactions during the case management process. Once the client gains this understanding through psychoeducation, the caseworker supports the client in identifying the emotions that seem to "take over" or be "uncontrollable", and building skills and tools for emotion regulation.

[Image 6] Pathway 5: Managing Acute Distress



Frequently Asked Questions

Where should focused MHPSS Activities be implemented? (i.e., considerations on location, privacy, etc.) Activities can be used wherever casework takes place; for example, a community center, or the client's home if it is safe and there is a reasonable degree of privacy throughout the duration of the session. Any meeting in a client's home should be discussed and decided on with the client before sessions take place. Prior to implementing a specific activity, it is important to review the activity and consider if the location you plan to meet the client in is appropriate for that specific activity (e.g., Is the space large enough? Is the topic sensitive and therefore requires more privacy?).

How should a caseworker work alongside the client to select appropriate focused MHPSS Activities? Caseworkers and clients work together to identify, select and practice different activities to find the right set of activities to support the clients MHPSS needs. It is a process of mutual curiosity and practice. The caseworker can suggest different activities based on the client's needs that are identified during the intake and protection assessment process or during any stage of the case management process. Caseworkers should create a safe and collaborative space that empowers the client to have a voice in and provide feedback on which activities they find useful and supportive. Caseworkers should never force or require their clients to complete activities that they do not feel comfortable doing.

Do the focused MHPSS Activities build on each other (i.e., is there a specific order that caseworkers should follow when implementing activities)? The activities follow a sequence when used within a specific pathway. Some activities build on others and, when relevant, this is noted in the activity instructions. For example, caseworkers would first support the client to complete the *Identifying My Sources of Stress* activity and then facilitate the relevant emotion regulation activity to strengthen the skill(s) to address the identified sources. Other activities, however, can be used as standalone activities.

Can caseworkers use the focused MHPSS Activities in a different order or outside of the five pathways? As caseworkers gain experience and become more familiar with activities, they can use the activities with less adherence to the sequences provided for each of the five pathways. When caseworkers are ready to work outside the given sequence or to use multiple pathways at the same time, they can look to the top right corner of each activity sheet to ascertain whether it can be adjusted to focus on multiple pathways. The activities that can be adjusted have two types of symbols in the top right corner. Adjustments often require slight changes to the script provided for the activity in the activity sheet as well as the addition of tailored reflection questions. Additional guidance on adaptations and adjustments are noted within the guidance below and in the activity sheets.

What to do if a client doesn't like a focused MHPSS Activity? Many activities may feel different or strange to the client at first. This is a normal reaction and can be expected. Many of the activities are skills that need to

be practiced to be effective for the client. Caseworkers can explain this to clients to prepare them for different emotions and feelings that may arise when trying these activities for the first time or even the first few times. Caseworkers and clients should think about many of the activities as tools. Not all tools will work for all clients. This is expected. If an activity does not feel useful to a client, there are other activities to try and you do not need to use that particular activity. Caseworkers can identify alternative activities to try within the same category (i.e., psychoeducation, emotion regulation, creative expression, or solutions-focused) by looking at the symbol(s) in the top right corner of each activity sheet. It is important to remember that all activities must be contextualized, and the caseworker and their supervisor should review all activities in advance to determine the ones that are appropriate for the context they are working in. Additionally, building and maintaining a trusting relationship between the caseworker and the client is essential, as this can greatly increase the client's willingness to follow the caseworker's guidance and engage in activities that may feel challenging or vulnerable.

What to do if a client is in "fight" mode (e.g., shouting, swearing, using harsh language, appears tense or agitated)? Approaching and effectively engaging with clients who appear to be in "fight" mode is a challenging task. The caseworker's objective in this situation is to help the client feel safe not to try and finish the planned activity.To help the client feel safe, caseworkers must first remain grounded and calm themselves, remembering that the client has likely not experienced much safety or care from others. Caseworkers should provide the client with the appropriate physical space (i.e., not too close where the client feels threatened or confined, and not too far that the client feels the caseworker is distancing themselves or scared) and use empathy and a neutral tone of voice to name and acknowledge the emotions the client is exhibiting and validate the client's experience. The caseworker can then offer the client some water or to take a walk together (if it is safe and there is appropriate space) to further help calm the client. If the caseworker and client have been working on emotion regulation activities, the caseworker can also suggest doing one of the grounding or relaxation strategies together. Once the client appears to have calmed down a bit, the caseworker can ask the client neutral questions to further ground the client in the present moment and continue to build rapport. The safety of the caseworker is a top priority; prior to implementing services, supervisors and caseworkers should establish a plan to ensure

that caseworkers know what to do in situations where they do not feel safe for any reason.

How can caseworkers prepare the client for focused MHPSS Activities that may spark overwhelming emotional and/or physiological reactions? Some activities may involve difficult or sensitive topics which could result in overwhelming emotional and physiological reactions in clients. Caseworkers should assess each client's unique situation and needs, review activities beforehand, and reflect on the possibility of sparking a reaction in the client before implementing new activities with the client. Caseworkers should always tell clients this may happen and should instruct them on what to do if the feelings become overwhelming. Caseworkers and clients can always choose to stop the activity and discuss if or when to return to the activity. See adaptation section below for additional details.

Contextualizing and Adapting focused MHPSS Activities

Prior to implementing the focused MHPSS activities, it is essential that all activities are reviewed and contextualized by the Protection Case Management team and their supervisors. Ongoing adaptation of the activities should also be done based on the needs of individual clients throughout the case management process. The Protection Case Management team should also consult with local, national, and international organizations providing MHPSS as they may have existing contextually relevant activities.

Key recommendations

When contextualizing focused MHPSS Activities for cultural appropriateness, it is important to ensure the overall goal of the activity stays the same. Caseworkers should select and adapt activities in collaboration with affected community members, peer caseworkers and their supervisors, and if available, engage with a local MHPSS working group or other MHPSS actor(s) for support in contextualization prior to implementing activities.

Key considerations include:

- The type of setting (e.g., acute emergency, protracted crisis, etc.);
- The priority needs/problems of the affected community;
- The age, gender, capacity, resources, language(s), culture(s), and other diverse characteristics of the affected population;
- The available human and material resources to implement MHPSS activities; and
- The available communication media and preferences of different population subgroups (e.g., social media, flyers, radio, announcements in community meetings or forums, etc.)

Importantly, focused MHPSS activities will have the greatest impact if they:

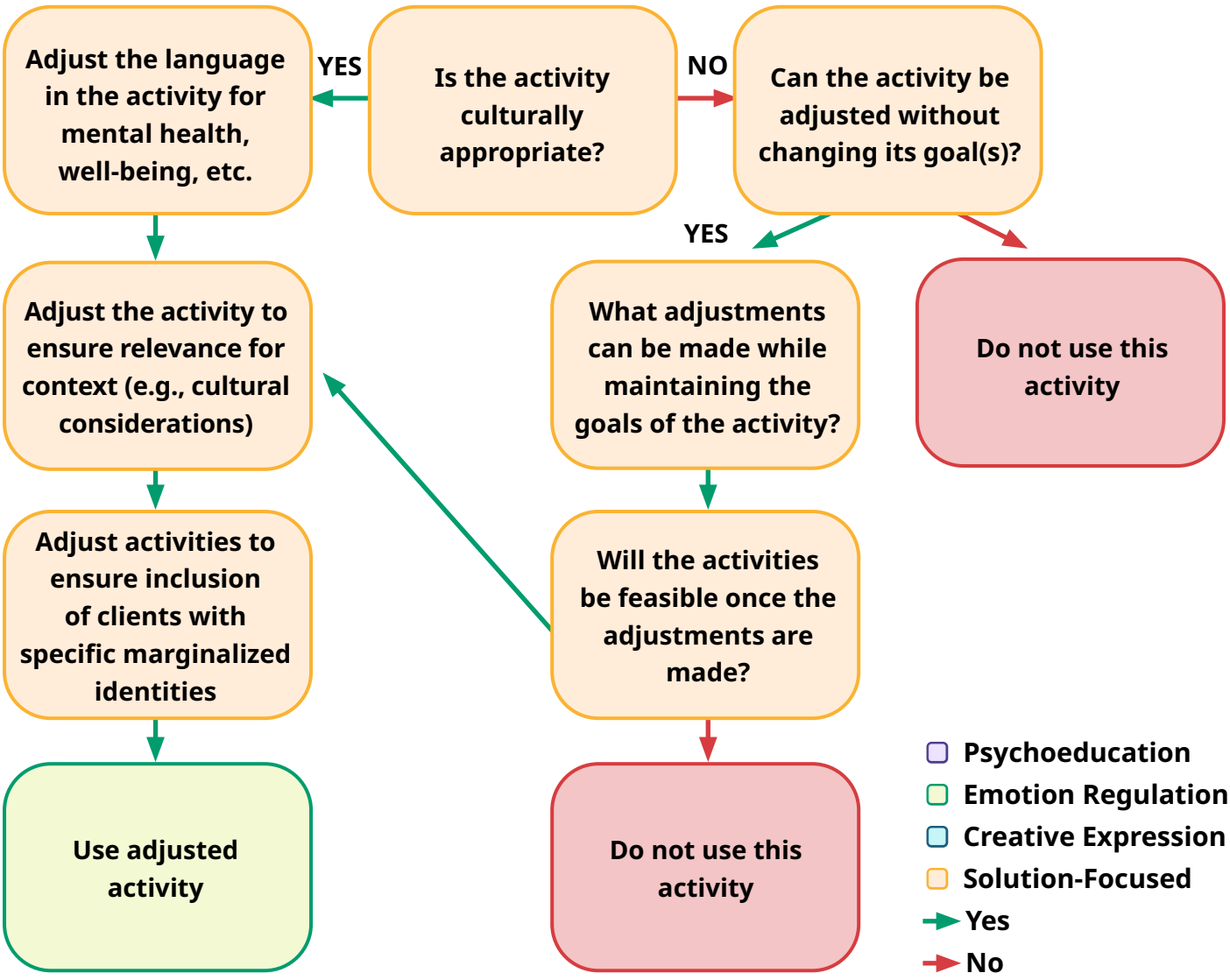
- Address pertinent needs/problems of the clients;
- Use local terminology for MHPSS-related concepts; and
- Use examples that resonate with the local context.

Seminal Global Resources, Guidelines and Tools:
MHPSS MSP Relevant key guidelines, standards and tools on contextualization. For additional participatory resources in the relevant guidance, standards and tools sections of MHPSS MSP activities 2.1)

How to contextualize and adapt focused MHPSS Activities?

The image below provides the recommended process for determining whether the activity is culturally appropriate and, if determined to be culturally appropriate, steps for how to contextualize and adapt the activity. Additional guidance on how to adapt the activity is provided below the image.

Image 7: Contextualizing MHPSS Activities



If the activity is determined to be culturally appropriate, review and adjust the activity to ensure appropriateness of/for:

1. Language
   - Adjust language in all activities to match cultural terms used to describe mental health and wellbeing and local dialects.
   - Include specific cultural words or names for experiences that may not exist in Western conceptions of stress, distress, mental health, and recovery.
2. Social/cultural norms
   - Adjust activities to match social and cultural norms
3. Persons who have historically been marginalized
   - Adjust activities to ensure appropriateness for populations that are marginalized, oppressed, and/or discriminated against in the local context.

- For example: If the client identifies as having diverse SOGIESC, their family members may not be supportive and could even cause the client further harm. The emotion regulation activity Identifying Systems of Support of the Annex 4.4: MHPSS Activities and Resources) may need to be adjusted to reflect this reality.

Once all focused MHPSS Activities have been reviewed, contextualized, and adapted, caseworkers will have an updated toolkit of activities relevant to the local context which they can begin using with clients.

How to adapt focused MHPSS Activities for individual clients?
Even after activities have been reviewed, contextualized, and adapted to fit the local context, additional changes may be needed to ensure relevancy for each individual client. Each client has unique needs and preferences. Not all activities will work with all clients. When preparing to facilitate a specific activity with a client, caseworkers should adapt the activity to meet that client's needs. Once caseworkers become more familiar with the activities and comfortable providing activities to clients, they may be able to adapt the activities for the client 'in the moment' rather than prior to the session.

Adaptations for individual clients must still adhere to the overall fidelity of the activity; therefore, any changes should:
- Maintain the overall goal of the activity; and
- Make only the minimum necessary adjustments.
- When adjusting activities for an individual client, consider the following questions:
- What barriers exist in the MHPSS activity in its current form that may prevent the client from reaching the intended goal(s)?
- If the client has any disabilities, what adjustments must be made to the activity to ensure the client receives the intended support?

What other unique social identity does the client have that may impact the efficacy of the activity if kept in its current form? What adjustments must be made to the activity to ensure the client receives the intended support?

Once the adjustments to activities have been made for individual clients, the caseworker and supervisor should discuss these adjustments during ongoing individual supervision sessions to ensure the adjustments have not impacted the overall focus and goal of the activities and discuss challenges, key learning, and recommendations for peers. Contextualization and adaptation of activities should also be discussed during group or peer supervision sessions for cross-learning.

Creating MHPSS Activities

While Annex 4.4 provides a set of focused MHPSS activities, these are not the only focused MHPSS activities protection caseworkers can use with clients. Once protection caseworkers become more comfortable using the activities in this guidance, they will undoubtedly notice opportunities for adding additional activities to meet the specific needs of their clients. They will also likely become more aware of cultural practices that are already used within local communities for healing and mental well-being that may be appropriate to integrate and use within protection case management.

Protection caseworkers and their supervisors will always have more cultural and contextual knowledge about sources of stress, mental health and well-being of communities, and culturally rooted and appropriate activities to bolster mental-well-being than this guidance provides. They can therefore work together to create additional activities for their clients using other materials and their own knowledge and skills. Remember, prior to implementing services, it is important for organizations to consider and adhere to any local and national regulatory requirements for providing MHPSS interventions.

Key recommendations

After adapting and implementing focused MHPSS Activities from Annex 4.4, protection caseworkers and their supervisors should set aside time to discuss and create new activities, when needed. During this time, caseworkers can raise MHPSS needs and client issues that have not yet been addressed through the activities in the guidance and put forward ideas for new activities and/or types of activities they would like to use.

How to create additional focused MHPSS Activities for the guidance?

When seeking to create additional focused MHPSS activities, protection caseworkers and their supervisors can use and adapt other MHPSS materials (e.g., group MHPSS activities, awareness raising sessions, global guidelines and resources, etc.). For example, caseworkers and supervisors may find there are specific behaviors, mental conditions, or reactions to adverse events where clients need more support. Additional psychoeducation topics and materials can be identified and adapted to help clients understand: specific mental conditions, how to support another family member, reactions to certain events, and beyond.

Caseworkers may also wish to include more coping strategies in the Annex 4.4: MHPSS Activities and Resources. There are multiple forms of breathing practices, meditations, and grounding exercises (e.g., tapping, squeezing, body movement) that may be appropriate to include. Caseworkers and supervisors are responsible for identifying the activities that may be useful to clients and how they will use them in protection case management. Caseworkers and supervisors will also need to contextualize and adapt the activity following the guidance above.

Examples of relevant resources that can potentially be pulled from and adapted are included below in the 'relevant resources section'.

Steps for creating or adding new focused MHPSS activities to the guidance

Below are recommended steps and key questions to consider when creating focused MHPSS activities.

Step 1: Identify unmet MHPSS needs and client issue to address

- What client needs are you trying to meet with this activity?
- Is this need currently not being met already through other activities included in the guidance?

Step 2: Brainstorm ideas for new focused MHPSS activities

- What MHPSS goal(s) are you seeking to accomplish (or

contribute to) with this activity?
- What focused MHPSS activities are used by organizations/ community members?
- Are there any additional global or local resources, guidance, curriculums that you can refer to for ideas on additional MHPSS activities to adapt and use with your clients (e.g., group activities that could be adapted for individual use)?

Step 3: Select one idea from the brainstorm and develop into a focused MHPSS activity using the PCM MHPSS Activity Template:

- What is the aim or objective of the activity?
- Which of the four categories of focused MHPSS activities (psychoeducation, creative expression, emotion regulation, solution-focused) does the activity belong to?
- Which pathways does the new activity fit into?
- In which setting should this activity take place?
- Who should participate in this activity? Who should not use this activity? Or when is this activity not appropriate for use?
- What is the time required to complete the activity?
- What materials are required or optional to complete the activity?
- What preparation needs to be done prior to facilitating the activity?
- What are the instructions for completing the activity?
- Are any contextual adjustments needed for gender, age, disability, and other social identities/ characteristics?
- Does this activity need to be flagged as a challenging activity that requires a more experienced caseworker to facilitate it with supervisor support?
- Does this activity need to be followed by an emotion regulation activity?
- How will this activity be reflected in the coping and/or action plan?

Step 4: Pilot the activity with caseworkers, make adjustments, and finalize the activity

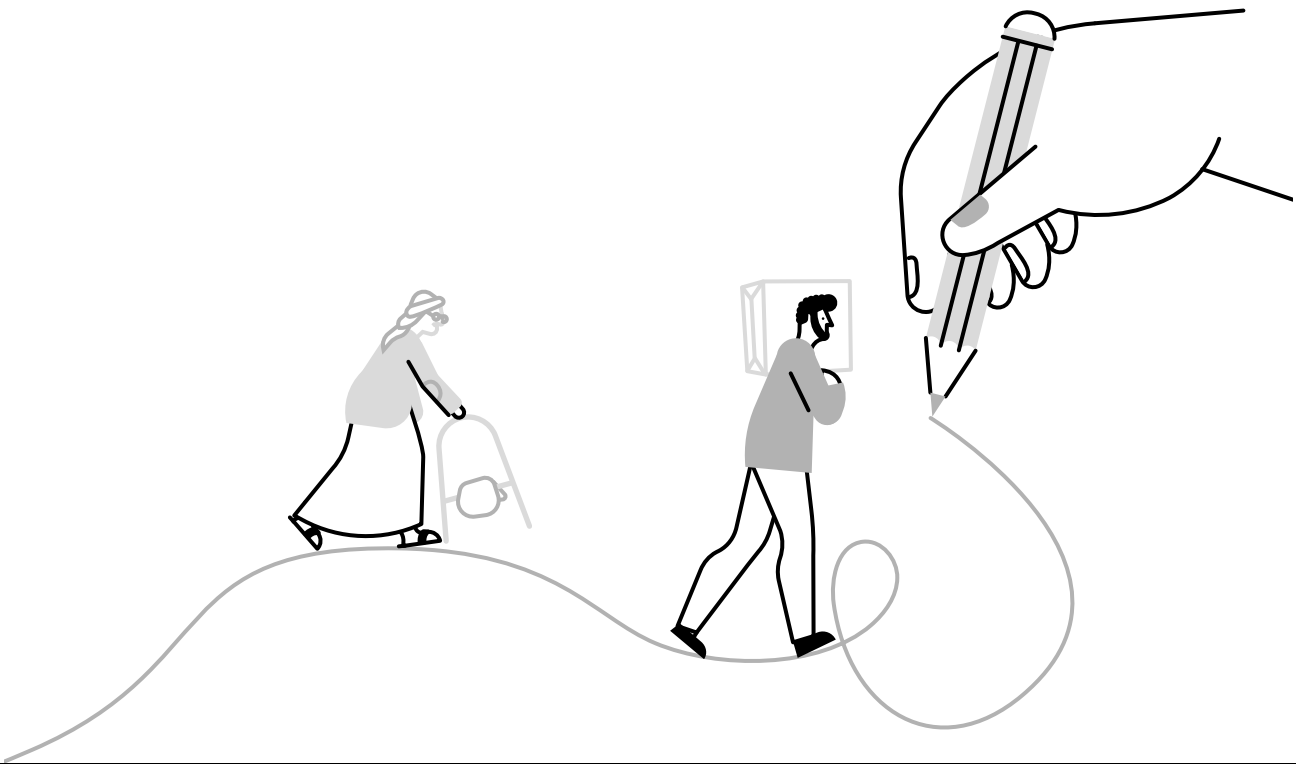
- Pilot the new MHPSS activity by facilitating it to caseworkers (e.g., during peer supervision or capacity building session with supervisor)

- Record feedback and any recommended edits to the activity
- Make edits to the PCM MHPSS Activity Template for the activity and finalize
- Add the new activity to the appropriate activity category(ies) and pathway(s)

Step 5: Use the new focused MHPSS activity with clients as needed/relevant

- Follow the guidance above to adapt the new activity to individual client identities and needs

Whether creating or adding new focused MHPSS activities to the guidance, all activities must be intentional, well thought out, developed complete (i.e., inclusive of the necessary reflection questions, guidance on use, etc.), and appropriate for the local context. Caseworkers and supervisors must allot ample time to develop and refine new focused MHPSS activities. The creation process should not be rushed to ensure the efficacy of new activities and to avoid causing harm to clients.



Annex 4.4.2: Client Coping Plan

My Coping Plan

Part I: Goals & Priorities to Support My Well-being

Use probing questions to understand the client's challenges and priorities regarding their mental health and psychosocial well-being, stress sources, and the impact on their daily life. (e.g.,"What problems are affecting your well-being?" "How have these issues impacted your well-being?" "Which problem would you like to prioritize addressing first? Second? Third?") If the client struggles to identify challenges and priorities, refer to the intake, protection assessment, and Basic MHPSS Assessment.

Problems or concerns related to my mental health and psychosocial well-being that I want to address:

Priority 1:

Priority 2:

Priority 3:

Part II: My Stress Reactions (i.e., signs I am stressed or experiencing distress)

When I feel stressed, I currently do the following....

In the future, when I feel stressed, I plan to try the following to help myself...

Client code	Date	Caseworker

Part III: My Strengths and Sources of Support

How I Feel Safe and Comfortable: *(Where do I feel safe and comfortable? Who is present in these spaces? What activities are happening in these environments? Are there places or people that I avoid?)*

My Strengths: *(What activities do I enjoy? What are my positive accomplishments or personality traits? What are examples of when I have overcome a problem or adversity? What gives me hope or joy?)*

My Sources of Support: *(Who are my sources of support? Specific friends, family, community networks, activity groups, religious/spiritual practices or groups, etc.?)*

Other Notes: *(Are there any relevant risks identified? Is there a need for a safety plan in place? If there are imminent physical safety concerns, shift to the safety planning form before completing the coping plan. Elements will be repeated across forms, but safety planning takes precedence.)*

Part IV: My Coping Tools

Things I can do to feel calm in my body:

1.

2.

3.

Things I can do to feel calm in my mind:

1.

2.

3.

Things I can do to feel calm in my emotions:

1.

2.

3.

What makes me feel safe and comfortable? *(Use answers from strengths/sources of support above)*

What are kind things I can say to myself to support my well-being? (*Use answers from affirmations activity or new ones)*

Who can I reach out to if things feel like they are getting too hard? *(Use answers from strengths/sources of support above)*

Focused MHPSS Activities I want to try or practice:	Focused MHPSS Activities I've tried that don't work for me:

Part VI: Actions I can take to Cope with Specific Problems or Concerns

Problem/concern:	Actions:
Problem/concern:	**Actions:**
Problem/concern:	**Actions:**

Part VII: My Sensory Kit for Grounding when I feel Stressed

Complete the focused MHPSS activity '5 Senses for Self-Soothing' and use the responses to fill in this section

I can touch:	I can smell:	I can hear:	I can see:	I can taste:

I can keep these in or at:

☐ **Home** ☐ **Work** ☐ **Bag/backpack** ☐ **Purse** ☐ **My pocket** ☐ **Other space:**

Part VIII: Progress Notes for follow-up, updates and other information

Use probing questions to understand the clients progress and needs. (e.g., "What coping tools have you used since we last spoke?" "Have the self-care and coping strategies helped?" "Do we need to review or revise them?" "How do you feel now?" Document any agreed actions in writing, including updates to the coping plan, additional strategies or tools discussed, or any new issues the client has prioritized. Note the date and any key observations related to the client's well-being or important information they have shared.

Date:
Notes:

Date:
Notes:

Date:
Notes:

Date:
Notes:

Date:
Notes:

Date:
Notes:

Date:
Notes:

Date:
Notes:

Annex 4.4.3: MHPSS Activity Template

Activity Type:	
Title:	
Objective	*What is the objective of the activity?*
Time	*How much time is required to complete the activity?*
Materials	*Are there any materials required or recommended to complete this activity?*
Participation	*Who should participate in the activity? (e.g., is it feasible/appropriate to engage with a family member or trusted adult for this activity?)*
Preparation	*What preparation do you need to complete prior to implementing this activity with a client?*

Facilitators note: Before completing this activity with a client, the caseworker should consider any adjustments needed for cultural context, gender/age/disability or other demographic, setting, specific issues or areas of concern, etc. The caseworker should also consider when NOT to complete the activity. Any key information for the caseworker can be added here before the instructions as a facilitator note.

Instructions

When creating an activity, include clear instructions on how to complete the activity and scripts for the caseworker. Include any visuals to demonstrate activities (e.g., images, examples, etc.). Include any 'alerts' or markers for special considerations or important things the caseworker must remember.

Use the following prompts when drafting the script:

DO: _____

SAY: _____

SHOW:_____

ASK: _____

EXPLAIN: _____

Include facilitators notes for any information that is important for the caseworker to know / be aware of when completing the activity with the client. Facilitator notes are information the caseworker will keep in mind but not say aloud to the client.

Facilitators note: _____

Include a prompt to update the client's coping plan.

ASK: Would you like to add any of what we discussed today to your coping plan?
DO: Update the client's coping plan as needed.

Activity Homework / Follow-up

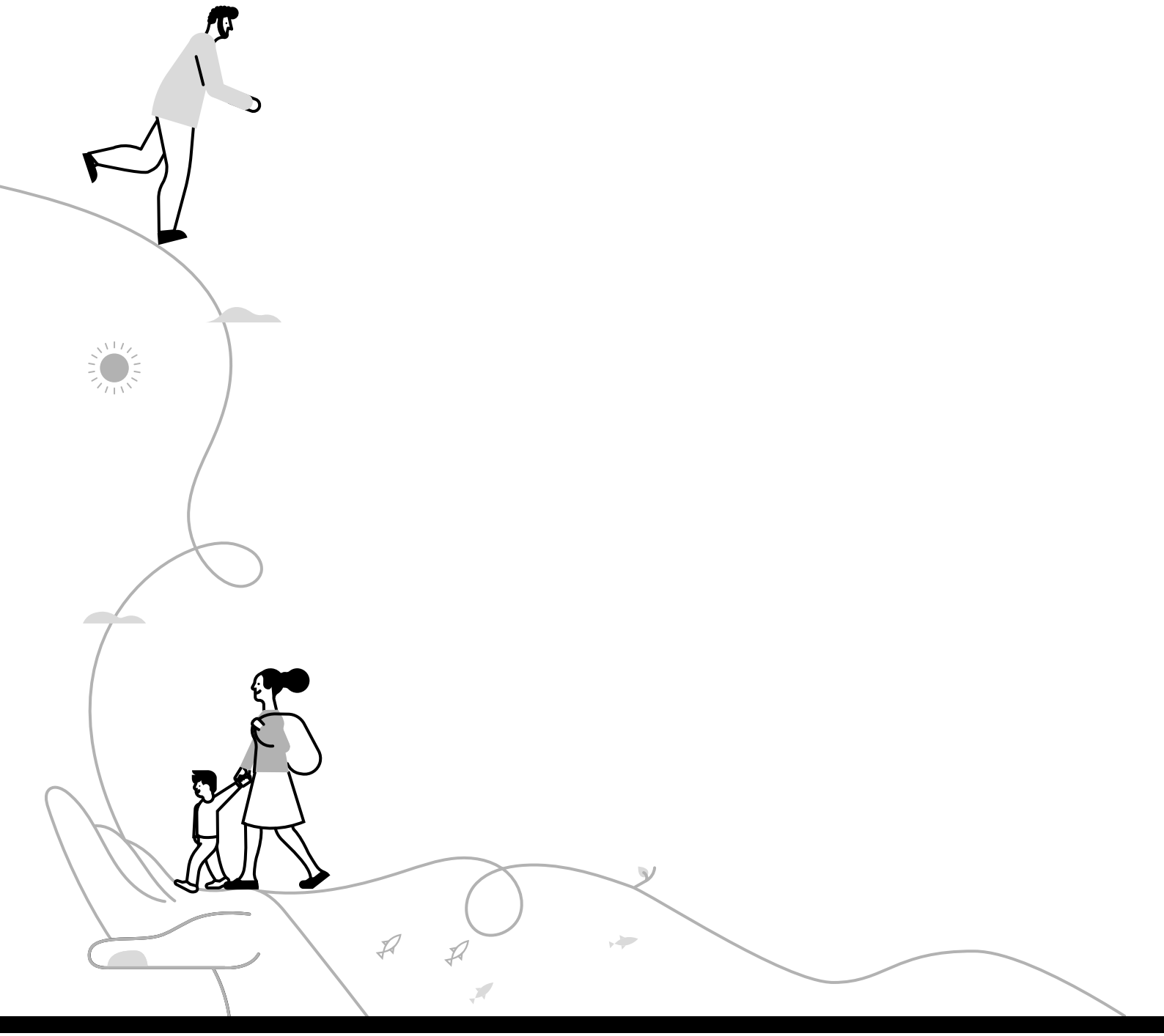
Facilitators note: Decide with the client if they would like any homework or follow-up for this activity and if so, discuss what the client should do to practise at home. Examples of homework may include:

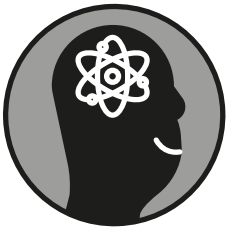
- *Practice skill _____ (insert number) times per week or _____ (insert number) times when feeling, sad, anxious, nervous, angry, etc.*
- *Reflect on _____ (insert feeling) feeling when it arises, notice feelings in your body, etc.*
- *Reflect on what you liked about this activity and what you didn't like and if you would like to practise it again during a future case management session (or individually).*

SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

DO: Select an emotional regulation activity and implement it with the client before they leave to close the session.





Annex 4.4.4: Psychoeducation

Annex 4.4.4.1: Understanding Stress

Objective	To support clients to recognize helpful and harmful forms of stress and begin to identify stressors in their lives.
Time	30 minutes
Materials	Paper, pens/markers/crayon, and flip chart
Participant(s)	Client; a trusted family member or friend can be included if the client wishes
Preparation	The caseworker should practice leading this activity with another caseworker or supervisor and receive feedback before using it with clients. The caseworkers should print the handout or write examples in a notebook or on flipchart ahead of time.

Instructions

EXPLAIN: We want to be able to recognize and define stress. We also want to understand how stress impacts our bodies, emotions and overall well-being.

ASK: What do you think of when you think of 'stress'? How would you define 'stress'?

DO: Give the client time to respond.

SAY: Stress is a normal part of life that happens to everyone. It is the body's automatic response to change and can be either helpful or harmful depending on various factors. Today, we will discuss examples of how stress can be helpful or harmful.

EXPLAIN: When change is perceived, our bodies react to prepare for that change. Examples of how our bodies react include increasing our heart rate, blood pressure, and energy supplies.

This can increase our focus and productivity in the short term.

SAY: Helpful stress is short-term, increases our focus and performance, and allows our bodies to return to a typical state after a productive period.

SAY: However, harmful stress occurs when stress is chronic or prolonged, preventing the body from returning to its typical state, which includes a lower heart rate and blood pressure. It is important to recognize what stress looks and feels like in our bodies.

DO: Give the client the handout of common stress reactions (or read the list to them if they have low or limited literacy skills).

Facilitator note: Handout of common stress reactions is included below.

SAY: We are going to go through this list together. As we go through it, circle the ones you have felt when stressed.

Facilitator note: For clients with limited literacy, read each reaction and ask them to identify which ones they recognize. Circle these for later review. Alternatively, have the client write the common stress reactions on paper (or write them down for them).

SAY: Now that we have gone through the list, think about a time you felt stressed. Identify both what caused the stress and how you felt (i.e., your stress reaction).

DO: After the client shares, ask them to check if their stress reaction is listed on the handout. If it is not, have the client write it under "other suggestions"(or write it for them).

ASK: Are there other times you have been stressed in the past that you would like to reflect on in the same way?

DO: If yes, have the client think of 1-2 more examples, identify the cause of stress, describe how they felt, and locate or write it down on the handout. If no, proceed to the next step.

SAY: We have identified past stressors. Now let's focus on current stressors.

ASK: What are the current stressors in your life? How do they make you feel (i.e., your current stress reactions)?

DO: Support the client in listing their stressors one by one. Help them locate or write down these stressors on the handout.

ASK: Are there any other signs of stress that you want to add to the list?

DO: Have the client write their stressors on the handout under, "my examples of stress" (or write them down for them).

EXPLAIN: the difference between helpful stress and harmful stress and provide examples of each type of stress.

- Helpful stress involves short-term stressors that improve focus and performance.
- Harmful stress involves chronic stressors that cause anxiety and unpleasant emotions often making it difficult to focus and function.

DO: Help the client differentiate between helpful and harmful stressors they identified. Fold a piece of paper in half or divide a flipchart in half and write "helpful stress" and "harmful stress" on each side. Write down the examples the client gives you for each.

DISCUSS: What makes these forms of stress feel helpful or harmful? Use questions like:

- How do helpful and harmful stress feel different for you?
- Can a helpful form of stress become harmful? If so, how?
- How can understanding types of stress help you cope more effectively?

ASK: Do you have any questions about what we discussed today?

SAY: In the next exercise, we will explore helpful and harmful stress more in depth. Would you like to continue to the next exercise now or save it for next time we meet?

DO: Offer to take a break if continuing to the next psychoeducation session on stress, or close the session if deferring the activity to the next meeting.

ASK: Would you like to add any of what we discussed today to your coping plan?

DO: Update the client's coping plan as needed.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.

SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.

ASK: Do you have any questions before we do our closing activity?

Closing Exercise

DO: Select an emotional regulation activity and implement it with the client before they leave to close the session.

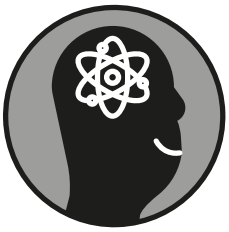
Handout

Possible signs of feeling stressed

- ☐ Eating too much or too little
- ☐ Sleeping too much or too little
- ☐ Extreme focus on a specific task or tasks
- ☐ Working extremely efficiently for short periods of time (can alternate with periods of incredibly low productivity)
- ☐ Difficulty concentrating
- ☐ Worrying a lot of the time
- ☐ Feeling guilty but not sure why
- ☐ Unexplained aches, pains (headaches, stomachaches, muscle tension – particularly in back or shoulders)
- ☐ Low or no energy
- ☐ Weight gain
- ☐ Trouble sleeping
- ☐ Feeling low, sad, or unable to function
- ☐ Difficulty with others – fighting or becoming aggressive, easy to anger
- ☐ Excessive drinking, smoking, using drugs
- ☐ Thinking of hurting yourself or others

Other suggestions:

My examples of stress



Annex 4.4.4.2: Types of Stress in the Body

Objective	Clients further understand how chronic stress may feel different in their bodies from helpful or everyday stress, and are able to identify signs of chronic stress in their bodies.
Time	30 minutes
Materials	Flip chart/paper, pens, markers, crayons
Participant(s)	Client; a trusted family member or friend can be included if the client wishes
Preparation	The caseworker should practise leading this activity with another caseworker or supervisor and receive feedback before using with clients. Draw the 5 stages of grief before starting the session.

Instructions

DO: Remind the client about the previous discussion on common reactions to stress and helpful stress and harmful stress.

ASK: What do you remember from that discussion? (Only ask this question if you are doing this exercise on a different day from Stress Session #1.)

DO: Give the client space/time to respond and affirm what they have shared and clarify any areas of misunderstanding or confusion.

SAY: Now we will explore different types of harmful stress and what these feel like, look like, and the key differences between them.

DO: Remind them that helpful stress is a short-term, natural response that temporarily increases focus and make us more productive. Stress becomes harmful when our bodies stay in a state of stress for a long time and are not able or does not have the chance to return to a calmer state.

EXPLAIN: Stress reactions are how the body responds when a change or threat is perceived. The body prepares for this change or to protect itself from the perceived threat by increasing heart rate, blood pressure, and energy supplies. The body should return to a more typical state once the change or perceived threat has passed.

SAY: However, sometimes the perceived threat does not go away. Or there are so many sources of stress that the body does not feel like it can return to its calm, typical state. This is what we call chronic stress.

EXPLAIN: What chronic stress is in greater detail using the points below.

- Chronic stress is a response to long-term emotional pressure (either from one continuing source or multiple sources).
- Chronic stress often occurs when people feel like they have little to no control over the outcome of a situation or are unable to make changes.
- We may be experiencing chronic stress if we are no longer increasing action (doing activities) and instead are fatigued, tired, and possibly even sick from the constant stress.

DO: Review the signs of stress handout with the client.

Facilitators note: See below for copy of handout with signs of stress included; this is the same handout used in previous activity (Stress Session #1).

ASK: Which of these do you think are some of the effects of chronic stress?

DO: Give the client time to think and answer.

DO: Reinforce or highlight answers the client gives that are common responses to chronic stress. Make sure to include:

- Physical reactions: having headaches, heart disease, and/or excessive weight gain or weight loss
- Emotional reactions: feeling sad, low, and/or anxious or nervous all the time
- Behavioural reactions: having difficulty with sleep (i.e., sleeping too much or too little) over multiple weeks/months, being unable to function for long periods of time, have eating problems (i.e., eating too much or too little) over multiple weeks/months

DO: Give the client paper or a flip chart and ask them to draw an outline of a body to represent themselves (or pre-draw an outline of a body for the client).

SAY: We are going to draw how stress and chronic stress feel in our bodies. You can use

different colours, symbols, and pictures to represent different types of stress reactions and how they feel to you.

SAY: Think about an everyday source of stress – a type of activity where stress can be helpful. For example – having enough time to take care of house chores, starting a new job, meeting a close friend or family member after not seeing them for a long time.

SAY: First, we are going to think about how stress impacts you, as an individual, directly.

ASK: What does it feel like in your body? Where in your body do you feel these kinds of stress?

DO: Give the client time to reflect on the questions.

SAY: Now I'd like you to draw where you feel stress in your body. For example, a headache could be some red lines across the forehead.

DO: Give the client time to draw on the outline of the body.

SAY: Stress impacts the way we act with others as well.

ASK: If you are stressed, how do you treat others? What happens outside of your body – in your family or environment?

SAY: As you think about this, draw symbols to represent what's happening outside of your body when you are stressed. It can be outside of the body in your picture or it can start in the body and move outward.

SAY: Now, think about chronic stress. That stress that does not let up and feels like it is always there.

ASK: How does this feel different in your body (if/when you experience it)? Where and how do you feel it in your body? What does it feel like in your body?

SAY: As you think about chronic stress in the body, draw a symbol for where you feel it and how. It might be a bigger symbol than the previous everyday stress or it might be multiple symbols in different places. Whatever feels right to you.

ASK: How does chronic stress impact the way you interact with others? What happens outside your body, in your environment with family, friends, and/or the community?

SAY: Draw any other symbols you want to add to represent chronic stress inside or outside of your body.

SAY: Now that we have an idea of what chronic stress feels like for you, we can discuss different potential coping strategies that may help with some of these feelings.

DO: Select at least one emotion regulation activity to try with the client. The emotion regulation activity you choose should connect to the stress reactions the client has identified in their body. If you have difficulty choosing, the following activities are helpful for most people: belly breathing, square breathing, and 5 senses for grounding. Explain the activity to the client and practice it with them.

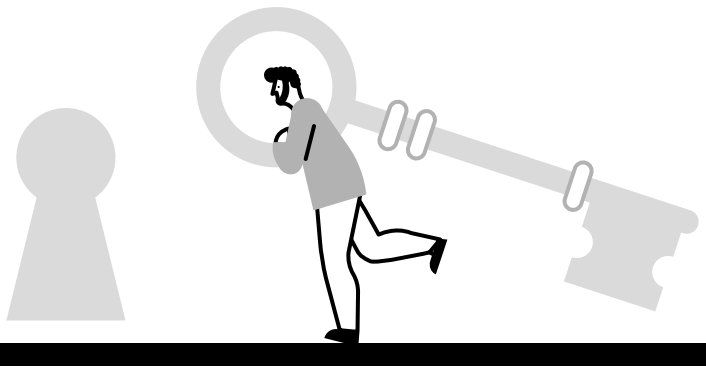
DO: Update the client's coping plan as needed to help them remember this activity and when to use it.

Activity Homework / Follow-up

Facilitators note: decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

DO: Select an emotional regulation activity (different from the one just practised with the client) and implement with the client before they leave to close the session.



Handout

Possible signs of feeling stressed

- ☐ Eating too much or too little
- ☐ Sleeping too much or too little
- ☐ Extreme focus on a specific task or tasks
- ☐ Working extremely efficiently for short periods of time (can alternate with periods of incredibly low productivity)
- ☐ Difficulty concentrating
- ☐ Worrying a lot of the time
- ☐ Feeling guilty but not sure why
- ☐ Unexplained aches, pains (headaches, stomachaches, muscle tension – particularly in back or shoulders)
- ☐ Low or no energy
- ☐ Weight gain
- ☐ Trouble sleeping
- ☐ Feeling low, sad, or unable to function
- ☐ Difficulty with others – fighting or becoming aggressive, easy to anger
- ☐ Excessive drinking, smoking, using drugs
- ☐ Thinking of hurting yourself or others

Other suggestions:

My examples of stress

Annex 4.4.4.3: Our Brains and Extreme Stress

Objective	To support clients understand how extreme stress and adverse events that cause it are distinct from other forms of stress. Clients understand how extreme stress impacts our brains and our reactions.
Time	30 minutes
Materials	Printed handout of 'Our brain' (or pre-drawn image on paper), flip chart/ paper, pens, markers, crayons
Participant(s)	Client; a trusted family member or friend can be included if the client wishes
Preparation	Facilitators must practice this activity multiple times before completing it with a client. Adjustments should be made to ensure the terms are relevant for the context (e.g., if the community is familiar with and uses "trauma" and "post-traumatic stress disorder" in their conversations, the term "traumatic event/experience" can be used instead of "extreme stress".) In advance of the meeting, draw a brain on a flip chart to help with explanations.

Facilitators note: This activity may not be appropriate or necessary for use with all clients. Only use this activity when clients describe dealing with symptoms associated with extreme stress. This activity is not appropriate to use when clients are actively in crisis. Caseworkers should not use this activity unless fully confident in providing information on and discussing extreme stress as well as teaching and practicing various coping strategies with the client. Caseworkers should also complete Stress Sessions 1 and 2 before completing this activity with clients.

Video Resource: To aid caseworkers in grasping this activity and practicing the concept before engaging with clients, several brief videos can be beneficial for review. For instance, the video, The Hand Model of the Brain shared on YouTube by Emotion Coaching UK serves as a helpful resource. Link: https://youtu.be/Kx7PCzg0CGE

Instructions

DO: Remind the client of what helpful stress and chronic/harmful stress look like.

ASK: Do you have any additional thoughts or reflections on chronic/harmful stress?

DO: Give the client space/time to respond and affirm what they have shared and clarify any areas of misunderstanding or confusion.

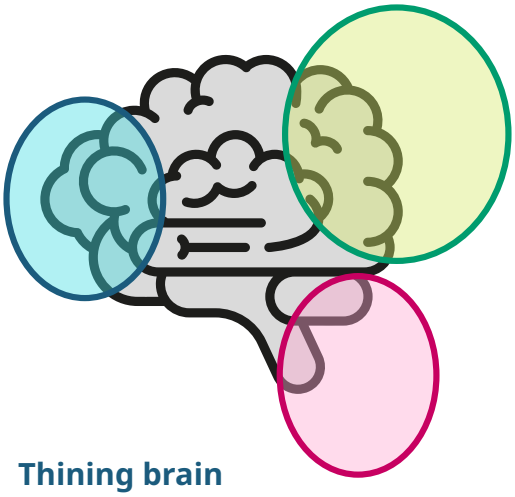
SAY: For today's activity, I would like to talk about extreme stress which is different from chronic stress. There have been times where what you described sounds more like extreme than chronic stress. It can be helpful to understand how our brains work in times of extreme stress. Many people experience extreme stress in times of war, natural disaster, displacement from home, loss, etc.

ASK: Would this be helpful for you?

DO: Give the client space/time to respond.

Facilitators note: If the client answers yes, continue the conversation below. If the client answers no, explore the reasons why they do not think this would be helpful and inform them that they do not have to do the activity and can revisit it in the future if they wish. You can then move ahead to the closing/ grounding activity.

SAY: In order to understand reactions that can occur after experiencing events that can cause extreme stress, we have to understand how our brains work first.



Thining brain
Emotional brain
Survival brain

DO: Bring out the picture of the brain (in a handout or on a flip chart). Use the picture to explain the three parts of the brain.

EXPLAIN: At the base of our neck we have the brain stem. This part of the brain is the ***'survival brain***'. It makes sure we do all the things we need to survive without actively thinking about it. For example, breathing, blinking, swallowing, etc.

In the middle we have the ***'emotional brain'***. This part of our brain thinks like an animal and attaches

emotions to experiences. For example, we know that snakes are dangerous; our emotional brain is the part of our brain that makes us jump out of the way from a snake before our thinking brain even realizes it is a snake.

Finally, towards the top and front of our brain is the ***'thinking brain'***. This is the part of the brain that can make slow, reasoned decisions based on facts, context, etc. and not just based on emotions.

ASK: What do you think happens in our brains during times of high stress, dangerous situations, or situations with a lot of emotions?

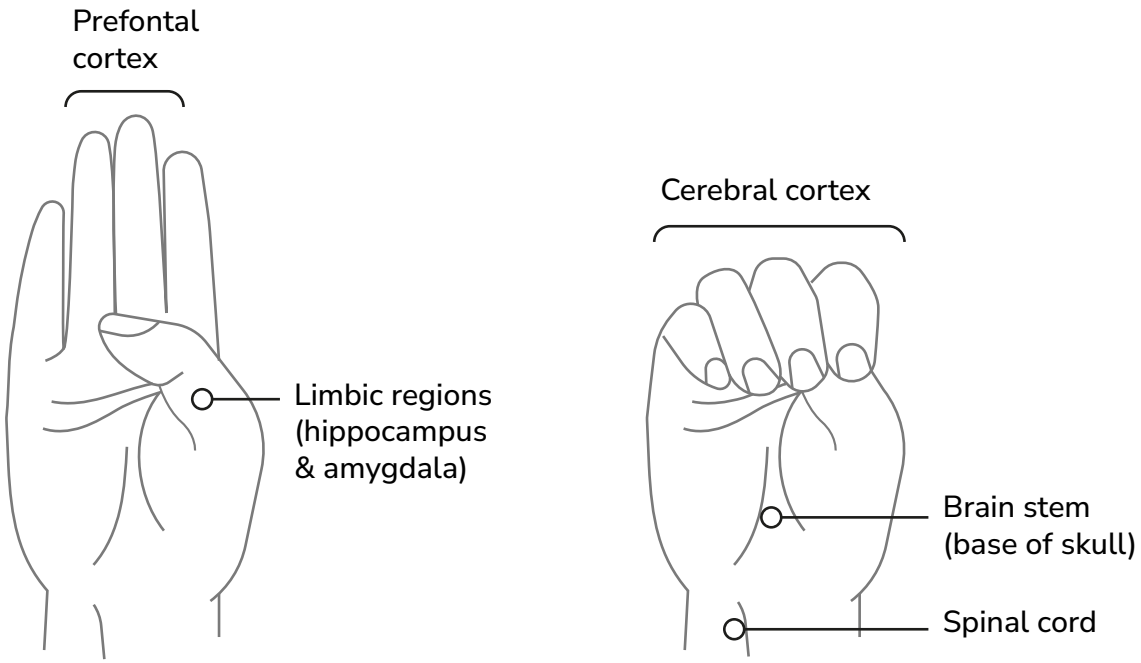
DO: Give the client time to think and answer. As the client gives suggestions, affirm any that are correct.

Facilitator note: suggestions like "our brain shuts down" or "there is not thinking, just acting" are correct to some degree and can be agreed with and then explained further.

SAY: Part of our brain shuts down during these times. We can do a short activity now to understand which parts of our brain shut down and which part takes over in these situations.

ASK: The client to take one hand and make a fist with their thumb inside their fingers. Then open the hand back up but keep the thumb where it is.

Hand Model of the Brain



EXPLAIN: Your fingers represent the ***'thinking brain'***. The palm is the ***'emotional brain'*** and the wrist/bottom of your hand is your brain stem ***'survival brain'*** and spinal cord (wrist and arm).

SAY: The thumb is the part of our brain that acts as a messenger. It sends messages about danger and safety to both the ***'emotional brain'*** and the ***'thinking brain'*** so that we can either stay safe or get to safety.

ASK: Do you notice anything about where this messenger (the thubb) is compared to the 'emotional brain' and the ***'thinking brain'***?

DO: Give the client time to reflect and tell you what they notice before moving on.

EXPLAIN: The thumb/messenger is much closer to the ***'emotional brain'*** than the ***'thinking brain'***. In fact, the messenger is so close to the 'emotional brain' that it touches part of the ***'emotional brain'***. It doesn't physically touch the thinking brain at all.

EXPLAIN: This means that when the messenger thinks there is danger or a problem, it can message the ***'emotional brain'*** much faster (this is why we jump automatically when we see a snake before fully realizing it is or isn't a snake). And in times when we are afraid for our lives, experiencing terror, or completely overwhelmed by a situation, the messenger can send messages to our 'emotional brain' and the 'emotional brain' can shut down/override the ***'thinking brain'***.

ASK: The client to close their fingers over their thumbs again.

SAY: When the messenger sends messages to our ***'emotional brain'*** and the ***'emotional brain'*** overrides the thinking brain, we sometimes call this "flipping your lid" – our emotional brain 'switches off' or 'pops off' our ***'thinking brain'***.

DO: Have the client continue to flip the fingers up and down over and over as you are speaking.

EXPLAIN: This is beneficial during times of danger and exposure to potential harm – times when we need to be focused on safety and survival. However, sometimes this happens when it shouldn't - when there is no harm or after the danger has passed. This means that we can often become overwhelmed by emotions, may not feel in control all the time, and do not always know what is going to cause extreme reactions for us.

SAY: Even if we do not fully reach the "flipping our lid" state, emotions can still feel overwhelming and carry more influence than our thoughts during these times.

ASK: Is this making sense so far? Do you have any questions?

Facilitator note: Think about questions you and other caseworkers had when you first learned this activity. Clients may have similar questions. Remember:

- *You may need to repeat some parts of the exercise or use different descriptions to help them understand.*
- *Understanding can be helped by having the client do the hand motion of "flipping the lid" with you as you repeat or reiterate.*
- *If you don't know how to answer the client's question, you can always tell them that you will find out and share with them next time or when you have the answer.*

SAY: What is important to remember is that our brain works in ways to keep us safe or get us out of unsafe situations. This, however, can be counterproductive or even harmful if our brains continue to react to new experiences or perceived threats/dangers in ways it has reacted to extreme stress in the past. For example, this can cause us to feel like we don't have control over our emotions and bodies, make us feel unsafe even in the calmest settings, and impact our ability to keep up with day-to-day activities.

DO: Pause and give time for the client to ask any questions. Answer any questions before moving on.

SAY: Now that we better understand how our brains work, we can dive deeper into understanding extreme stress. Extreme stress can occur as a reaction to an event or events that are very distressing, frightening, life threatening, out of our control, and/or difficult to cope with. When we experience such an event, we often react in one of three ways: fight, flight, or freeze. Following the event, we may think, feel, and behave differently than we did before it happened.

EXPLAIN: It is important to understand how this extreme stress is different from and similar to helpful, everyday stress and harmful, chronic stress. Survivors of distressing, frightening, and/or life threatening events can feel a higher level of stress on a constant basis, which can be debilitating. Extreme stress is different from chronic, everyday stress because extreme stress is more intrusive, disruptive, and affects day-to-day functioning. It is important to be able to recognize extreme stress in ourselves and others in our lives.

ASK: Do you have any questions about the difference between everyday, helpful stress, chronic stress, and extreme stress?

DO: Give space for the client to ask questions and respond accordingly.

DO: Review a few of the common symptoms of extreme stress:

- Unwanted, distressing memories of the disturbing, distressing, frightening, and/or life-threatening event
- Feeling like you are reliving the event
- Severe emotional or physical reactions if something reminds you of the event
- Hopelessness about the future
- Difficulty feeling close to people, even from family and friends
- Always being "on guard" for danger
- Feeling overwhelmed by guilt or shame

ASK: Have you experienced any of these reactions?

_____If YES, then_____

SAY: That must be very challenging. Know that you are not alone. I am here to help and we can work on coping mechanisms to bring some relief to the stress reactions that you are experiencing. I'd also like to refer you to a close colleague of mine, who focuses on this type of service.

ASK: Would you like me to refer you for additional support services to help manage and overcome some of these challenging symptoms?

DO: Give space for the client to ask questions and respond accordingly.

SAY: It can be difficult to experience these things. And these conversations can bring up many emotions and difficult memories for us. Because of this, we're going to do a grounding exercise to help us close this conversation.

Facilitators note: Make sure to complete the necessary referral process for the client. If the caseworker has not already completed the Basic MHPSS Assessment with the client, complete this assessment during this session or the next in order to better understand the needs of the client and refer appropriately.

_____If NO, then_____

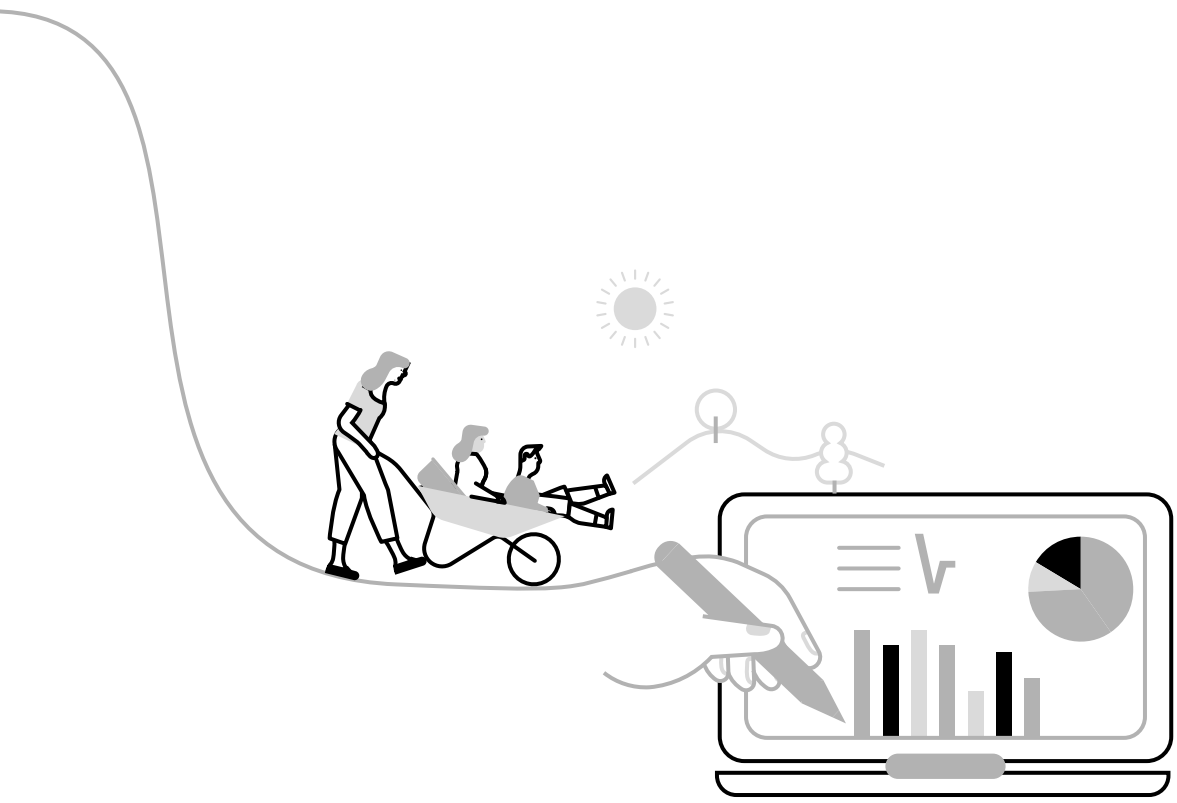
SAY: I am glad to hear that you are not experiencing any of these reactions. If you ever notice these reactions in yourself, you can always reach out and let me know and we can figure out how to address them.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close this conversation. These types of conversations can bring up a lot of emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement it with the client before they leave to close the session.



Annex 4.4.4.4: Identifying Emotions and Feelings

Objective	To help the client to gain a greater understanding of the core emotions and feelings that result from them.
Time	30 minutes
Materials	Flipchart/paper, marker, pens
Participant(s)	Client; a trusted family member or friend can be included if the client wishes
Preparation	Make sure to understand the distinction between emotions and feelings. Have a list of culturally common feelings written down to use.

Instructions

SAY: Our emotions help guide the decisions we make every minute of our lives. The world around us (and the thoughts in our minds) cause us to have emotional reactions all the time. Much of what we do is motivated by a desire to change or maintain how we feel. For example, we usually want to hold on to good feelings and to remove or avoid bad feelings.

SAY: Sometimes it is difficult to identify what emotions we are having and how to manage our emotions in difficult times. In this activity, we will explore emotions and the feelings they create in our bodies. This can help us be more aware of how emotions are affecting us. We will also explore how we deal with the emotions we experience.

ASK: When I say 'emotions', what comes to your mind?

DO: Give space for the client to reflect and respond.

ASK: What are some emotions that people experience?

Facilitators note: If the client is having difficulty, tell them they can name emotions in general that all people experience. This does not need to be specific emotions that the client is personally experiencing in the present or has experienced in the past.

DO: Write all the emotions they name on a flipchart or paper.

EXPLAIN: Emotions are intense, short-lived reactions to specific stimuli. Emotions are often brief and intense, triggered by internal or external events, and accompanied by physiological changes. For example, we may experience joy after receiving a job offer or anger when we stub our toe on a chair. We have a limited number of emotions. Emotions usually originate without our conscious effort; they develop in the part of our brain that assesses for danger.

Facilitator's note: If you completed psychoeducation activity "Stress Session 3" with the client, you can refer to the "emotional brain" and the amygdala.

SAY: Some of the most common emotions are sadness, anger, surprise, joy, disgust, and fear. Everyone experiences a range of different emotions throughout their life. This is normal.

DO: Circle the emotions you just named on the flipchart/paper or add them if they are not on the list.

ASK: How are emotions different from feelings?

DO: DO: Give space for the client to reflect and respond.

EXPLAIN: Feelings are subjective experiences that arise from emotions. Feelings are influenced by personal beliefs, experiences, and interpretations. Feelings are individual and subjective and shaped by personal perceptions and often last longer than emotions. For example:

Emotion	Associated Feelings
Joy	Delightness, confidence, self-acceptance
Sadness	Disappointment, neediness, loneliness
Anger	Jealousy, dissatisfaction, intolerance

ASK: What questions do you have about emotions vs feelings?

DO: Give the client time to respond.

EXPLAIN: There are many more feelings than emotions and feelings may not be the same in

every culture. We learn and experience feelings based on our experiences, our culture, our individual personalities.

ASK: What are some other emotions and/or feelings that people experience in their lifetime?

DO: Add the emotions and/or feelings the client names on the flipchart. Work with the client to circle the emotions and to underline any feelings listed on the flipchart.

ASK: Do you think all these feelings are normal?

DO: Give the client time to think and respond.

ASK: Do you think it is important to talk about feelings? Why or why not?

DO: Give the client time to think and respond.

ASK: Would you feel comfortable sharing with me about the feelings you have experienced in the past as well as the feelings you are currently experiencing?

_____If the client says yes, then_____

ASK: Looking at the list of feelings we created, which of these have you felt in the past?

DO: Listen to the client and add a star to the feelings the client has experienced in the past (or allow the client to add the star as they wish).

ASK: Which of these feelings are you experiencing in the present/these days?

Facilitators note: It is up to the client and caseworker to define the time for 'present', e.g., it could be that day, that week, that month.

DO: Listen to the client and add an exclamation point !, an arrow --> or another symbol to the feelings the client names they are experiencing in the present.

_____If the client says no, then_____

SAY: That's okay if you are not comfortable talking about this today. If you want to revisit this conversation and talk more about this another day, just let me know.

SAY: We all experience different feelings at different times. All feelings are normal and completely natural. There are no bad feelings. Everyone has different ways of dealing with their feelings. What is important is learning how to express them or deal with them in ways that are healthy and helpful, rather than damaging to ourselves or others. When we allow ourselves to explore and acknowledge our feelings in a healthy and safe way, we are better prepared to cope with difficult feelings.

ASK: What are some healthy or helpful ways of dealing with or expressing feelings?

DO: Give the client time to reflect and respond. Write down their answers on a flipchart or piece of paper in green marker or crayon, or on one side of the sheet labeled “healthy/helpful”.

ASK: What are some potentially harmful ways of dealing with or expressing feelings?

DO: Give the client time to reflect and respond. Write down their answers on a flipchart or piece of paper in red marker or crayon, or on one side of the sheet labeled “harmful”.

ASK: What are the different ways you deal with or work through your feelings? Are there any on this list that you do that you feel comfortable sharing with me?

DO: Give the client time to reflect and respond.

SAY: As we work together, we can learn and practice different activities and skills that can help you process and move through the feelings you are experiencing.

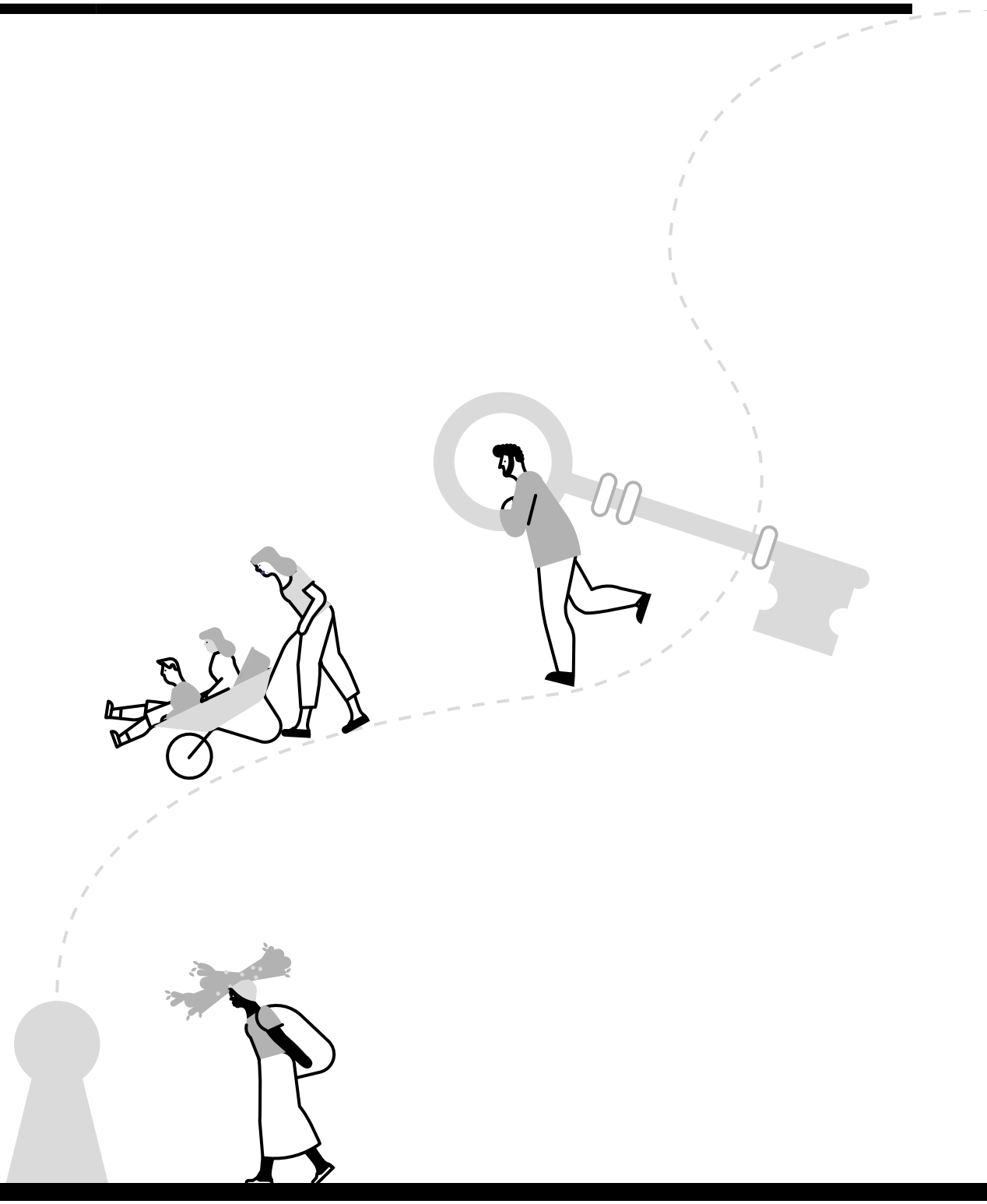
DO: Work with the client to add what was discussed today in their coping plan as needed.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close this conversation. These types of conversations can bring up a lot of emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement it with the client before they leave to close the session.



Annex 4.4.4.5: Understanding Grief and Loss

Objective	To help the client understand what grief is and how the grieving process can look and feel, and to identify effective coping strategies.
Time	30 minutes
Materials	Flip chart /paper, markers/pens
Participant(s)	Client; a trusted family member or friend can be included if the client wishes
Preparation	The caseworker should practise leading this activity with another caseworker or supervisor and receive feedback before using it with clients. Draw the 5 stages of grief before starting the session.

Instructions

SAY: It can be useful to understand what grief is and how it manifests in different situations.

EXPLAIN: Grief is the normal process of reacting to a loss. The loss may be physical (such as a death), social (such as a divorce), or occupational (such as a job). Grief is a normal emotional reaction to any kind of loss.

ASK: What do you think of when you hear the word ‘loss’ or ‘losses’?

Facilitator note: You may need to help them expand their list. Grief can be used to mourn any kind of loss, including death, divorce, miscarriage/abortion, moving, loss of home, loss of possessions, loss of friends,loss of health, change in lifestyle, change in social status, etc. It is much broader than death which is what many people think of when we say grief.

SAY: Many of us often have to cope with the grief of losing loved ones, losing homes, losing opportunities, or losing our connection to our culture.

Facilitator note: Adjust this to reflect the common experiences of people in the context. If it is a displacement site, you can reference the grief that comes with being forced to leave home. If it is a site where a natural disaster has recently occurred, you can reference the grief of that experience.

EXPLAIN: Everyone grieves differently and our experiences are linked to many different factors, including level of attachment, personality, recent life circumstances, other losses experienced before, access to and level of support, etc.

SAY: The pain of loss can be increased by the stressors that result from the loss (e.g., loss of primary provider leading to financial stressors, loss of parenting support).

Facilitator note: This is especially difficult in cases of displacement and for those who lack other support structures.

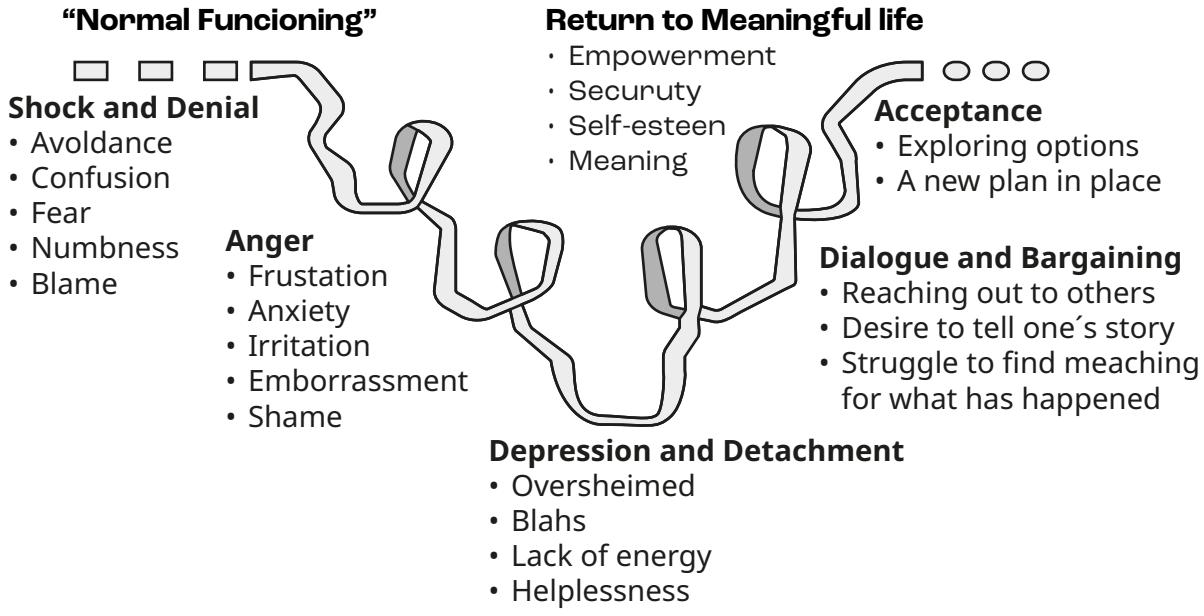
ASK: What does the grieving process look like for you and others in your community?

DO: Give the client time to answer.

SAY: Grief can be individual or communal or both . For example, the death of someone impacts their friends and family, but a _____ [Typhoon/Earthquake/Flood/ Other natural disaster that occurs in the setting] impacts and can cause grief for the whole community.

DO: Bring out the flipchart with the 5 stages of grief.

SAY: For many of us experiencing individual grief, it can look something like what is on this flipchart/paper.



EXPLAIN: Anyone experiencing grief usually experiences each of these stages: shock and denial, anger, depression and detachment, dialogue and bargaining, and acceptance. The stages of grief are usually not experienced in a linear manner. While some people experience the stages of grief in the order shown on the flipchart/paper, most people will experience the stages in a nonlinear fashion and will go back to specific stages over and over again before accepting and integrating the loss into their lives rather than struggling against it. The length and severity of the stages can also be different for everyone.

ASK: Can you think of a time you or someone else experienced grief?

DO: Give the client time to reflect and respond.

ASK: When you or this other person experienced grief, what was your or their experience with each of these stages? How did your/their grief change over time?

DO: Give the client time to reflect and respond.

SAY: Thank you for sharing that with me. It is okay if some of the stages resonate with your experience of grief or what you have observed in other's grieving process and others do not.

Facilitator's Note: The client may have experienced ambiguous loss, communal grief, or both. Caseworkers should review the provided information and select the relevant psychoeducation materials from the sections below to meet the clients need before meeting with the client. Share only the information pertinent to the client's specific experience. If the client has faced both ambiguous loss and communal grief, choose one topic to discuss during the initial session, and schedule a follow-up session to cover the other topic. Addressing both ambiguous loss and communal grief, along with the other content in this activity, in a single session may be overwhelming for the client.

SAY: Grieving can look particularly different if it involves an ambiguous loss, which is a loss that occurs without a clear understanding of what happened so that the grieving persons are left searching for answers. Ambiguous losses are losses that are unclear or unconfirmed without a significant likelihood of reaching emotional closure. An example of an ambiguous loss is when there is no official verification of life or death of a person.

EXPLAIN: Complicated reactions can arise with ambiguous loss, such as hope, confusion, grief, and the possible differences/disagreements in beliefs of the loss within a family or community.

DO: Explore the differences between a known loss and an ambiguous loss. Note how ambiguous loss can affect an individual emotionally and mentally, as well as how it can affect a family and community.

SAY: Ambiguous loss can be felt both on an individual level and a communal level.

ASK: Have you experienced times when grief is experienced by a whole community? If so, how?

DO: Give the client time to answer.

EXPLAIN: Communal grief often happens after major crises, natural disasters, and man-made disasters such as war.

Facilitator note: If the client has the emotional space to discuss prior experiences of communal grief that have occurred, you can reference specific events that may have been a cause – a prior flood or earthquake, etc.

EXPLAIN: Major symptoms of communal grief include but are not limited to: feelings of helplessness and hopelessness, lack of activity, dependency, frustration, aggression/violence, and the communal image being damaged. These are all common in the aftermath of a communal event/disaster.

SAY: Most of the time, communities are able to recover and these feelings fade. Life returns to normal or a new normal. However, this can take time and requires support for and from the community.

ASK: What are ways that you / your community recognize loss (e.g., funerals, community gatherings, etc.)? What are ways that they have experienced community recovery from loss? What were some of the key supports that helped your (or another) community recover?

DO: Give the client time to answer.

ASK: What, if any, of these ways helped you return to a sense of normalcy? Would any of them be useful in your current experience of grief?

ASK: If you feel comfortable, could you share a loss that you are grieving in this present moment?

DO: Give time for the client to reflect and respond. If the client does not share a loss they are presently grieving, tell them it is no problem and suggest an experience of grief they previously shared.

SAY: It can be especially difficult to regain a sense of normalcy following a loss when we lack support structures and/or when we experience many losses. However, we often recover more quickly when we actively seek to keep the memory of our losses alive rather than try to ignore or push away those memories.

ASK: Can you think of some ways you could keep alive the memory of this loss?

DO: Give the client time to answer.

DO: Build on their answer by adding other suggestions. These could be:

- For grieving a death or ambiguous loss of a person
  - Creating memorials to keep the memory alive,
  - Actively remembering our loved one and identifying what we have learned from them
  - Building and strengthening qualities and strengths in ourselves that we learned from or admired in the loved can honour the loved one.
  - Drawing on these strengths can help to cope with stressors and rebuild after multiple losses
  - Develop a practice or memorial to your loved one(s) and write down or draw a picture of some of the gifts and strengths they have given you.
  - Pick a regular time to remember your loved ones.
  - Focus on connecting with others — your family, friends and group members — and on making new connections.
- For grieving a loss like divorce, a job, home, etc. without a death
  - Remembering the good times and happy memories.
  - Creating a special place for items from a lost home that you may have
  - Reflecting on what you learned from the experience and who you connected with/what you gained from the experience even after it has ended.
  - Think about ways that you can rebuild your life, using these strengths from your loved ones
  - Focus on connecting with others — your family, friends and group members — and on making new connections.

ASK: Which of these ideas could be helpful for you?

DO: Give the client time to answer.

EXPLAIN: We can add this to your coping plan and your homework.

DO: Update the client's coping plan as needed to help them remember this activity.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close this conversation. These types of conversations can bring up a lot of emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practised with the client) and implement it with the client before they leave to close the session.

Annex 4.4.4.6: Healthy Relationships

Objective	To educate participants on the significance of healthy relationships and how they contribute to overall well-being. This session aims to increase awareness of the characteristics of healthy relationships and the positive impact they have on mental and emotional health.
Time	45-60 minutes
Materials	Handouts or pre-written list of characteristics of healthy relationships; pens/pencils and notebooks or paper for notes (optional)
Participation	This activity is primarily for the caseworker and client. Engaging a family member or trusted friend, with whom the client has a healthy relationship with, might be beneficial for additional support and discussion.
Preparation	Prepare handout or pre-written list detailing the characteristics of healthy relationships. Set up a comfortable and private space for the session. Review any cultural, age, or gender-specific or known relationship challenges / considerations that might impact the discussion.

Facilitators' note: Before conducting this activity with a client, caseworkers should closely review and make necessary adjustments for cultural context, gender, age, disability, and other demographic factors. Additionally, it's crucial to consider clients' backgrounds and relationship experiences with relationships, making any necessary edits to the psychoeducation activity beforehand. Remember to be aware that some individuals may have had negative experiences that make this topic sensitive. Be ready to offer additional support and follow up with emotional regulation activities as needed. Caseworkers must make essential referrals to key providers, such as GBV actors, when necessary.

Instructions

DO: Welcome the participants and introduce the session topic and objective of the psychoeducation activity.

SAY: Today, we are going to talk about the importance of healthy relationships and how they contribute to our well-being. Understanding what makes a relationship healthy can help us foster better connections with others and improve our mental and emotional health.

SAY: Our psychological health and physical well-being depend heavily on our ability to form close relationships – including non-romantic and romantic relationships. The process of relationship building begins with our families, moves to the formation of friendships, and may eventually lead to romantic relationships. All these relationships help us to develop interpersonal skills and provide experiences that assist us in fine-tuning our emotions and feelings. One of the keys to creating a meaningful and special relationship for life is to affect someone positively at an emotional level. Caring about someone, particularly at a time of need, learning to have faith and trust in others and ourselves, and sharing ourselves with others are some ways to build healthy relationships and to bring about positive outcomes, which will enrich our lives and the lives of others.

EXPLAIN: Healthy relationships are essential for our well-being. They provide emotional support, increase our sense of belonging, and help us cope with stress. In contrast, unhealthy relationships can lead to stress, anxiety, and a sense of isolation.

ASK: What are some common characteristics of a healthy relationship?

DO: Pause for the client to reflect and then share.

SHOW: Relationships are based on some commonly accepted values (e.g., trust, respect, effective communication, equality, support, boundaries and beyond). Share the handout with key characteristics of healthy relationships. (This can be shared verbally or a printed handout).

ASK: Can you think of a relationship in your life that you consider healthy? What are the qualities that make it so?

DO: Pause for the client to reflect and share.

ASK: How does this relationship positively impact different aspects of your life? (i.e., what are the benefits of this healthy relationship?)

DO: Provide examples and discuss together of how healthy relationships positively impact different aspects of life, such as physical health, emotional well-being, and overall happiness. For instance, good relationships help regulate stress, reducing the risk of chronic health issues like heart disease and high blood pressure. Additionally, strong social connections are consistently linked to greater happiness and longer life.

ASK: What are some ways we can work towards building healthier relationships in our lives?

EXPLAIN: Building healthy relationships involves effective communication, setting boundaries, showing appreciation, and being supportive. It's also important to recognize and address any issues that may arise and to seek help if needed.

DO: Discuss with the participants how they can practice building healthy relationships in their daily lives. Encourage them to identify one relationship they would like to improve and to apply the strategies discussed during the session.

Facilitators Note: Be sure to encourage open discussion and validate participants' feelings and experiences. Offer practical tips and strategies for improving relationships, such as active listening, empathy, and conflict resolution.

ASK: Would you like to add any of what we discussed today to your coping plan?

DO: Update the client's coping plan as needed.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity and if so, discuss what the client should do to practise at home. Examples of homework may include:

- *Practice active listening in conversations with a friend or family member.*
- *Reflect on and express appreciation for a loved one.*
- *Set a boundary in a relationship where it is needed and observe the outcome.*

SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

DO: Select an emotional regulation activity and implement it with the client before they leave to close the session to support them in coping with any distressing thoughts or emotions that may have arisen during the session.

Psychoeducation Handout: Understanding Healthy and Unhealthy Relationships

Characteristics of Healthy Relationships

Trust:

- In Romantic Relationships: Partners trust each other with their feelings, privacy, and boundaries.
- In Non-Romantic Relationships: Friends or colleagues rely on each other to keep confidences and respect each other's personal space.

Respect:

- In Romantic Relationships: Partners value each other's opinions, feelings, and boundaries. They support each other's goals and aspirations.
- In Non-Romantic Relationships: Mutual respect is shown by listening, valuing different viewpoints, and appreciating each other's contributions.

Effective Communication:

- In Romantic Relationships: Open and honest communication is key. Partners discuss their feelings, listen actively, and resolve conflicts constructively.
- In Non-Romantic Relationships: Clear communication helps avoid misunderstandings and fosters a supportive environment. This includes active listening and expressing oneself clearly and respectfully.

Equality:

- In Romantic Relationships: Both partners have an equal say in decisions and neither person dominates the relationship.
- In Non-Romantic Relationships: Each person feels valued and respected, and responsibilities are shared fairly.

Support:

- In Romantic Relationships: Partners encourage and uplift each other during tough times and celebrate successes together.
- In Non-Romantic Relationships: Friends or colleagues provide emotional support, practical help, and encouragement.

Boundaries:

- In Romantic Relationships: Recognizing and respecting each other's personal boundaries, including privacy, physical space, and time alone.
- In Non-Romantic Relationships: Understanding and respecting individual limits and ensuring that no one feels pressured or uncomfortable.

Independence:

- In Romantic Relationships: Both individuals maintain their own identities and interests outside of the relationship.
- In Non-Romantic Relationships: Encouraging each other's personal growth and pursuits without feeling threatened.

Characteristics of Unhealthy Relationships

Control:

- In Romantic Relationships: One partner tries to control the other's activities, relationships, or choices.
- In Non-Romantic Relationships: One person demands that things be done their way, often disregarding the other's input or feelings.

Lack of Trust:

- In Romantic Relationships: There may be constant jealousy, accusations, or checking up on the other person.
- In Non-Romantic Relationships: Mistrust manifests as skepticism about the other person's intentions, leading to a lack of open communication.

Poor Communication:

- In Romantic Relationships: Partners might avoid discussing important issues, shout, or use hurtful language.
- In Non-Romantic Relationships: Communication might be characterized by passive-aggressiveness, frequent arguments, or complete avoidance of conflict resolution.

Disrespect:

- In Romantic Relationships: One partner belittles, mocks, or dismisses the other's feelings and opinions.
- In Non-Romantic Relationships: There is a lack of consideration for each other's viewpoints, often leading to dismissive or condescending interactions.

Inequality:

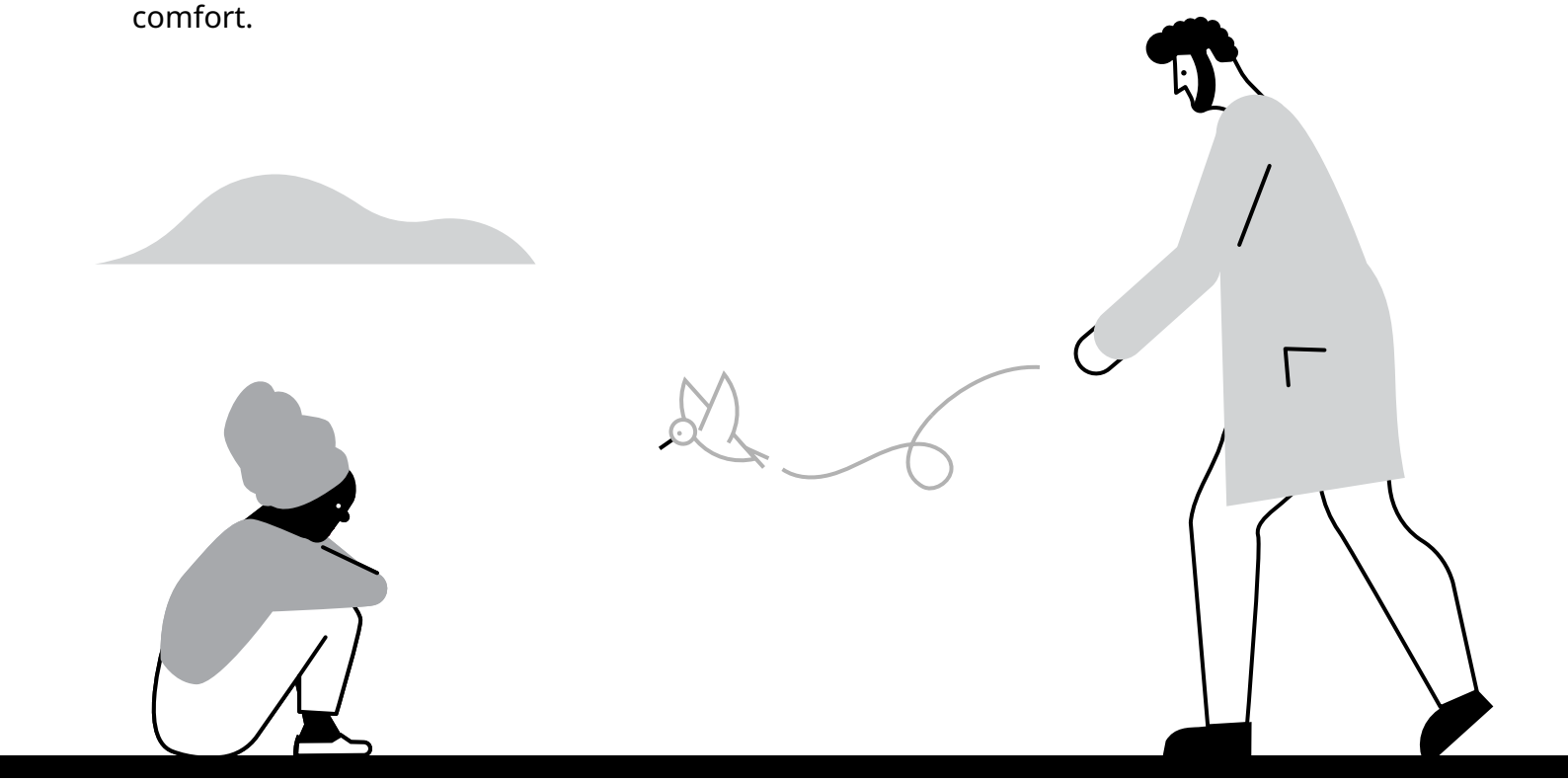
- In Romantic Relationships: One partner dominates decision-making or asserts power over the other.
- In Non-Romantic Relationships: A power imbalance where one person consistently takes control or marginalizes the other's contributions.

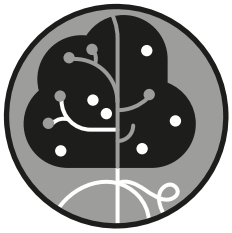
Lack of Support:

- In Romantic Relationships: Partners fail to support each other's goals, often sabotaging or dismissing ambitions.
- In Non-Romantic Relationships: Friends or colleagues might not offer help or encouragement, and may even undermine each other's efforts.

Violated Boundaries:

- In Romantic Relationships: Ignoring or disrespecting personal boundaries, such as excessive neediness, invasiveness, or coercion.
- In Non-Romantic Relationships: Overstepping boundaries like privacy, time, and personal space without regard for the other person's comfort.





Annex 4.4.5: Emotional Regulation

Annex 4.4.5.1: Deep Belly Breathing

Objective	For the client to be able to create a sense of calm, regulate breathing, and become aware of the connection between emotions and breath.
Time	10 minutes
Materials	None
Participant(s)	Client
Preparation	The caseworker should practice leading this exercise with another caseworker or supervisor and receive feedback before using with clients.

Facilitators note: The first time this activity is used, it should be done in a quiet, calm setting to allow focus and undisturbed practice. Stop the activity or discontinue use if the client reports starting to feel anxious or overwhelmed while doing the breathing activity.

Instructions

DO: Use a calm, gentle voice. Speak slowly and clearly.

SAY: Today we are going to learn how to take deep belly breaths. Breathing deeply from your belly can help you to:

- Slow down your breathing
- Feel calmer
- Feel refreshed

SAY: Find a seated position that feels comfortable, where you can sit with little movement, similar to how I am sitting.

Facilitator note: Show your seated position. If seated on chair, make sure that you are seated comfortably upright with both your feet firmly touching the floor. You can roll your shoulders back to show the client how they might get more comfortable in their seat. If you are seated on the floor, you can sit on a pillow or mat to get more comfortable and have your hands resting gently on your legs.

EXPLAIN: That the client should make any adjustments to be comfortable. Adjust as needed to find a seated position that is comfortable and allows them to sit upright with a straight spine (if physically able).

DO: Wait until the client is seated comfortably.

SAY: I'd like you to focus on your breath. Notice if you are taking shallow or deep breaths, and if your breathing is fast or slow. Also try to notice where in your body you are breathing. Are you breathing from your belly? Or your chest? Take note in your mind.

DO: Give the client time to notice how they are breathing. If they begin to share what they are noticing with you, validate what they have shared and gently tell them that you will have more time to discuss after practicing the breathing exercise.

SAY: Now that you've noticed how you usually breathe, I'd like for you to focus on breathing through your nose all the way down into your belly. You can also put one hand on your heart and one hand on your belly like this.

DO: Put one hand over your heart and one hand on your belly and allow the client to observe you.

SAY: As you inhale, try to visualize and feel your breath going in through your nose and down to your belly, and your belly getting bigger with your breath. You can even visualize your breath as a color if you'd like. I like to pick the color blue because it is soothing for me.

Facilitator's note: You can switch the color for another color of your choice. It is recommended to choose a soothing or calming color.

DO: Begin to breathe in slowly through your nose as you provide the instruction above, allowing your belly to fill with your breathe.

SAY: Then, exhale all your breath out slowly through your nose until all the breath has left your belly and your belly is back to its normal resting position.

DO: Exhale slowly through your nose as you provide the instruction above, allowing your belly to deflate.

SAY: It is important to breathe out slowly and to spend more time on your outbreath/exhale because this is what calms your nervous system down. Sometimes it also helps to count 1-2-3 as you breathe in, and 1-2-3-4 as you breathe out to help remember to exhale slowly.

DO: Demonstrate breathing in through your nose at the count of 1-2-3 and breathing out through your nose at the count of 1-2-3-4.

SAY: Now, I'd like you to practice. For this first time, find one spot in front of you to gently gaze at. If you want to close your eyes after this first round, you can.

ASK: Are you ready?

DO: Wait for the client to confirm they are ready to begin.

SAY: Place one hand on your heart and one hand on your belly. Now, begin to breathe in slowly through your nose and feel your belly fill up with air. Now exhale slowly through your nose.

Facilitators note: As you guide the client to breathe, observe how they are breathing and support them if they appear to be struggling.

SAY: Breathe in again, allowing your breath to travel through, down your throat and into your belly, filling your belly with air. Exhale slowly through your nose, doing your best to empty out your belly.

SAY: This time, I will count to 4 as you breathe in, and count to 5 as your breathe out. Inhale through your nose at my count of 1-2-3-4, and exhale slowly through your nose at my count of 1-2-3-4-5.

DO: Repeat this inhale and exhale at least 2 more times.

SAY: Now, come back to your regular breath. Notice how you feel after taking these deep belly breaths.

DO: Give the client time to come back to their normal breath and notice how they are feeling. If the clients eyes are closed, you can gently tell them to open their eyes whenever they are ready.

ASK: How was this breathing exercise for you?

DO: Ask the additional reflection questions below as needed.

- How did you feel when taking these big belly breaths?

- What did you notice in your body when doing these breaths?
- What did you notice about your thoughts, feelings, or how you felt physically when doing these breaths?
- How do you feel now after doing these breaths?
- What do you think this type of breathing can help with? How might you use these deep breaths?

DO: Validate the client's reflections and ask whether they would like to add deep belly breathing to their coping plan. Update the client's coping plan as needed to help them remember this activity.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we practiced today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.

Annex 4.4.5.2: Box Breath

Objective	For the client to be able to create a sense of calm, regulate breathing, and become aware of the connection between emotions and breath.
Time	10 minutes
Materials	None
Participant(s)	Client
Preparation	The caseworker should practice leading this exercise with another caseworker or supervisor and receive feedback before using with clients.

Facilitators note: The first time this activity is used, it should be done in a quiet, calm setting to allow focus and undisturbed practice. Stop the activity or discontinue use if the client reports starting to feel anxious or overwhelmed while doing the breathing activity.

Instructions

DO: Use a calm, gentle voice. Speak slowly and clearly.

SAY: We will do a breathing exercise called box breath. This breathing exercise can help you to:
- Slow down your breathing
- Feel calmer
- Feel refreshed

EXPLAIN: To do the box breath, we will repeat a pattern with our breath. We will inhale to a count of 4, hold our breath to a count of 4, exhale to a count of 4, and then hold our breath again to a count of 4. The reason it is called 'box breath' is because it is helpful to visualize or draw a box or square in the air with your finger to guide your breathing.

SAY: Watch as I give an example. You do not have to try this breath yet. Just watch.

Facilitator note: Demonstrate the breathing exercise to the client by doing the box breathe while saying aloud the following and gesturing with your finger according to the directions below in parenthesis. Take the same amount of time for each step of the pattern noted above.

SAY: Inhale..2....3.....4 (DO: Using your finger, slowly draw a vertical line in the air moving from bottom to top. I.e., your finger should slowly move up in a line as you count. Stop when you get to 4.)

SAY: Hold..2...3....4 (DO: Use the same finger and start at the point you just stopped at above to slowly draw a horizontal line in the air from left to right. Stop when you get to 4.)

SAY: Exhale.. 2... 3....4 (DO: Use the same finger and start at the point you just stopped at above to slowly draw a vertical line in the air from top to bottom. I.e., Your finger should slowly move down in a line as you count. Stop when you get to 4.

SAY: Hold..2...3....4 (DO: Use the same finger and start at the point you just stopped at above to slowly draw a horizontal line in the air from right to left. Stop when you get to 4. The result from each step of the breathing exercise is that you should have drawn a box or square in the air.)

DO: Repeat the example for the client.

SAY: Sometimes this breath can make you feel slightly nervous or anxious, especially on the holds. If this starts to happen, you can return to a normal breath and start the box breath again whenever you are ready.

ASK: Are you ready to try the box breath exercise?

SAY: Find a seated position that feels comfortable, where you can sit with little movement, similar to how I am sitting.

Facilitator note: Show your seated position. If seated on chair, make sure that you are seated comfortably upright with both your feet firmly touching the floor. You can roll your shoulders back to show the client how they might get more comfortable in their seat. If you are seated on the floor, you can sit on a pillow or mat to get more comfortable and have your hands resting gently on your legs.

EXPLAIN: That the client should make any adjustments to be comfortable. Adjust as needed to find a seated position that is comfortable and allows them to sit upright with a straight spine (if physically able) but without being stiff or tense.

SAY: This first time, find one spot in front of you to gently gaze at. If you want to close your eyes after this first round, you can.

SAY: First, let's take a big inhale together.

Facilitator note: Take a big big breath in through your nose while using body language to encourage the client to follow you in taking a big breath in.

SAY: Now a big exhale together.

Facilitator note: Take a long, slow exhale out through your nose while using body language to encourage the client to follow you in taking a big breath out.

SAY: Great. Now we will start the box breath exercise on our next breath and do it 5 times together. You can either make the box in the air with your finger like me, or watch my finger as I create the box.

Facilitators note: Draw the box with your finger in the air as you provide the breathing instructions below.

SAY: Starting our box breath:
- Inhale...2...3...4
- Hold...2...3....4
- Exhale...2....3...4
- Hold...2...3....4

Facilitator note: Repeat this exercise 4 more times with the client, observing the client to see that they are following along without confusion or anxiety. If you observe that the client is confused or anxious, pause the breathing exercise and check-in with them.

SAY: Now return to a normal, easy breath.

DO: If the clients eyes are closed, invite them to open their eyes when they are ready.

SAY: Now that you have returned to your regular breath, notice how you feel after doing the box breath.

ASK: What did you notice?

DO: Allow the client space and time to reflect.

Facilitator note: If the client needs support reflecting, you can use these additional prompts for reflection:

- *What did it feel like when you took these breaths?*
- *How does it feel now that you have returned to a normal breath?*
- *What emotions did you feel when you were doing the box breath exercise?*
- *How do you feel now that you have completed the box breath exercise?*

DO: Give the client time to respond.

ASK: How did you feel about doing this activity?

DO: Give the client time to respond.

ASK: Do you think you would try using this at home?

> *IF YES, SAY:* This activity can bring up a lot of different emotions. You may notice more if you do it again. Practice will help you remember how to do the box breath at home. Would you like to practice again right now?
> DO: Another round of the box breath exercise with the client, inviting them to close their eyes if they wish.
> ASK: How did it feel doing another round?
> DO: Give the client time to respond.
> ASK: Would you like to add the box breath exercise to your coping plan?
> DO: Update the client's coping plan as needed to help them remember this activity.
> *Facilitators note: Go to the "Activity Homework / Follow-up" section.*
>
> *IF NO, SAY:* This activity can bring up a lot of different emotions. You may notice something different if you do it again. Would you like to try it again to see if your feelings or experience change?
> DO: Practice the breath at least once more unless they have a severely negative reaction to it or really strongly do not want to do it again. If the client is willing to practice the breathing exercise again, continue to the prompts below. If the client has a severely negative reaction or strongly does not want to do the breathing exercise again, do not push them to do the exercise again. Validate their reaction/experience.
> ASK: Do you feel comfortable sharing what made the exercise challenging/ difficult/ uncomfortable?
> *Facilitator's note: For the highlighted words above, replace them with the words the clients used or the sentiments they shared about the activity.*

DO: Validate their response.

SAY: Thank you for being willing to try this breathing exercise out. Not all activities work for everyone since we are all unique with different experiences. We can make note in your coping plan that this was not the most helpful exercise for you and either try another one next time or revisit again in the future. How does that sound to you?

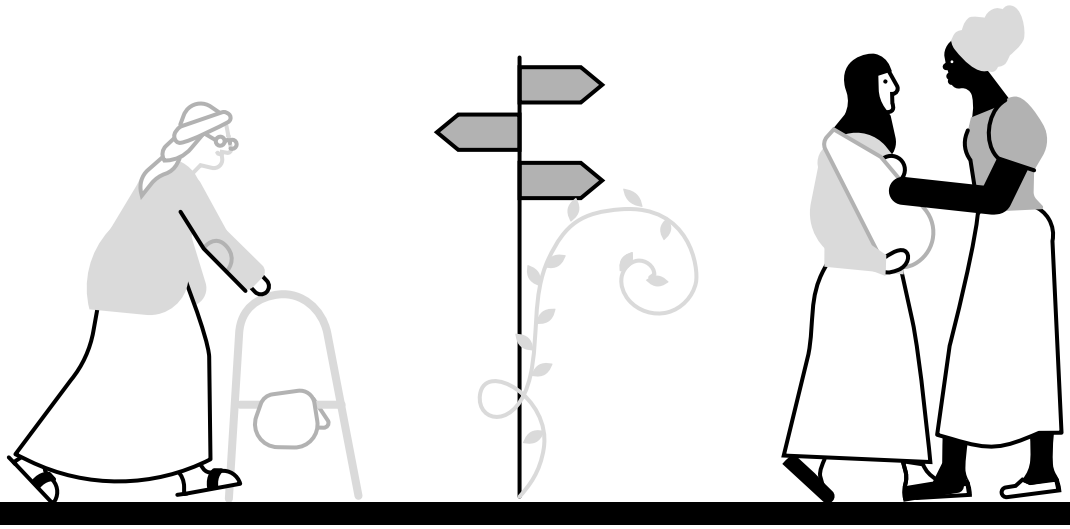
DO: Update the client's coping plan as needed to help them remember this activity.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we practiced today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.



Annex 4.4.5.3: Progressive Muscle Relaxation

Objective	For the client to become aware of the physiological impact of stress on the body, the tension they are holding in their body from stress, and to practice relaxing and releasing tension from different muscles.
Time	15 min
Materials	None
Participant(s)	Client
Preparation	The case manager should practice leading this exercise with another case worker or supervisor and receive feedback before using with clients.

Facilitators note: The first time this activity is used, it should be done in a quiet, calm setting to allow focus and undisturbed practice.

Instructions

DO: Use a calm, gentle voice. Speak slowly and clearly.

SAY: When we experience stress, our bodies respond by increasing heart rate, blood pressure, and energy supplies as a part of preparing to guard against whatever real or perceived challenges or changes that come our way. Our bodies also tighten our muscles, almost as a reflex reaction to stress, as a way of protecting our bodies against injury and pain. With the sudden onset of stress, our muscles tense up at once, and then release their tension when the stress passes. When we experience chronic or extreme stress, our bodies often struggle to release the tension even when stress passes.

Facilitators note: If you did the psychoeducation activity "Types of Stress in the Body" (Stress Session #2) with the client, you can remind them of where they identified stress in their bodies.

ASK: Have you ever experienced or seen someone experience this kind of muscle tension before in reaction to a stressful event?

DO: Give the client time to reflect and respond. Validate the client's response.

SAY: To help reduce stress and tension in your body and ease overall anxiety, we are going to do an exercise called progressive muscle relaxation. We will slowly tense and then relax different muscles in our bodies.

EXPLAIN: This is something that works best when it is practiced frequently. With practice, you will likely become more aware of when your body feels tense, where tension is held in your body, and how you can help release that tension.

SAY: During this exercise, I will ask you to tense different muscles or body parts. Tighten the muscles but do not strain so hard it becomes painful. If you have any injuries or pain in any of the areas mentioned, you can skip that area of your body. Do your best to pay attention to releasing the tension and how each muscle feels after you release the tension.

ASK: Do you have any questions?

DO: Give the client time to ask any questions. If the client has questions, do your best to answer before moving on.

SAY: Let's begin. Find a seated position that feels comfortable, where you can sit with little movement, , similar to how I am sitting.

Facilitator note: Show your seated position. If seated on chair, make sure that you are seated comfortably upright with both your feet firmly touching the floor. You can roll your shoulders back to show the client how they might get more comfortable in their seat. If you are seated on the floor, you can sit on a pillow or mat to get more comfortable and have your hands resting gently on your legs.

EXPLAIN: The client should make any adjustments to be comfortable. Adjust as needed to find a seated position that is comfortable and allows them to sit upright with a straight spine (if physically able) but without being stiff or tense.

SAY: You can close your eyes while we practice this breathing exercise or you can find an object to focus your gaze. Do whichever feels most comfortable to you.

Facilitators note: Do the progressive muscle relaxation together with the client as your say aloud the steps so that they can watch and learn from you.

SAY: Focus on your breath. Begin by taking a deep breath in through your nose and filling your lungs and belly. Hold your breath for a few seconds.

DO: Pause briefly.

SAY: Release your breath slowly through your nose and let the tension from holding your breath leave your body.

DO: Pause briefly.

SAY: Take another deep breath through your nose and hold it.

DO: Pause briefly.

SAY: Release your breath slowly again through your nose.

DO: Pause briefly.

SAY: Now breath in through your nose again even slower. Fill your lungs and belly and hold your breath.

DO: Pause briefly.

SAY: Slowly release the breath. As you breathe out, imagine all of the tension leaving your body.

DO: Pause briefly.

SAY: Keep taking slow, deep breaths in and out as we move through the rest of this exercise.

DO: Pause briefly.

SAY: Now begin to focus your attention on your feet. Curl your toes and the arches of your feet to tense them. Hold the tension and notice what it feels like for you.

DO: Pause for 5-10 seconds.

SAY: Release the tension from your feet. Notice how your feet feel after releasing.

DO: Pause briefly.

SAY: Move your attention to your lower legs. Tense the muscles in the back of your lower legs. Hold them tightly. Pay attention to the feelings as you hold this tension.

DO: Pause for 5-10 seconds.

SAY: Release the tension from your lower legs. Again, notice how your legs feel now and any feelings of relaxation.

DO: Pause briefly.

SAY: Now tense the muscles in your upper legs and hips. Squeeze your legs and thighs together to bring tension into your upper legs. Be sure to avoid straining your muscles.

DO: Pause for 5-10 seconds.

SAY: Release. Let the tension leave your legs.

DO: Pause briefly.

SAY: Move to your stomach and chest. Bring tension into these parts of your body by drawing your stomach in as you exhale and squeezing. Hold this as you breathe. Keep holding.

DO: Pause for 5-10 seconds.

SAY: Release. Allow your whole body to go limp if you can. Notice any feelings coming up.

DO: Pause briefly.

SAY: Continue taking deep breaths. Breathe in slowly and out slowly, noticing the air filling your lungs and belly, and then slowly leaving your belly as you exhale.

DO: Pause briefly.

SAY: Now, tense the muscles in your back by squeezing your shoulders towards each other behind you. Hold them tightly. Tense them as much as you can without straining. Keep holding.

DO: Pause for 5-10 seconds.

SAY: Release the tension in your back. As you feel the tension leaving, notice new feelings of relaxation that may come up. Notice how different it feels to hold the tension and then release it.

DO: Pause briefly.

SAY: Move to your arms – focus from your hands all the way to your shoulders. Make fists with your hands and squeeze tightly. Bring that tension all the way up your arms. Hold it.

DO: Pause for 5-10 seconds.

SAY: Release your arms and hands. Notice how different they feel as you release. Remember to keep taking deep breaths.

DO: Pause briefly.

SAY: Now move to your shoulders and neck. Squeeze your shoulders tightly up to your ears and hold it.

DO: Pause for 5-10 seconds.

SAY: Release your shoulders. Notice how different they feel as you release.

DO: Pause briefly.

SAY: Now tense your face by making an angry face or scrunching your eyes and mouth in. Clench your jaw to bring tension to your neck. Remember to avoid strain and pain.

DO: Pause for 5-10 seconds.

SAY: Release the tension again.

DO: Pause briefly.

SAY: Now we will tense our entire bodies. Tense feet, legs, stomach, chest, arms, back, shoulders, neck, and head. Hold everything.

DO: Pause for 5-10 seconds.

SAY: Release everything. Allow your whole body to go limp and sink into the chair. Pay attention to how your body feels now. Notice how this feels different from the tensing you were just doing.

DO: Pause for 5-10 seconds.

SAY: Begin to move your body gently and bring awareness to this space. Take any movements or stretches and come back to a comfortable seated position.

DO: Guide the client in reflecting on the progressive muscle relaxation exercise. Some suggested questions to guide the client's reflection are below. If asking more than one question, pause and give the client time to reflect and answer and validate them before moving on to the next question.

- How did you feel when tensing your muscles?
- What did you notice in your body when doing this?
- What differences did you notice when you released?
- What did you notice about your thoughts, feelings, or how you felt physically while doing this exercise?
- How do you feel now?
- How might you use this exercise in the future?

ASK: Would you like to add the progressive muscle relaxation exercise to your coping plan?

DO: Update the client's coping plan as needed to help them remember this activity.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we practiced today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.

Annex 4.4.5.4: Five Senses to Ground

Objective	To support the client to stay in the present and gain a sense of calm when experiencing distressing thoughts and difficult emotions such as fear, anxiety, and overwhelm.
Time	10 minutes
Materials	A small cookie or refreshment to be able to taste. (This can be done without using taste if no refreshments are available.)
Participant(s)	Client
Preparation	Ensure if possible there are 4 things to touch with different textures and at least two things that smell differently/distinct. The caseworker should practice leading this exercise with another caseworker or supervisor and receive feedback before using with clients.

Facilitators note: Do not actively try to teach what the activity does or its purpose with someone actively in crisis or emotionally overwhelmed.

Instructions

DO: Use a calm, gentle voice. Speak slowly and clearly.

SAY: Many people who experience stress, including chronic and extreme stress, find grounding very helpful. Grounding is an exercise we do to turn our attention to the outside world and present moment, and to shift away from our inner world of overwhelm, anxiety, fear, or other difficult emotions and feelings. In this grounding exercise called the 'Five Senses', we will focus our attention away from our difficult feelings by focusing our attention even more strongly on the outside world.

ASK: Do you have any questions before we practice this grounding exercise?

DO: Give the client time to ask questions and answer to the best of your ability.

SAY: Let's begin. First, find a seated position that feels comfortable, where you can sit with little movement, similar to how I am sitting.

Facilitator note: Show your seated position. If seated on chair, make sure that you are seated comfortably upright with both your feet firmly touching the floor. You can roll your shoulders back to show the client how they might get more comfortable in their seat. If you are seated on the floor, you can sit on a pillow or mat to get more comfortable and have your hands resting gently on your legs.

EXPLAIN: The client should make any adjustments to be comfortable. Adjust as needed to find a seated position that is comfortable and allows them to sit upright with a straight spine (if physically able) but without being stiff or tense.

SAY: For this exercise, I will ask you to keep your eyes open the entire room and to look around the room as much as you like. I will guide you by ask you questions focused on items that are in the room around you. Remember, you are always in control.

ASK: Are you ready to begin?

DO: Give the client time to respond yes.

ASK: First, can you look around the room and name 5 things you see?

SAY: For example, look for small details such as a pattern on the ceiling, the way light reflects on the floor or an object you don't easily notice.

DO: Give the client time to look around the room and name 5 things they see.

ASK: Now can you name 4 things you can feel or touch?

SAY: For example, notice the feeling of the breeze or fan on your skin, the feeling of the chair or pillow you are sitting on... or you can pick up an object and examine its weight and texture. Try to feel four different things.

DO: Give the client time to identify and describe how 4 different things feel to their touch.

ASK: Now, can you name 3 things you can hear?

SAY: For example, try to hear sounds you may not normally pay attention to - the sound of the wind blowing the leaves on the trees, voices of people talking outside, the buzz of traffic in the distance. Try to hear three different things.

DO: Give the client time to listen and name 3 different things they hear.

ASK: Now, can you list 2 things you can smell?

SAY: You can try to notice smells in the air around you or search for something that has a scent, such as a bar of soap, toothpaste, or a marker. Try to smell 2 different things

DO: Give the client time to identify 2 things to smell and to describe the smell to you.

Facilitator note: Make sure you have some small snack for the next step – for example: gum, candy, or biscuits.

DO: Give the client a snack or present a few snacks for them to choose from.

ASK: Finally, can you list 1 flavor you can taste in this snack?

DO: Give the client time to taste the snack.

SAY: Focus your attention closely on the flavors.

ASK: What is the most prominent one?

DO: Give the client time to respond.

ASK: Do you notice other flavors as time goes on?

SAY: Great job.

ASK: How did it feel to complete this activity?

DO: Give the client time to respond.

SAY: You can do this activity any time you feel overwhelmed, anxious, or just stuck in the difficult emotions and feelings you are experiencing.

ASK: Would you like to this exercise to your coping plan?

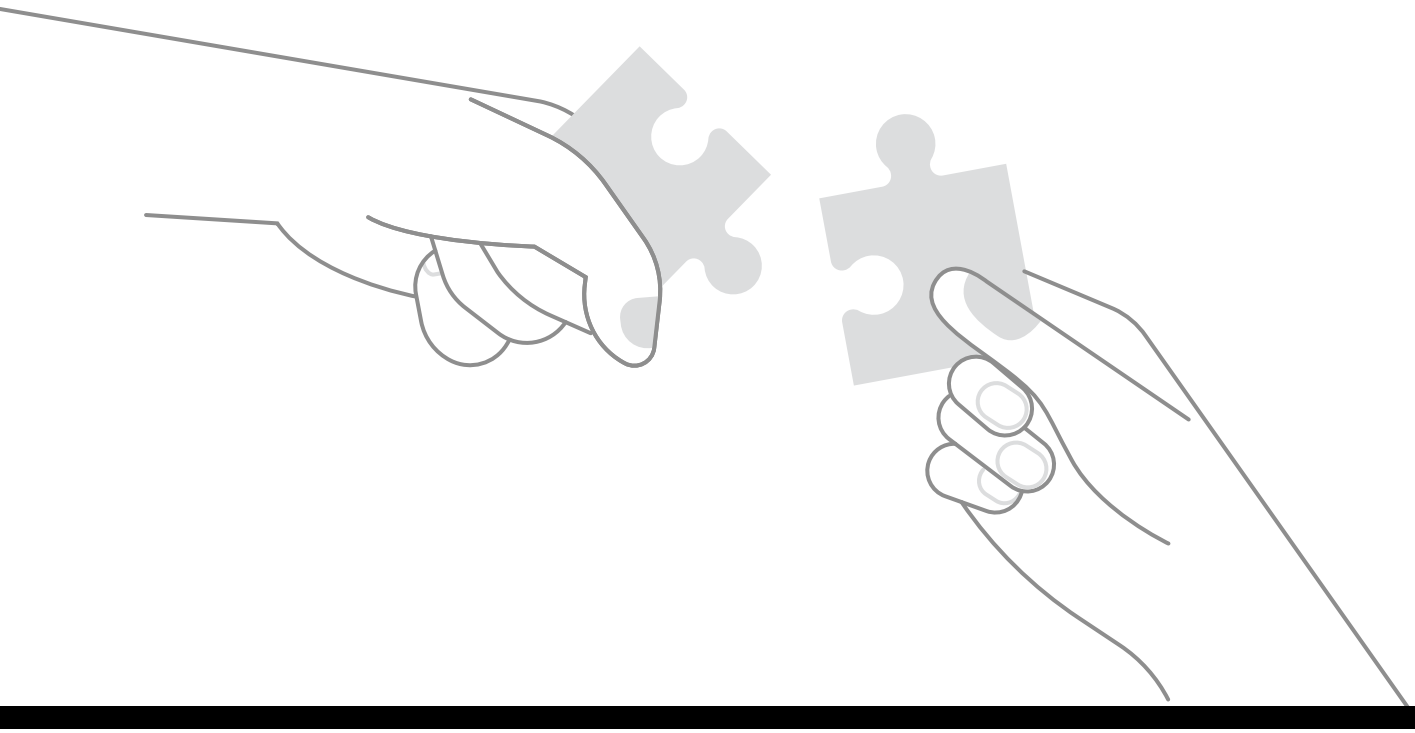
DO: Update the client's coping plan as needed to help them remember this activity.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we practiced today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.



Annex 4.4.5.5: Grounding Objects

Objective	To support the client to stay in the present and and gain a sense of calm when experiencing distressing thoughts and difficult emotions such as fear, anxiety, and overwhelm.
Time	15 minutes
Materials	Paper, pens or pencils, and a few examples of grounding objects such as a smooth stone, a stress ball, a key chain, small piece of cloth, etc. that can easily be held in a hand or pocket
Participant(s)	Client
Preparation	The caseworker should practice leading this exercise with another caseworker or supervisor and receive feedback before using with clients. Make sure to have a few examples of grounding objects on hand for the client to see and touch.

Facilitators note: Do not actively try to teach what the activity does or its purpose with someone actively in crisis or emotionally overwhelmed.

Instructions

DO: Use a calm, gentle voice. Speak slowly and clearly.

SAY: Many people who experience stress, including chronic and extreme stress, find grounding very helpful. Grounding is an exercise we do to shift away from our inner world of overwhelm, anxiety, or other difficult emotions, and to shift our attention to the present moment. There are many different types of grounding exercises.

DO: Pause to see if the client has any reflections or questions.

SAY: One way to ground when we feel difficult emotions is to have a grounding object with us.

Grounding objects provide a tangible anchor to the present moment, helping us to shift away from our overwhelming emotions and intrusive thoughts.

EXPLAIN: Grounding objects can distract you from distressing thoughts or feelings by redirecting your attention to something concrete and immediate. Grounding objects can also have a calming effect when held or touched (depending on what the object is). Grounding objects can also serve as a reminder of the present moment and reality, to help you anchor in the here and now. Finally, touching or holding a grounding object can provide physical sensations that counteract the intensity of your emotions. Overall, grounding objects offer a simple yet effective way to manage emotions by providing a physical anchor to the present moment and offering comfort and distraction.

ASK: Do you have any questions about grounding objects?

DO: Give the client time to ask questions and answer to the best of your ability.

SAY: Today, we will brainstorm on what might be a helpful grounding object for you.

EXPLAIN: Identifying a grounding or soothing object is a personal process since different objects hold different meanings and calming effects for different individuals.

SAY: First, think about the things that usually bring you comfort or joy. This could be a particular texture (e.g., something soft or smooth or cold), scent, or shape. Reflecting on what has helped you feel comfort or calm in the past can guide you. I also have a few objects here that you can try touching and holding to see if you feel a positive sensation. I purposely chose objects that are small enough to be held in your hand or in your pocket, as it is helpful to have a grounding object that you can easily carry around with you and access whenever you need it without causing too much attention from others.

DO: Give the client time to reflect and to touch and hold the grounding objects.

SAY: Did anything come to mind that you feel comfortable sharing with me?

DO: Make note of what the client says and affirm them.

SAY: Great. Now, I would like you to pay attention to your senses and to think about objects that appeal to your sense of touch, smell, sight, or even taste. For example, a smooth stone to hold, a scented candle, a visually pleasing piece of artwork, or a piece of chocolate could all serve this purpose.

DO: Give the client time to reflect.

SAY: Did anything come to mind that you feel comfortable sharing with me?

DO: Make note of what the client says and affirm them.

SAY: You can also think about objects that may hold sentimental value for your or remind you of positive experiences. These can be particularly effective at providing comfort and grounding during stressful times. Can you think of such an object?

DO: Give the client time to reflect and respond.

SAY: Now that you have reflected on objects that bring you comfort or joy, objects that appeal to your senses, and objects that hold sentimental value, can you think of any objects you could easily carry around with you that could help you soothe and ground?

DO: Give the client time to reflect and respond.

EXPLAIN: If the client is having difficulty thinking of possible grounding objects, encourage them to try out the different objects you brought or other objects around the room to see how they make them feel. There may be objects that have an unexpected calming effect on them.

DO: If the client still has difficulty, give them the option of trying out one of your grounding objects for the week that is easily replaceable (e.g., smooth stone) or exploring in their home for one.

Facilitators note: If the client chooses to look for a grounding object at home, you can suggest the remaining part of this exercise for homework. If the client chooses one of your objects, you can continue with the rest of the exercise or allow them to bring the object home with them and to do the rest of the exercise for homework.

SAY: Once you have identified a potential grounding object, spend some time with it (holding, touching, and looking at it) and notice how your body responds to it. Notice whether you feel more relaxed, centered, or focused when holding or interacting with it.

EXPLAIN: If the object feels comforting and calming, then it is likely a good choice for a grounding object. You can try carrying it with you and interacting with it (holding, touching, looking) whenever you begin

ASK: Do you have any questions about the grounding object?

DO: Give the client time to ask questions and respond as best you can.

ASK: Would you like to this exercise to your coping plan?

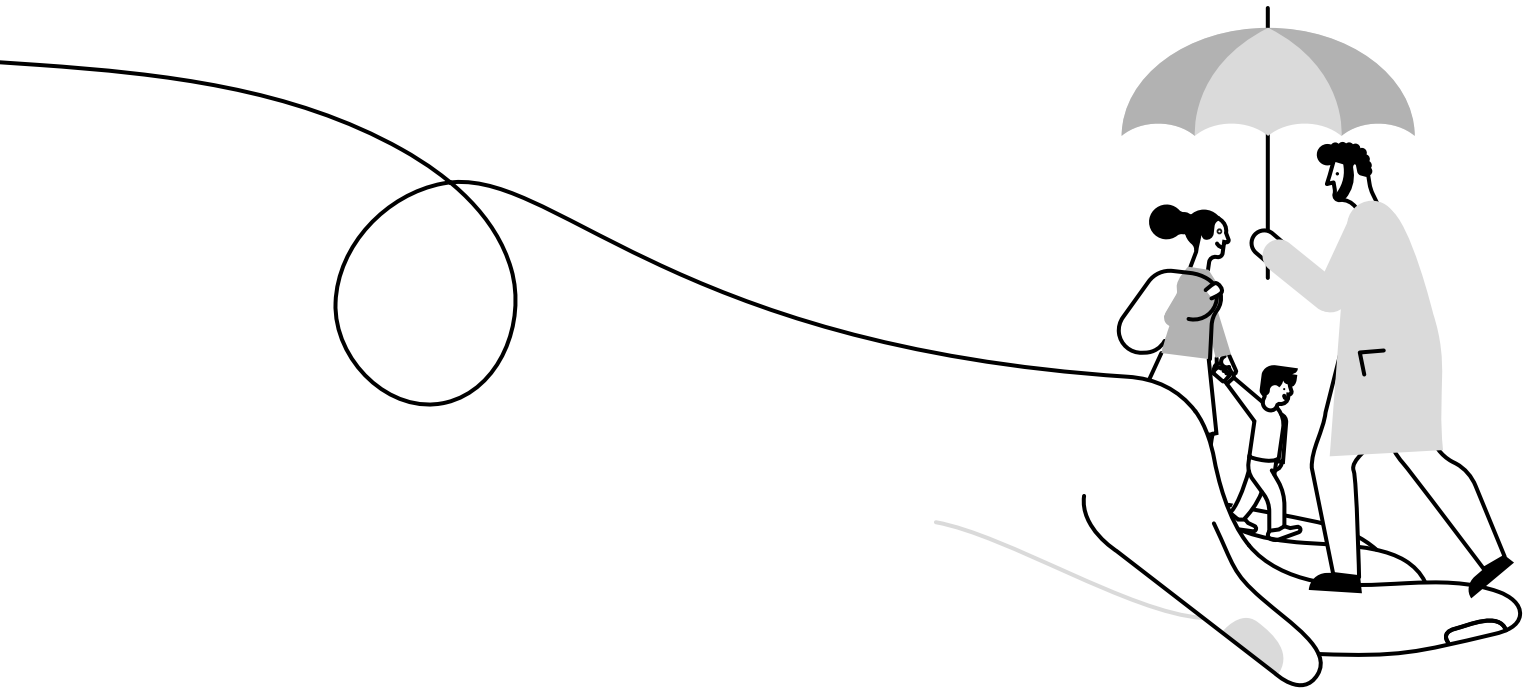
DO: Update the client's coping plan as needed to help them remember this activity.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we practiced today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.



Annex 4.4.5.6: Identifying Sources of Stress

Objective	To support the client in identifying sources of stress in daily life and the emotions that arise from those sources of stress.
Time	15 minutes
Materials	Blank paper or 'Identifying Sources of Stress' activity sheet, pens or pencil
Participant(s)	Client
Preparation	The caseworker should practice leading this exercise with another caseworker or supervisor and receive feedback before using with clients.

Facilitators note: Do not actively try to teach what the activity does or its purpose with someone actively in crisis or emotionally overwhelmed.

Instructions

Facilitator note: It will work best to use this activity after doing the psycho-education session on 'Understanding Stress' and potentially after 'Our Brains and Extreme Stress'.

DO: Introduce this activity to the client.

SAY: We are going to work on identifying sources of stress in your life right now that you feel disrupt your daily activities or emotionally overwhelm you. Right now, we are focusing on identifying those sources of stress and how they make you feel. We will use this to identify areas you want to focus on as we build your coping plan.

ASK: Are you ready to begin?

SAY: Think about each of the questions I ask and write down what first comes to mind. When you are finished, you can decide if you want to discuss what you have written or if you want to move on.

Facilitator's note: If the client has limited literacy, you can write for them as they speak as long as they feel comfortable to do so.

DO: Go through each of the questions on the activity sheet 'Identifying Sources of Stress'. If the client is comfortable, discuss and ask follow-up questions about their answers, including their thoughts and feelings about these experiences. This will help when adding to their coping plan.

ACTIVITY SHEET: Identifying Sources of Stress

Starting with what feels most stressful: What happened/is happening that feels stressful for you?

When did it last happen?

- ☐ Today
- ☐ Yesterday
- ☐ This week
- ☐ This month
- ☐ This year
- ☐ Other:

How often does it happen?

- ☐ Hourly
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ So often I lose track
- ☐ Other

How does it make you feel when it happens?

- ☐ Angry
- ☐ Disappointed
- ☐ Frustrated
- ☐ Sad
- ☐ Hurt
- ☐ Lonely
- ☐ Guilty
- ☐ Shameful
- ☐ Scared
- ☐ Weak
- ☐ Tired
- ☐ Worried
- ☐ Confused
- ☐ Unsafe
- ☐ Other:

How does it make you feel when you think about it now?

Which feelings do you feel able to manage or handle when they come up?

Which feelings do you feel unable to manage or handle when they come up?

Repeat for additional sources of stress as needed.

Additional sources of stress: What happened/is happening that feels stressful for you?

When did it last happen?

- ☐ Today
- ☐ Yesterday
- ☐ This week
- ☐ This month
- ☐ This year
- ☐ Other:

How often does it happen?

- ☐ Hourly
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ So often I lose track
- ☐ Other

How does it make you feel when it happens?

- ☐ Angry
- ☐ Disappointed
- ☐ Frustrated
- ☐ Sad
- ☐ Hurt
- ☐ Lonely
- ☐ Guilty
- ☐ Shameful
- ☐ Scared
- ☐ Weak
- ☐ Tired
- ☐ Worried
- ☐ Confused
- ☐ Unsafe
- ☐ Other:

How does it make you feel when you think about it now?

Which feelings do you feel able to manage or handle when they come up?

Which feelings do you feel unable to manage or handle when they come up?

For all identified sources of stress:

Who can help you? How might they help you?

What do you do to help yourself when this happens?

Do you feel able to handle or manage this? ☐ I think I am able to manage these issues ☐ I think I need some help to manage these issues ☐ I think I need a lot of help to manage these issues.	If client feels like they need some help or need a lot of help, ask: What can I or others do to help?	
	Actions: 1 2 3 4	Who:

DO: Update the client's coping plan as needed according to identified sources of support and agreed upon actions.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we practiced today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.

Annex 4.4.5.7: Identifying Sources of Support

Objective	To help the client identify people and resources in their lives that provide support in times of need and with identified stressors/issues.
Time	15 minutes
Materials	Pens or pencils, coping plan
Participant(s)	Client
Preparation	The caseworker should familiarise themselves with Part I and Part II of the coping plan as this serves as a foundation for this activity. The caseworker should also review the client's protection risk assessment to build off of what the client has shared. The caseworker should practice leading this exercise with another caseworker or supervisor and receive feedback before using with clients.

Facilitators note: Do not actively try to teach what the activity does or its purpose with someone actively in crisis or emotionally overwhelmed.

Instructions

SAY: We have been talking about the issues that brought you in to seek support and other issues that are concerns for you.

EXPLAIN: That we want to identity which issues feel the most pressing to the client.

ASK: What things/people/situations are causing you stress right now? What happens when these things happen?

ASK: How do these issues impact you day-to-day?

DO: Give the client time to think and answer.

ASK: Are there one or two of these issues that feel the most important to try to address right now?

DO: Give the client time to answer.

Facilitator note: If you have already completed the "Identifying Sources of Stress' activity, you can skip the questions above and share back with the client what they identified as their main sources of stress and confirm that these are the issues they would like to focus on.

SAY: Now that we have identified the sources of stress that are causing you the most overwhelm and disruption to your daily life, we now want to think about who and what sources of support you have that can help you manage these issues.

Facilitator note: If you have already completed the "Identifying Sources of Stress" activity, you can review the people they identified in that activity who can help them when they are feeling stressed, as well as the agreed upon actions at the end of the activity sheet as a starting point for this discussion.

ASK: When do you feel particularly safe or comfortable? For example, is there a particular time of day that feels more calming for you? Or, are there places you will go when feeling stressed or overwhelmed?

DO: Give the client time to answer. Then ask follow-up questions such as:
- What contributes to helping you feel more calm during that particular time of day?
- What is it about that particular place that helps you to feel comfortable/safe?
- What is usually happening during that particular time of day or in that place when you feel most calm/comfortable/safe?
- Is anyone else with you during that time of day/in that place when you feel calm/ comfortable/ safe?

DO: Reflect back what you have heard the client share. Note down (or have the client note down) the times of day, places, and people and attributes that help the client to feel calm, comfortable, and/or safe.

ASK: What activities do you do that feel supportive for you?

DO: Give the client time to answer. Then ask follow-up questions such as:
- When and how often do you do these activities?
- Who is usually present when you do these activities?
- What is it about these activities that feel supportive?

- Would the individuals present with you when doing these activities be supportive persons to speak with when you are feeling stressed?

DO: Reflect back what you have heard the client share. Note down (or have the client note down) the activities and people and related attributes that feel supportive for the client.

ASK: What resources exist in your community that feel supportive for you? For example, this could be a community center, faith-based group, or other type of organization, group, or activity.

DO: Give the client time to answer. Then ask follow-up questions such as:
- Who within this community resource feels supportive to you?
- What makes this person/these people feel supportive? What do they do that makes you feel supported?
- What specific activities do you do with this community resource that feel supportive?

DO: Reflect back what you have heard the client share. Provide a summary of supports that have been identified.

SAY: Now that you have identified these different sources of support, you can begin to think more about how you might engage these sources of support when feeling stressed.

ASK: Is there anyone listed here that you feel like could help you with “xxx” issue?

DO: Give the client time to respond. Then ask follow-up questions such as:
- How would you like them to support you?
- What specific activities or actions could they take that would be supportive?

DO: Give the client time to reflect and respond. Then reflect back what the client has shared and note down or have the client note this down as needed.

ASK: Are there any activities you identified that might could help you with “xxx” issue?

DO: Give the client time to respond. Then ask follow-up questions such as:
- How would you use these activities to support you?
- What could help you in remembering to engage in these activities when feeling stressed?

ASK: Would you like to add any of the sources of support you identified to your coping plan?

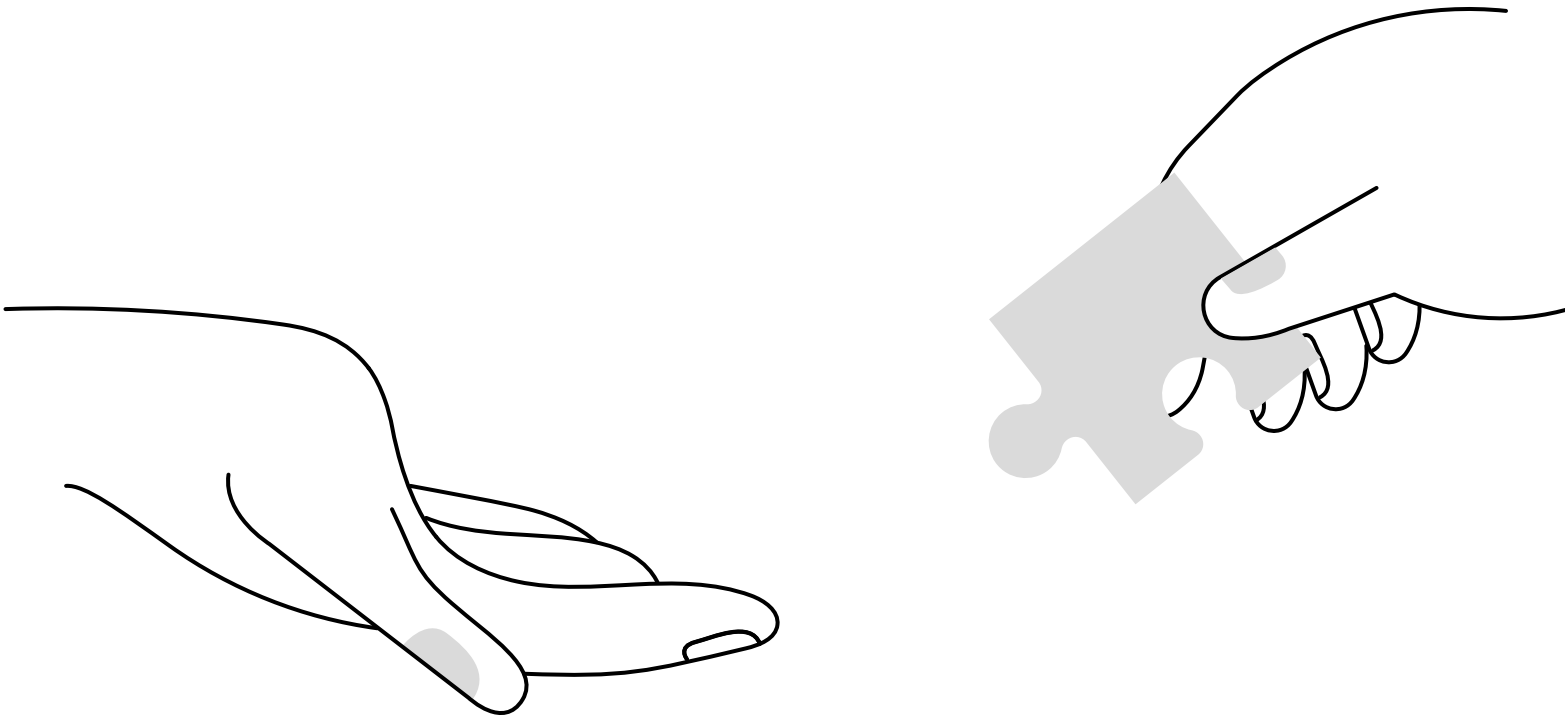
DO: Update the client’s coping plan as needed to help them remember this activity and the sources of support they identified.

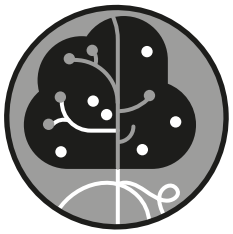
Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we practiced today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.





Annex 4.4.5.8: Identifying My Strengths

Objective	To help the client identify sources of internal strength and appreciate these qualities about themselves.
Time	15 minutes
Materials	Pens or pencils, activity sheet
Participant(s)	Client
Preparation	The caseworker should practice leading this exercise with another caseworker or supervisor and receive feedback before using with clients.

Facilitators note: Do not actively try to teach what the activity does or its purpose with someone actively in crisis or emotionally overwhelmed.

Instructions

SAY: It can be helpful to focus on our positive qualities, what we like about ourselves, and what we think we do well as a way to improve self-esteem and recognize our inherent strengths.

ASK: What is a strength of yours?

DO: Give the client time to reflect and respond.

Facilitator note: If the client has trouble thinking of a personal strength, you can use yourself as an example and say one of your personal strengths or you say the prompt below.

SAY: Our individual strengths can be hard for us to identify. This means that sometimes it is easier to think about what our friends and family would say our strengths are and decide if we too feel that these are personal strengths.

ASK: What would your family say are your strengths? What would your friends say are your best strengths?

DO: Give them a few more minutes to think and come up with answers.

Facilitator note: If the client has trouble thinking of what their family or friends might say are their strengths or positive qualities, the caseworker can name a strength they have observed about the client. Examples of strengths that are likely true of many clients are: their support-seeking behavior since they are engaged in case management services; their timeliness (if they come to case management meetings on time); their ability to take risks (since they took a risk in trusting you as the caseworker and the case management process); their respectfulness (assuming the client has been respectful to the caseworker and other staff members).

DO: Give the client a few more minutes to reflect and share additional strengths. Validate the strengths they have shared.

EXPLAIN: It can be helpful to write the strengths you have identified down on a piece of paper to remind yourself of who you are and all you can do and all you have accomplished despite significant challenges. This can be especially helpful to contradict negative self-talk and negative thoughts about yourself.

Facilitator's note: It can be helpful to discuss what negative self-talk looks like and how it can impact someone's self-esteem. You can give some examples of both positive and negative self-talk to assist the client in recognizing these patterns in themselves such as:

- *I always try my hardest. (positive self-talk)*
- *I can't do anything right. (negative self-talk)*
- *ASK: Would you like to write these strengths down or draw them on a piece of paper?*

EXPLAIN: If the client inquires about drawing their strengths, explain that they can draw themselves in a scene that shows their different strengths. They can also draw different symbols or images to represent different strengths, or draw a self portrait and put symbols of different strengths around the portrait. They could also cut pictures out of magazines or newspapers to represent themselves and their strengths. There are many options.

DO: Give the client time to write down or draw their strengths.

Facilitator's note: The caseworker can also offer to write down the strengths for the client as needed. If drawing the activity, this can also be an expressive activity.

DO: Continue to identify strengths with the client and fill out a piece of paper with either pictures or written statements. Once finished, update the client's coping plan as needed to help them remember this activity and their strengths.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we worked on today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.

Annex 4.4.5.9: Affirmations

Objective	To support the client to reduce negative self-talk and strengthen their self-esteem.
Time	20 minutes
Materials	Note cards or blank paper, pens or pencils
Participant(s)	Client
Preparation	It may be useful to complete this activity after the activity "Identifying My Strengths" because the caseworker can help the client use those strengths as a foundation for developing their personal affirmations. Prior to implementing this activity, caseworkers should prepare a list of culturally appropriate affirmations for clients to choose from if they are having difficulty creating their own affirmations. Caseworkers should practice this activity with their supervisor or peers before facilitating with a client.

Facilitation note: Do not actively try to teach what the activity does or its purpose with someone actively in crisis or emotionally overwhelmed.

Instructions

EXPLAIN: Positive affirmations are simple phrases that can be remembered and repeated. They can help change negative thoughts or feelings about yourself, can help you recognize your own strengths and what you accomplish daily, and help to move through difficult moments.

SAY: It is important to create affirmations that feel personal and true to you. An affirmation that works for someone else, may not feel authentic or effective for you.

DO: Give examples of affirmations using either personal affirmations that you are comfortable with sharing or more general affirmations that may be applicable and resonate with the client. For example, "I am talented" or "I am a caring provider for my family".

SAY: Affirmations can be helpful to use at different times during the day and in many different ways. Some of these are:

- Each morning when you get up (to start the day with a feeling you want to carry through)
- When you are preparing for a task, conversation, or experience that may be difficult for you (to help you prepare yourself mentally)
- When you are feeling intimidated or inadequate around others (to help 'reset' your mood/ emotions by reminding yourself of your strengths)

ASK: Can you think of other times affirmations may be helpful for you personally?

DO: Give the client time to reflect and respond. Reflect back what you hear from the client.

SAY: Now that we have identified times where it may be useful for you to use affirmation, we are going to identify and develop affirmations you can use during these times. I have a list of affirmations we can look at first to see if any resonate with you.

DO: Share the list of contextualized affirmations with the client for them to read or verbally share some aloud for the client to hear.

ASK: Do any of these affirmations resonate with you?

DO: Give the client time to reflect and respond. Have them mark or write down the affirmations they find helpful, or note them down for the client.

SAY: Now that we have reviewed the list of affirmations, I would like you to develop some additional affirmations for yourself. Can you come up with 3 personal affirmations?

DO: Give the client the cards or paper and give them time to reflect and write or draw their affirmations. If needed or helpful, offer to write down the affirmations for the client.

Facilitator note: People often struggle to think of positive things about themselves. If the client is having difficulty coming up with personal affirmations, below are three ways the caseworker can support the client.

1. *If the client has completed the 'Identifying My Strengths' activity, remind them of the strengths they identified as a starting point.*
2. *Help the client think about how they would talk about other people they love and admire. You can say:*
    - *Think about your best friend or your mother or father. What would you tell that person if they were doubting themself or feeling bad about themself? How would you speak to them?*

- *Now, can you think about yourself and speak to yourself the way you would speak to that person, like the good friend or family member you are to them? What would you say if you are being a good friend to yourself? How would you say it?*

3. *Use the 'Affirmations' activity sheet included at the end of this document to help the client think about and write down things they like about themself, their strengths, what others appreciate about them, and traits they are working on.*

DO: After the client has finished writing (or drawing) their affirmations, ask them to share them with you (verbally).

Facilitators note: It is important to have the client practice saying the affirmations out loud. If the client is not comfortable saying them at first, then you can read each affirmation one at a time and ask the client to repeat after you. It can be very supportive for clients to hear the affirmations out loud. If you are reading the affirmations to the client, then try to look at them in the eyes rather then looking at the paper. After you have read the client's affirmations out loud, ask them again if they are willing to practice saying them aloud on their own.

DO: Give the client time to practice saying their affirmations aloud.

ASK: How did it feel to hear / say these affirmations out loud?

DO: Give the client time to reflect and respond.

SAY: Now that you have created your affirmations and practiced them, can you commit to practicing them this week? either each morning when you wake-up, before you start a task, or when you are feeling intimidated or inadequate?

DO: Give the client time to reflect and respond. If the client is hesitant, explore the reasons for their hesitance and request that they just try it for the week to see how it goes. Once you receive their agreement to try, ask them to choose when they will try using the affirmations (each morning OR before starting a task OR when feeling intimated or inadequate). Remind the client that using these affirmations regularly and as often as possible will increase their effectiveness and impact.

ASK: Would you like to add your affirmations to your coping plan?

DO: Update the client's coping plan as needed to help them remember this activity and their affirmations..

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we worked on today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.

ACTIVITY SHEET: Identifying Sources of Stress

Think about things you like about yourself
I am....

Think about your personal strengths and what you are good at
I am....

Think about what others appreciate about you
I am....

Think about qualities or strengths you are working on or want to develop further
I am....

Annex 4.4.5.10: Quick Grounding Exercises to Manage Acute Distress

Objective	To help the client manage their distress by calming their nervous system and getting them back into their window of tolerance. These exercises can be used with a client experiencing acute distress, as well as with clients who are not in acute distress but may need additional coping strategies.
Time	5-10 minutes per grounding exercise
Materials	Chair, water (either hot or cold)
Participant(s)	Client
Preparation	The caseworker should practice facilitating these grounding exercises with their supervisor or peer before using them with a client. The caseworker must feel comfortable with facilitating all of the grounding exercises and many times because when someone is in distress or overwhelmed by emotion, it may take repetition or more than one exercise to help them calm their nervous system and get back into their window of tolerance.

Facilitators note: These grounding exercises can be used any time the client is experiencing acute distress and/or feeling detached from themselves or their surroundings, struggling to focus, and beginning to feel overwhelmed. If the client is in acute distress, do not actively try to teach what the activity does or its purpose. Rather, guide them to do the activity.

Instructions

Facilitator's note: The instructions are written for when a client is experiencing acute distress and cannot focus or calm themselves. The grounding exercises are listed in a loose order of activities to start with and move through as needed. Each exercise is labelled with a title to help differentiate from the other exercises.

DO: Speak calmly and clearly no matter how upset or distracted the client seems. Even if it seems like they cannot hear you, keep speaking to them in short, calm sentences.

SAY: I need you to look at me and focus on my voice.

Grounding Exercise 1: Deep Breathing

SAY: We are going to take 5 long, deep breaths together. We are going to breathe in through our noses and out through our mouths. Taking deep breaths can help us to calm our bodies and minds.

SAY: One – Inhale (DO: inhale slowly through your nose, observing the client to make sure they are also breathing in slowly)

SAY: Exhale (DO: exhale slowly through your mouth, observing the client to make sure they are also breathing out slowly)

SAY: Two – Inhale (DO: inhale slowly through your nose, observing the client to make sure they are also breathing in slowly)

SAY: Exhale (DO: exhale slowly through your mouth, observing the client to make sure they are also breathing out slowly)

SAY: Three – Inhale (DO: inhale slowly through your nose, observing the client to make sure they are also breathing in slowly)

SAY: Exhale (DO: exhale slowly through your mouth, observing the client to make sure they are also breathing out slowly)

SAY: Four – Inhale (DO: inhale slowly through your nose, observing the client to make sure they are also breathing in slowly)

SAY: Exhale (DO: exhale slowly through your mouth, observing the client to make sure they are also breathing out slowly)

SAY: Five – Inhale (DO: inhale slowly through your nose, observing the client to make sure they are also breathing in slowly)

SAY: Exhale (DO: exhale slowly through your mouth, observing the client to make sure they are also breathing out slowly)

ASK: Are you feeling more calm now?

Facilitator note: If the client says yes, ask if they would like to do another exercise. If the client agrees to do another exercise, move to the next exercise in this document ('Clench and Unclench Fists'). If the client does not agree to do another exercise, skip to the section of this document 'ONCE A CLIENT HAS REGAINED CALM'. If the client does not answer whether they are feeling calmer or says no, immediately facilitate the next grounding exercise with them ('Clench and Unclench Fists').

If they say no or are unable to answer your question because they are still overwhelmed, move to the next exercise.

Grounding Exercise 2: Clench and Unclench Fists
SAY: We are going to make fists with our hands. We will clench or squeeze them very tightly and then let go several times.

DO: Demonstrate making fists with both your hands, squeezing and holding them tightly for a few seconds, and then releasing them. Do this a couple of times as you explain the instructions to the client.

SAY: Do this with me now. As you squeeze your fists, try taking a deep breath in. And when you release your fists, exhale.

DO: Clench and unclench your fists while breathing in and out several times, observing the client to make sure that they are doing the exercise with you.

ASK: How are you feeling now?

DO: Wait for the client to respond.

ASK: Would you like to do another exercise?

Facilitator note: If the client says yes, ask if they would like to do another exercise. If the client agrees to do another exercise, move to the next exercise in this document ('Muscle Relaxation'). If the client does not agree to do another exercise, skip to the section of this document 'ONCE A CLIENT HAS REGAINED CALM'. If the client does not answer whether they are feeling calmer or says no, immediately facilitate the next grounding exercise with them ('Muscle Relaxation').

Grounding Exercise 3: Muscle Relaxation

SAY: We are going to try to focus on tightening all of our muscles and then relaxing them as much as possible.

SAY: First, clench all of your muscles as tightly as possible – just like you did with your hands, now do it with as many muscles as you can. Everywhere in your body from your head, to your shoulders, to your arms, to your stomach, to your legs and feet - squeeze or clench tightly and breathe in as you d this. Squeeze your whole body as tightly as possible and hold your body and breath for a few seconds.

DO: Demonstrate squeezing your whole body together while breathing in, holding your body in this clenched position as well as breath for a few seconds, and then releasing your body while exhaling so that the client has a visual understanding of what to do.

SAY: Now let's do it together. Squeeze everything in and breathe in... Hold it (pause for a couple breaths)... Now, let go of all the tension in your body and exhale deeply and forcefully as you do this.

DO: Observe the client to ensure they are doing the activity with you and to notice whether the activity is helping them to regain their sense of calm.

SAY: Let's repeat that two more times.

SAY: Clench all of your muscles as tightly as possible again, as many muscles as you can. Squeeze, squeeze, squeeze while breathing in. (DO: Demonstrate this while practising with and observing the client.)

SAY: Hold it.... (pause for a couple breaths) Now, let go of all the tension in these muscles. Breath out deeply.

SAY: One more time, clench all of your muscles as tightly as possible. (DO: Demonstrate this.)

SAY: Hold it.... (pause for a couple breaths) Now, let go of all the tension in these muscles. Exhale deeply as you you release.

ASK: How are you feeling now?

DO: Wait for the client to respond.

ASK: Would you like to do another exercise?

Facilitator note: If the client says yes, ask if they would like to do another exercise. If the client agrees to do another exercise, move to the next exercise in this document ("Anchoring Phrase'). If the client does not agree to do another exercise, skip to the section of this document 'ONCE A CLIENT HAS REGAINED CALM'. If the client does not answer whether they are feeling calmer or says no, immediately facilitate the next grounding exercise with them ('Anchoring Phrase').

Grounding Exercise 3: Anchoring Phrase

SAY: I want you to repeat after me if you can.

SAY: I am in xx place (centre name, their home, etc.). Today is (date) at (time).

DO: Let the client repeat the phrase.

SAY: Repeat after me again and this time add your name.

SAY: I am in _____ place (centre name, their home, etc.). Today is (date) at (time). My name is _____.

DO: Let the client repeat the phrase, making sure that the client add's their name. If they do not add their name, say the sentences again and ask them to say the sentences back to you, adding their name.

SAY: Great, now repeat the phrase again with your name and add your age.

SAY: I am in _____ place (centre name, their home, etc.). Today is (date) at (time.) My name is _____. I am_____ years old.

DO: Let the client repeat the phrase, making sure they add their name and age.

SAY: You can continue adding details to the phrase and repeating it until you feel calmer. You can add things like your hair colour, your job, how many children you have, etc.

DO: Let the client repeat the sentences and add additional details. After a few minutes, check-in with them to see how they are feeling.

ASK: How are you feeling now?

DO: Wait for the client to respond.

ASK: Would you like to do another exercise?

Facilitator note: If the client says yes, ask if they would like to do another exercise. If the client agrees to do another exercise, move to the next exercise in this document ("Visualization'). If the client does not agree to do another exercise, skip to the section of this document 'ONCE A CLIENT HAS REGAINED CALM'. If the client does not answer whether they are feeling calmer or says no, facilitate the next grounding exercise with them ('Visualization').

Grounding Exercise 4: Visualization

SAY: I want you to imagine an activity you enjoy doing and to describe that activity aloud to me. For example, if you like cooking a certain type of food, describe to me what the food is and how you make it. As you describe the activity to me, engage all of your senses - tell me what you see, hear, feel (or touch), taste, and smell.

ASK: Do you have an activity in mind?

DO: Give the client time to think and respond. As the client describes the activity, prompt them to engage their five senses. For example:

- What do you see?
- What do you hear?
- Is your body touching anything? How does it feel?
- Can you taste anything? Describe it to me.
- Describe to me what you smell around you.

Facilitator note: If the client is unable to visualize an activity or is having a difficult time doing so, skip to the next activity.

DO: After the client has finished describing their activity, check-in with them to see how they are feeling.

ASK: How are you feeling now?

DO: Wait for the client to respond.

ASK: Would you like to do another exercise?

Facilitator note: If the client says yes, ask if they would like to do another exercise. If the client agrees to do another exercise, move to the next exercise in this document ("Warm/Cool Water') at the end of the document. If the client does not agree to do another exercise, continue to the next section of this document 'ONCE A CLIENT HAS REGAINED CALM'. If the client does not answer whether they are feeling calmer or says no, facilitate the next grounding exercise with them ('Warm/Cool Water').

Once a client has regained calm:
DO: Take some time to talk with the client about using these activities when they are feeling overwhelmed or distressed in their everyday life.

EXPLAIN: That it is normal to feel upset, overwhelmed, and/or distressed, and that it is normal to cry and/or struggle to feel calm again. These feelings, however, can make us feel out of control and disrupt our ability to function (or complete daily tasks). It is therefore important to have tools to help us quickly regain a sense of calm.

ASK: What would it be like to use some of these activities in your home or community when you are feeling upset?

DO: Give the client time to reflect and respond.

ASK: Would it be helpful to practice a few more quick grounding exercises?

Facilitator note: If the client says yes, practice the three additional grounding exercises at the end of this document. If the client says no, move on to the following prompts.

ASK: Would you like to add any of these grounding exercises your coping plan?

DO: Update the client's coping plan as needed.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we worked on today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.

ADDITIONAL EXERCISES:

Grounding Exercise 5: Warm/Cool Water
EXPLAIN: We are going to use warm (or cool) water to focus.

DO: Either walk the client to a faucet or water pump, or set a bowl of water in front of them that they can place their hands into.

SAY: Place your finger-tips into the water. Notice how it feels.

DO: Give the client time to place their fingers into the water and to notice how it feels.

SAY: You can move your hands in and out of the water slowly. As you do, notice changes you feel in the water and out of the water. As you do this, take slow deep breaths.

DO: Let the client run their hands under the water for 1-2 minutes. Observe if they are taking the breaths. If they are not, gently encourage them to do so.

ASK: Are you feeling more calm now?

DO: Wait for the client to respond.

ASK: Would you like to do another exercise?

Facilitator note: If the client says yes, ask if they would like to do another exercise. If the client agrees to do another exercise, move to the next exercise in this document ('Name the Objects Around You') at the end of the document. If the client does not agree to do another exercise, continue to the next section of this document 'ONCE A CLIENT HAS REGAINED CALM'. If the client does not answer whether they are feeling calmer or says no, facilitate the next grounding exercise with them ('Name the Objects Around You').

Grounding Exercise 6: Name the Objects Around You

SAY: Look around the room/space/place around we are in. Name as many colors as you can that you see.

DO: Give the client time to name different colors they see until they cannot name anymore.

SAY: Great. Now name as many objects as you can.

- Facilitator note: If the client is having a hard time naming objects, ask questions about objects or things that are around you that the client can turn their attention to and see such as:
- How many trees do you see? How many clouds in the sky?
- How many windows are in this room? How many chairs?

SAY: Wonderful. Now, pick one object or thing around us and describe everything you can about it - its color, shape, how heavy it is, the smell it has, etc.

DO: Give the client time to respond. After the client has finished describing their activity, check-in with them to see how they are feeling.

ASK: How are you feeling now?

DO: Wait for the client to respond.

ASK: Would you like to do another exercise?

Facilitator note: If the client says yes, ask if they would like to do another exercise. If the client agrees to do another exercise, move to the next exercise in this document ('Counting Breaths') at the end of the document. If the client does not agree to do another exercise, continue to the next section of this document 'ONCE A CLIENT HAS REGAINED CALM'. If the client does not answer whether they are feeling calmer or says no, facilitate the next grounding exercise with them ('Counting Breaths').

Grounding Exercise 7: Counting Breaths

SAY: Count each breath you take in and out until you reach 10. Every time you notice you have been distracted by a thought, return to 1 and start over. Take slow, deep breaths as you count.

DO: Give the client time to breathe and count. Sit quietly and calmly as they do this. After they have been able to reach 10, check-in with them to see how they are feeling.

ASK: Are you feeling more calm now?

DO: Wait for the client to respond. If the client is not feeling calmer, suggest that the client take a break and continue breathing deeply. Most clients should feel better at this point, even if they still have some overwhelming emotions. The caseworker can sit with the client and when the client is ready, continue to the section 'ONCE A CLIENT HAS REGAINED CALM'. If the client is still in acute distress after taking the break and not showing any signs of feeling a little calmer, explain to the client that you would like to call your supervisor for additional support and make the call with the client there with you.

Annex 4.4.6: Creative Expression

Annex 4.4.6.1: Walking Our Emotions

Objective	To help clients connect emotions to physical sensations, improving their understanding of the mind-body connection. This activity helps clients recognize and process emotions physically, fostering a better understanding of their emotional experiences and supporting mental health and psychosocial wellbeing.
Time	15 minutes
Materials	None.
Participant(s)	None.
Preparation	This activity can be done with the client and caseworker, independently at home, or with a trusted family member or friend.

Facilitators note: Avoid using this activity with a client actively experiencing crisis. Ensure a private area for comfort. The setting should have enough space for the client to walk for 20-30 seconds at a time; a larger space is preferable, but a small room can suffice.

Instructions

Facilitator note: Caseworkers should complete the entire activity with the client.

DO: Provide a clear space for walking.

SAY: “Our emotions impact how we feel in our bodies. This activity helps us consciously experience different emotions physically. Would you like to try it now?”

If the client agrees, proceed. If not, offer an alternative activity.

EXPLAIN: We will walk around the room. As we walk around the room, I will call out different emotions. When I name/say an emotion, really try to feel that emotion and let the sensations come into your body.

Facilitators note: For each emotion that is named, walk 20-30 seconds, then return to a normal/ typical walk before moving to the next emotion. If the space you are in is small (I.e., minimal to no space to walk), then identify a different area (preferably private) that you can complete this activity.

SAY: If this activity ever becomes overwhelming, just return to your typical walk and walk slowly around the room focusing on each step you take and/or tell me that you'd like to take a break and we can shift the activity together.

SAY: First, we will both stand up. Next, we will begin walking slowly around the room.

DO: Walk with the client around the room (or outside in a private space) for 10 seconds.

SAY: Now, walk like a young child who is happy. (walk 30-45 seconds)

SAY: Return to your typical, everyday walk (walk 20-30 seconds)

Facilitators note: instruct the client to repeat the walking activity for 30-45 seconds using the following prompts – angry young child, joyful, angry, excited, sad, happy, anxious or scared, and absolute happiest. After each prompt, instruct the client to return to a typical walk for 20-30 seconds. Below is a script for reference.

SAY: Now, walk like a young child who is angry. (walk 30-45 seconds)

SAY: Return to your typical, everyday walk (walk 20-30 seconds)

SAY: Walk like you feel joyful. (walk 30-45 seconds)

SAY: Return to your typical, everyday walk (walk 20-30 seconds)

SAY: Walk like you feel angry. (walk 30-45 seconds)

SAY: Return to your typical, everyday walk (walk 20-30 seconds)

SAY: Walk like you feel excited. (walk 30-45 seconds)

SAY: Return to your typical, everyday walk (walk 20-30 seconds)

SAY: Walk like you feel sad. (walk 30-45 seconds)

SAY: Return to your typical, everyday walk (walk 20-30 seconds)

SAY: Walk like you feel happy. (walk 30-45 seconds)

SAY: Return to your typical, everyday walk (walk 20-30 seconds)

SAY: Walk like you feel anxious/scared. (walk 30-45 seconds)

SAY: Return to your typical, everyday walk (walk 20-30 seconds)

SAY: Walk like you feel your absolute happiest. (walk 30-45 seconds)

SAY: Return to your typical, everyday walk (walk 20-30 seconds).

SAY: Go ahead and sit down.

ASK: What did you notice when you were walking like you were happy? What about when you were feeling sad or angry? What sensations or feelings did you notice in your body? How did your walk change?

DO: Give them time to reflect on and then share their responses.

Facilitators note: For clients who enjoys writing, invite them to journal their reflections, give them time, and then invite them share a summary of verbally.

EXPLAIN: Emotions are not 'good' or 'bad', but they result in different sensations and reactions. Some can be more difficult to move through and return to a 'typical' state. Recognizing these can help us manage them and reduce their impact on our lives.

Facilitators note: Everyone's 'typical' state can be different. The goal is to support clients in recognizing when they are at their 'typical' state and what that feels like and also to recognize how different emotions can impact them throughout their day, week, or different times in their life. By recognizing these emotions, clients can better work to address and manage them and subsequently reduce their impact on their everyday lives.

EXPLAIN: We need to find supportive and healthy ways to process emotions and how they feel in our bodies. Different exercises and tools can help us process emotions and move those sensations out of our bodies.

ASK: Would you like to add any of what we discussed today to your coping plan?

DO: Update the client's coping plan as needed.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity. Possible homework includes:

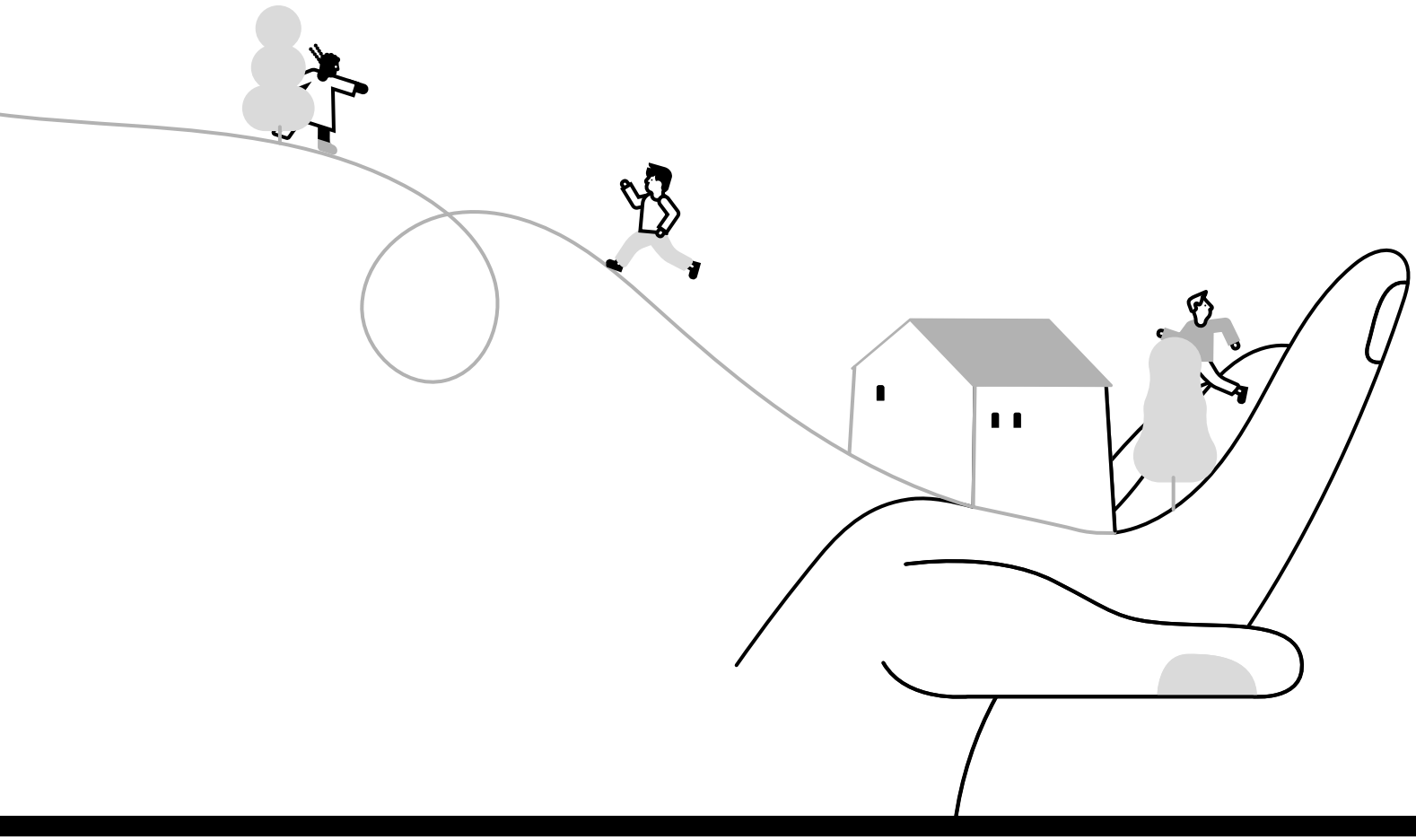
- *Noticing and connecting with how different emotions feel in their body*
- *Identifying which emotions come up most frequently and in which situations*

SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.

ASK: Do you have any questions before we do our closing activity?

Closing Exercise

DO: Select an emotional regulation activity and implement it with the client before they leave to close the session.



Annex 4.4.6.2: Traditional Song or Dance

Objective	To help clients use traditional cultural expressions to regulate emotions, express themselves, and work through difficult feelings.
Time	15 minutes
Materials	None. Optional: music.
Participant(s)	Initial introduction to this activity and practice should be completed in a private area.
Preparation	The caseworker should think of traditional songs and/or dances from their own culture to use as examples. They can brainstorm with peers to identify appropriate, contextually relevant examples of songs and/or dances for their clients.

Facilitator notes: Avoid this activity if the client is actively in crisis, presenting with signs of severe distress or has low emotional regulation and is easily triggered by memories. Consider cultural context, gender, age, and specific issues. In some cultures, certain groups (e.g., women) may not be allowed to dance, or there may be stigma around it. Adjust the activity accordingly.

Instructions

EXPLAIN: In many cultures, traditional songs and dances are a form of expression that everyone knows and loves. These expressions can be particularly helpful during difficult times. For some cultures, this type of expression may be seen as only for young children, adolescents or for specific genders, but in many cultures' song, dance, storytelling are important across ages and genders. Some songs or dances are only done during certain times or events.

SAY: We can use these songs and dances when feeling strong emotions (e.g., upset, anxious, sad, or angry) to help 'reset' ourselves, feel better, and move through those emotions. Movement is important because is important because it helps us to process and release emotions.

ASK: Are there particular songs or dances that come to mind that you enjoy and/or already use for this purpose?

DO: Give them time to answer.

ASK: How would it look if you used these intentionally to 'rest' when feeling a difficult emotion or after a difficult conversation? Could you use these during times of stress?

DO: Give them time to answer and share examples of songs and dances they have used.

Facilitator's Note: If the client says "no" to having any particular songs or dances they enjoy or do frequently, ask them to think about songs or dances they enjoyed when they were younger or if there are any that are used in their culture during times of celebrations or specific events. The client and the caseworker can work together to brainstorm ideas together. Discuss whether the client likes music and movement; if they do, but can't think of specific examples, they can collaborate to identify some suitable songs or dances.

SAY: We can practice using a song or dance right now to help 'reset' our body and mind. Would you like to do that?

Facilitators note: If yes, follow the steps below. If no, skip ahead to the section below.

ASK: Before we start, think about an emotion that you have been feeling this week that may have been difficult for you. when you are ready, tell me which emotion you want to focus on today.

Facilitators note: If the client has a hard time identifying an emotion, prompt them with examples of emotions they have mentioned during the current or prior sessions together (e.g., "earlier today, you said that you feel very frustrated and overwhelmed at the end of the day before bed because there is still so much to do and you don't have any help. Do you want to use that or a different example?)

DO: Give them time to answer.

SAY: Sit or stand comfortably. Close your eyes or focus on one point on the floor. Remember a time when you felt very [name emotion they listed]. Let yourself feel the sensation in your body that comes with this emotion.

SAY: When you are ready, begin _____ (singing or dancing the pre-selected song or dance). Sing or dance at least one full time through the (song or dance) or as long as it takes you to release the emotion. If you would like, I can join you, or I can observe or step out of the room to give you privacy.

DO: Allow the client time to complete the exercise. Join if invited, otherwise observe silently or step out of the room. Let the client decide how they want you to engage and when to end the exercise.

DO: Once they have completed the exercise, have the client sit down again if they were standing.

ASK: How do you feel now after singing or dancing.

DO: Give them time to reply.

ASK: Would you like to continue this exercise by selecting another song or dance (or repeating the same) to help 'reset' the body and mind?

ASK: follow up questions such as,

- How can you use this activity in the future?
- How will you know when would be a good time to use this activity?
- Will you use the song/dance when you start feeling overwhelming sensations in your body? (like rapid breathing, muscle tension, flush, etc).
- You can also do this alone or with family and friends. Will you use the song/dance with others during times of stress (e.g., with friends or family) or only when alone?

SAY: Today we identified one (or more) songs or dance that you can use to help regulate your emotions. I encourage you to continue to think about additional songs or dances that you want to use to help 'reset' when you are feeling different emotions. As you continue to practice this activity, you will find that some songs and dances may be more uplifting or empowering for you, while others might be more calming and grounding.

_____ If client is not comfortable practicing immediately _____

Facilitators note: If the client responds 'no', they would not like to participate in this activity at this time, then or the client has very low emotional regulation skills and is easily triggered, then the caseworker can explain the activity and encourage the client to think about potential songs or dances, but not complete the activity (i.e., practice) during this specific session.

SAY: That's okay too. We can instead identify times when it would be helpful to use different songs or dances instead of practicing now.

ASK: What are some situations where you feel intense emotions?

DO: Give the client time to think, identify and share situations.

SAY: Which of these situations would you feel comfortable singing or dancing (or listening to music) to help with the emotions you are experiencing?

DO: Give them time to answer.

ASK: follow up questions such as,

- "How will you know when to use the song/dance?"
- "Will you use the song or dance when feeling overwhelming sensations in your body?"
- "Will you use it with others or alone?"
- "Will you use it as a first response, or try other strategies first?"

ASK: Would you like to add any of what we discussed today to your coping plan?

DO: Update the client's coping plan as needed.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity. Possible homework includes:

- *Identify additional songs/dances that you can use to help yourself 're-set' when you are feeling specific emotions.*
- *Practice this activity any time you feel _____ [identified emotion or scenario] and notice sensations afterward.*

SAY: Next time we meet, we can review what we learned today, check-in on how this is working for you and discuss what is most helpful for you moving forward.

ASK: Do you have any questions before we do our closing activity?

Closing Exercise

DO: Select an emotional regulation activity and implement it with the client before they leave to close the session.

Annex 4.4.6.3: Mapping My Safe Space

Objective	To help clients identify and visualize a personal safe space where they can mentally retreat to feel secure and calm. This activity promotes a sense of safety and grounding.
Time	30 minutes
Materials	Blank paper (A4 size), coloured pencils/markers or crayons. Optional: calming background music.
Participant(s)	This activity is suitable for individual participation. It may also be adapted for use in group settings, with each participant creating their own safe space map and then sharing if they feel comfortable.
Preparation	Ensure you have enough blank paper and drawing materials for each client. Set up a quiet, comfortable space for the activity. Optional: Prepare a playlist of calming instrumental music to play softly in the background.

Facilitators note: Before beginning, ensure the client understands the purpose of the activity and feels comfortable with creative expression. Adjust the activity as needed to fit cultural contexts, individual preferences, and any disabilities. Be aware of any trauma triggers related to the concept of "safe spaces.

Instructions

Facilitator Note: Remind clients that there are no right or wrong ways to create their safe space. Encourage them to use colors and images that make them feel comfortable.

DO: Provide the client with a piece of blank paper and access to drawing materials.

SAY: "Today, we are going to create a map of a safe space—a place where you can feel secure and at peace. This can be a real place you know, or an imaginary one. It's your personal space, so it can look however you want it to."

SHOW: Demonstrate by drawing a simple example of a safe space (e.g., a community center, a room or space in their home, a friends house, a place that brings them comfort such as a river or tea house).

ASK: "What are some places or things that make you feel safe? Can you think of colors, objects, sounds, smells, or people that help you feel calm and protected?"

EXPLAIN: "Take your time to draw your safe space. Use any colors or shapes that feel right to you. This space is yours, and you can put anything in it that makes you feel safe. This can be a place that you know and go currently or a place that you create in your mind."

DO: Allow clients to work on their drawings, providing encouragement and support as needed. Play calming music in the background if you choose.

SAY: "When you're ready, we can talk about your safe space. If you'd like, you can share your drawing with me and tell me about the different parts of your safe space."

Facilitator Note: Be sensitive to the client's comfort level in sharing their drawing. Some clients may prefer to keep their safe space private.

EXPLAIN: To the client that the goal of this activity helps them to identify and visualize a personal safe space where they can mentally retreat to feel secure and calm.

ASK: "Can you think of a time recently when you felt stressed or anxious? How might imagining your safe space help you feel better in that moment?"

DO: Allow the client time to reflect and respond.

ASK: "Are there any small items or reminders from your safe space that you can carry with you or keep in your home to help you feel calm during the day?"

DO: Allow the client time to reflect and respond.

ASK: "How can you incorporate the feelings of safety and calm from your safe space into your daily routine? For example, can you spend a few minutes each day visualizing your safe space?"

DO: Allow the client time to reflect and respond.

ASK: "Would you like to add any of what we discussed today to your coping plan?"

DO: Update the client's coping plan as needed.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity. Possible follow-up could include:

- *Practice visualizing their safe space when feeling stressed or anxious.*
- *Reflect on the feelings they experience when thinking about or visualizing their safe space.*

SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.

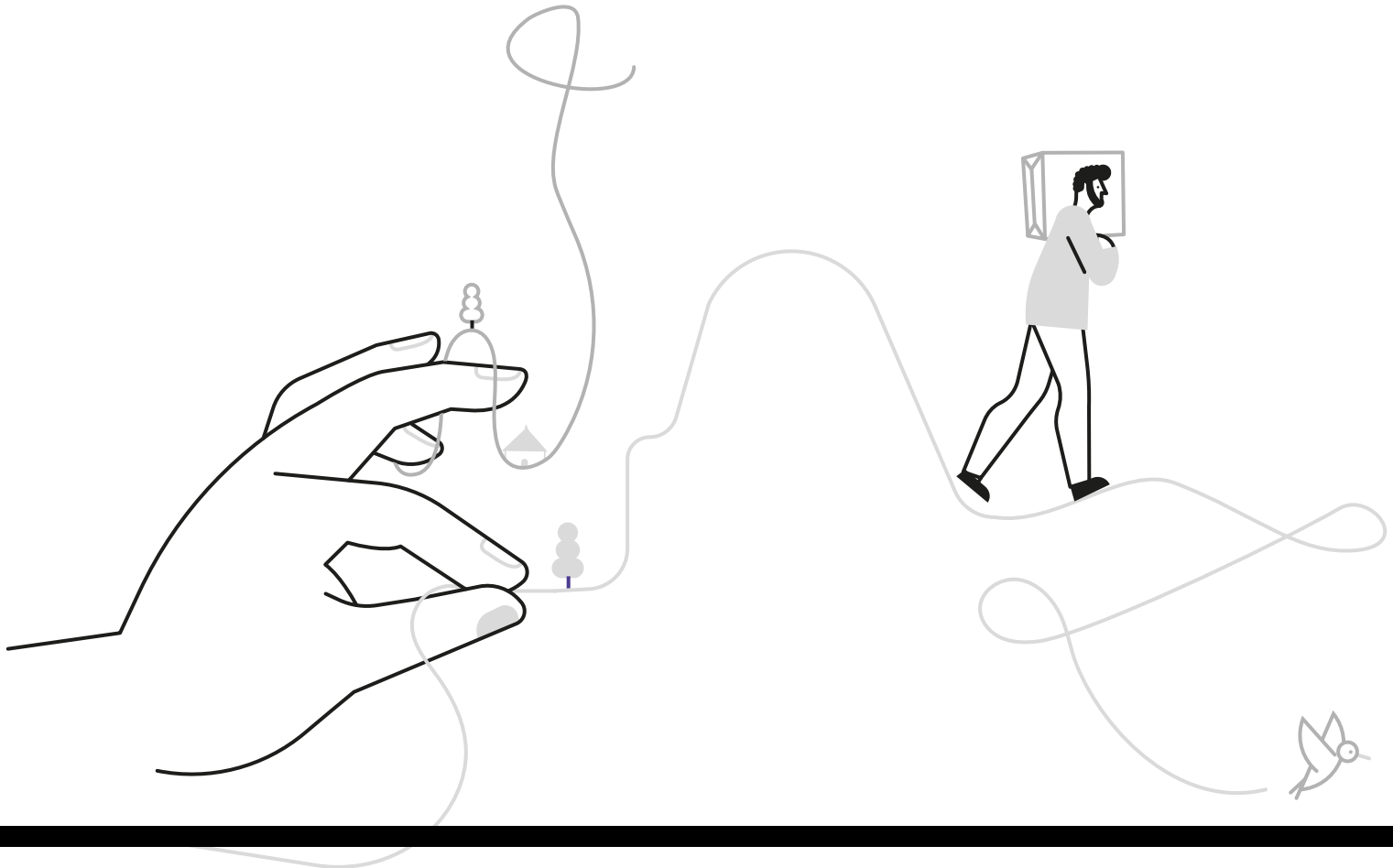
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

DO: Select an emotional regulation activity and implement it with the client before they leave to close the session.

SAY: "Let's end our session with an emotional regulation activity to help you feel calm and grounded before you leave."

DO: Guide the client through an emotional regulation activity.



Annex 4.4.6.4: Drawing Your Past, Present and Future

Objective	Client can visualize how they want life to look in the future and develop goals to reach some of that vision through reflecting on past and present circumstances, experiences, and growth.
Time	30 minutes
Materials	Paper, pens, pencils, crayons, etc. Optional to have newspapers, magazines and other similar materials to facilitate creativity and the use of pictures/words, etc. to add to drawings. If using more than drawing materials, scissors and glue/tape are necessary.
Participant(s)	Complete activity with the client and caseworker. Better for a private area. Recommended to complete with client on an individual basis.
Preparation	The caseworker should practice leading this exercise with another caseworker and / or supervisor and receive feedback before using with clients.

Instructions

EXPLAIN: that the client will have the opportunity to now reflect on challenges in the past as well as times when they felt happy and content in life, where they are now in life, and their hopes for the future.

- PAST: They can think about what it felt like in the past when they struggled vs when they felt content – what was happening? When they felt content/happy, what was life like? Who was present? What were their worries and hopes in these moments?
- PRESENT: the qualities and skills that they have now. How they have grown and changed over the years and what they like about their life and themselves right now.
- FUTURE: What do they want to bring from the past and present into their future? What do they want to leave behind? (certain emotions, feelings, fears, challenges, etc.).

SAY: We will complete this reflection exercise by using drawing (or art) as a medium. The drawing does not need to be beautiful or 'perfect'; this is not an art test! We want to reflect

and represent different emotions, experiences, strengths and challenges in whatever way you choose. If you want, you can draw people and/or use symbols to represent different ideas.

DO: Give out a few pieces of paper.

SAY: Divide your paper into three sections – in whatever way your want. (e.g., one page for each or one piece of paper divided into three sections).

EXPLAIN: In these sections write and draw:

- PAST: Consider a challenge they successfully overcame in their life in the past. Ask client to draw what skills or qualities they used to overcome this challenge as well as support and resources they may have used.
- PRESENT: Consider and draw their current positive qualities and skills and how they use them in their life right now. And any supports/resources they have right now?
- FUTURE: Consider their hopes for the future – one goal or change that they would like to work on during case management sessions.

SAY: Draw the skills, qualities, support, and resources you will need to accomplish this goal.

Facilitator note: Make sure that the client knows to choose a goal that they want to work on throughout the sessions. This is a goal that the client and caseworker can add to the clients coping plan and come back throughout their time together.

ASK: What is the same or similar between your past, present and future? What is different?

ASK: How did you feel reflecting on the goal for the future? What support do you need to reach your future goal? What do you feel like we need to focus on during case management sessions first?

ASK: How did you feel recalling the challenge you overcame and your present skills/qualities?

SAY: We can come back to these drawings throughout our time together and we will be able to add to them as we work towards your goals.

ASK: Would this be helpful for you?

- If yes, make sure to keep the drawings in their file to return to throughout the case management process.
- If no, you should still keep the drawings in their file in case they change their mind. Make sure to say that it is fine to not want to revisit this.

EXPLAIN: Drawing and other types of activities can help us think about things in new ways and uncover things we have not thought about before. We can continue doing activities like this throughout the case management process if they feel useful to you.

ASK: Would you like to add any of what we discussed today to your coping plan?

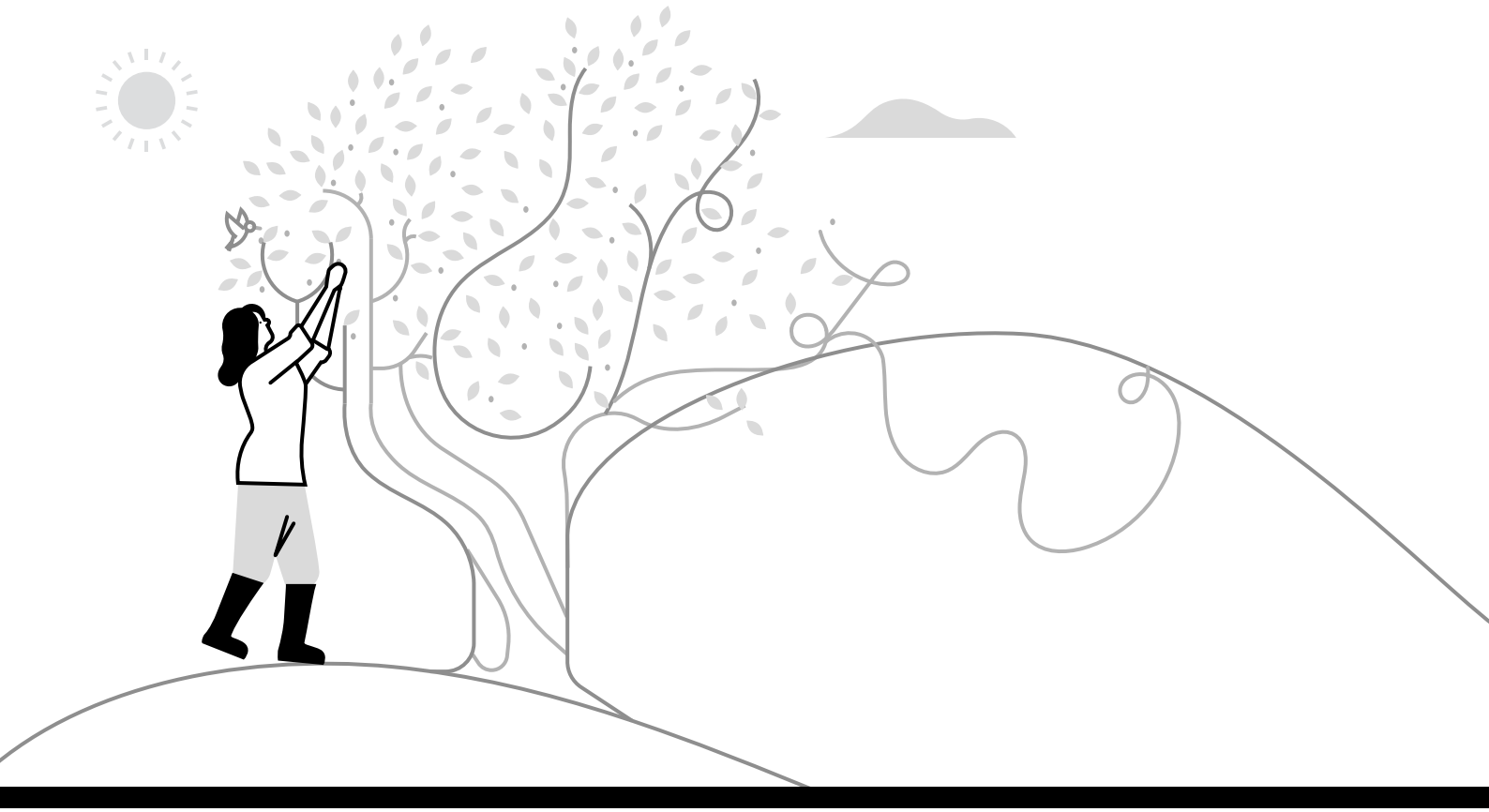
DO: Update the client's coping plan as needed.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

DO: Select an emotional regulation activity and implement it with the client before they leave to close the session.



Annex 4.4.6.5: Affirmation Cards

Objective	To strengthen self-esteem through affirmations
Time	15 - 20 minutes
Materials	Note cards, pencils, coloured pencils, markers.
Participant(s)	Complete the activity with the client and caseworker. Client can complete activity independently at home. Client can complete with trusted family member or friend.
Preparation	The caseworker should practise leading this exercise with another caseworker and / or supervisor and receive feedback before using with clients.

Instructions

EXPLAIN: How using positive affirmations, or simple empowering phrases, can change negative self-talk, help you grow, and move on after difficult times.

GIVE: Examples starting with "I am . . . " that address past mistakes or trigger positive thoughts to create a growth mindset. For example, "I am strong."

DO: Tell client that now they are going to create their own positive affirmation cards.

DO: Give examples of when positive affirmations can be especially helpful—for example, when feeling inadequate around others. Discuss with the client specific times when positive affirmations can be helpful for them.

Facilitator note: Provide a variety of examples of positive affirmations to inspire the client to find one that really resonates. Client can use one of the examples for one affirmation card and then should be encouraged to think of their own words to use for a second affirmation card. The client can make as many affirmation cards as they want during this session (or as time affords).

SAY: Using the materials we have, you are now going to create affirmation cards on note cards. You can write the affirmation and then decorate the card with the materials we have if you want.

SAY: You can take these cards with you if you wish and put them in an easily accessible place to use in a troubling moment.

ASK: Where is a place where you can put your affirmation card(s) so that you can easily access it and see it?

DO: Remind them to use their affirmation cards as often as they need to possible—even while doing mundane tasks.

ASK: Would you like to add any of what we discussed today to your coping plan?

DO: Update the client's coping plan as needed.

Activity Homework / Follow-up
Facilitators note: Decide with the client if they would like any homework or follow-up for this activity. SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you. ASK: Do you have any questions before we do our closing activity?

Closing Exercise
DO: Select an emotional regulation activity and implement it with the client before they leave to close the session.

Annex 4.4.7: Solution-focused

Annex 4.4.7.1: Adding to the Client's Action Plan

Objective	To support the client in developing concrete next steps based on their prioritised issue and the MHPSS pathway they are working through.
Time	15 minutes
Materials	The client's existing case management action plan (or a blank case management action plan if not completed yet), the client's coping plan (if you have been completing it with the client), paper, pens or pencils
Participant(s)	Client
Preparation	Review the client's existing action plan and coping plan (if you have been completing it with the client) and have both on hand to look at together with the client.

Facilitator note: The instructions include suggested questions and discussion points for 4 of the MHPSS pathways. ('MHPSS Pathway 5: Managing Acute Distress' is not included because caseworkers should prioritize activities to support the client's acute distress first using emotion regulation activities.) Skip to the pathway you are using with the client (or the pathway that most closely aligns to the client's prioritised issue and your previous work with them) to find suggested guiding questions to ask the client. You can adapt the guiding questions based on the client's specific situation. The guiding questions should help the client develop concrete next steps to add to their action plan.

Instructions

DO: Navigate to the MHPSS pathway you are currently using with your client or the pathway that aligns closest to the client's prioritised issue and/or your work with them. Once you have identified the appropriate MHPSS pathway, follow the instructions for that pathway, adapting as needed to the client's situation.

MHPSS Pathway 1: Identifying and Regulating Overwhelming Emotions

SAY: Now that we have completed different activities to help identify and manage overwhelming emotions we may be experiencing, let's think about concrete ways to integrate these activities in your daily life.

ASK: Which of the activities we completed felt most useful to you?

DO: Give the client time to reflect and respond. Remind the client of some of the activities you completed if they are having trouble remembering.

SAY: I'm glad you found those activities helpful.

ASK: What support do you need to be able to confidently use those activities when feeling overwhelmed by emotions or feeling very stressed?

SAY: Remember, sources of support are not just people or things in your life, but your own strengths and characteristics too.

DO: Give the client time to reflect and respond. Provide ideas, suggestions, or additional questions if the client is struggling to come up with support needs.

ASK: What would help make it more realistic to use these exercises?

DO: Give the client time to reflect and respond. Provide ideas, suggestions, or additional questions if the client is struggling to respond.

ASK: What are the specific situations when you anticipate needing to use some of these activities and when are these situations happening?

DO: Give the client time to reflect and respond.

ASK: How much would you like to practice these activities more before trying to use them on your own, and in particular in anticipation of the situations you mentioned?

DO: Give the client time to reflect and respond.

ASK: What would be a realistic schedule to practice over the next week (or leading up to the situations you mentioned)?

DO: Give the client time to reflect and respond. Then, based on what they have shared, help

them to develop a concrete action to practice over the next week or other relevant time frame according to the client's needs and/or situations they named where they believe they may need to use the activities. For example: I will practice x exercise xx times over the next week. Write down or ask the client to write down the agreed upon goals and next steps in their action plan.

MHPSS Pathway 2: Engaging in Difficult Conversations

Facilitators note: Make sure to first complete the previous activities in 'MHPSS Pathway 2: Engaging in Difficult Conversations' pathway and in particular the activities 'Identifying Sources of Stress' and 'Mapping Sources of Support' as you will reference them in this solutions-focused activity.

SAY: Now that we have completed different activities to help us engage in difficult conversations, let's think about concrete ways to use these to support you in having difficult conversations. Remember, sources of support are not just people or things in your life, but your own strengths and characteristics too.

DO: Reflect back to the client the sources of support they identified when completing the 'Mapping Sources of Support' activity.

SAY: Since you have identified these sources of support, it can be a good time to think about how you can rely on and use these sources of support when trying to talk about _____ issue.

Facilitators note: Fill in the blank space above with the specific issue(s) the client has named has needing support with.

SAY: We can work together to update your action plan to reflect how you can try to address this issue and have these conversations with _____.

Facilitator's note: Fill in the blank space above with whoever the client has identified needing to have the conversations with – this could be one person or multiple people.

ASK: What sources of support (or who) do you think will be most helpful to you in this/these conversations?

DO: Give the client time to reflect and respond.

ASK: How will the support you have identified help you? What would support look like for you?

DO: Encourage the client to be as specific as possible with what support would look and feel like for them, and who or what could provide different aspects of support during the process.

ASK: What can these supports do for you during this/these conversation/s?

DO: Encourage the client to get specific on whether they would like the support to be present during the conversation, the support they may need before and after the conversation, etc.

ASK: How can you engage these supports to help you? When/where/what words will you use?

DO: Give the client time to reflect and respond. Provide ideas, suggestions, or additional questions if the client is struggling to respond.

ASK: What will be your next steps if you are able to engage the supports? What will be your next steps if the supports are not available to or cannot help?

DO: Give the client time to reflect and respond. Then, based on what they have shared, help them to develop concrete next steps over the next week or other relevant time frame according to the client's needs and/or situation(s). Write down or ask the client to write down the agreed upon goals and next steps in their action plan.

MHPSS Pathway 3: Enhancing Self-Esteem and Self-Worth

SAY: Now that we have completed different activities to help enhance your self-esteem and self-worth, let's think about concrete ways to integrate these activities in your daily life.

ASK: Which of the activities we completed felt most useful to you?

DO: Give the client time to reflect and respond. Remind the client of some of the activities you completed if they are having trouble remembering.

SAY: I'm glad you found those activities helpful.

ASK: What support do you need to be able to confidently use those activities when feeling stuck in negative self-talk and/or unhelpful thoughts about yourself?

SAY: Remember, sources of support are not just people or things in your life, but your own strengths and characteristics too.

DO: Give the client time to reflect and respond. Provide ideas, suggestions, or additional questions if the client is struggling to come up with support needs.

ASK: What would help make it more realistic to use these exercises?

DO: Give the client time to reflect and respond. Provide ideas, suggestions, or additional questions if the client is struggling to respond.

ASK: What are the specific times or situations when you anticipate needing to use some of these activities?

DO: Give the client time to reflect and respond. If the client is struggling to respond, provide suggestions based on what the client has shared about challenges they have or have had.

ASK: What might help you to remember to use these activities when you begin to ruminate in negative self-talk and/or unhelpful thoughts about yourself?

DO: Give the client time to reflect and respond. Provide ideas, suggestions, or additional questions if the client is struggling to respond.

ASK: How much would you like to practice these activities more before trying to use them on your own, and in particular in anticipation of the times/situations you mentioned?

DO: Give the client time to reflect and respond.

ASK: What would be a realistic schedule to practice over the next week (or leading up to the situations you mentioned)?

DO: Give the client time to reflect and respond. Then, based on what they have shared, help them to develop a concrete action to practice over the next week or other relevant time frame according to the client's needs and/or situations. For example: I will practice x exercise xx times over the next week. Write down or ask the client to write down the agreed upon goals and next steps in their action plan.

MHPSS Pathway 4: Building and Maintaining Healthy Relationships

SAY: Now that we have completed different activities to help us build and maintain healthy relationships, let's think about concrete ways to use these to support you to have healthy relationships. Remember, sources of support are not just people or things in your life, but your own strengths and characteristics too.

ASK: Based on the activities and reflection you have done regarding healthy relationships, which relationships do you want to focus on?

DO: Give the client time to reflect and respond. If the client is struggling to respond, reflect back people they have previously mentioned that they'd like to strengthen their relationships with.

ASK: When thinking about your relationship with this person, what is in your control to work on or do to strengthen the relationship in a healthy manner?

DO: Give the client time to reflect and respond. Gently redirect the client if they name things that are clearly outside of their control.

ASK: What support do you need to be able to work on those areas that are within your control?

SAY: Remember, sources of support are not just people or things in your life, but your own strengths and characteristics too.

DO: Give the client time to reflect and respond.

ASK: How will the support you have identified help you? What would support look like for you?

DO: Encourage the client to be as specific as possible with what support would look and feel like for them, and who or what could provide different aspects of support during the process (including sources of support they have within themselves).

ASK: How can you engage these supports to help you? When/where/what words will you use?

DO: Give the client time to reflect and respond. Provide ideas, suggestions, or additional questions if the client is struggling to respond.

ASK: What will be your next steps if you are able to engage the supports? What will be your next steps if the supports are not available to or cannot help?

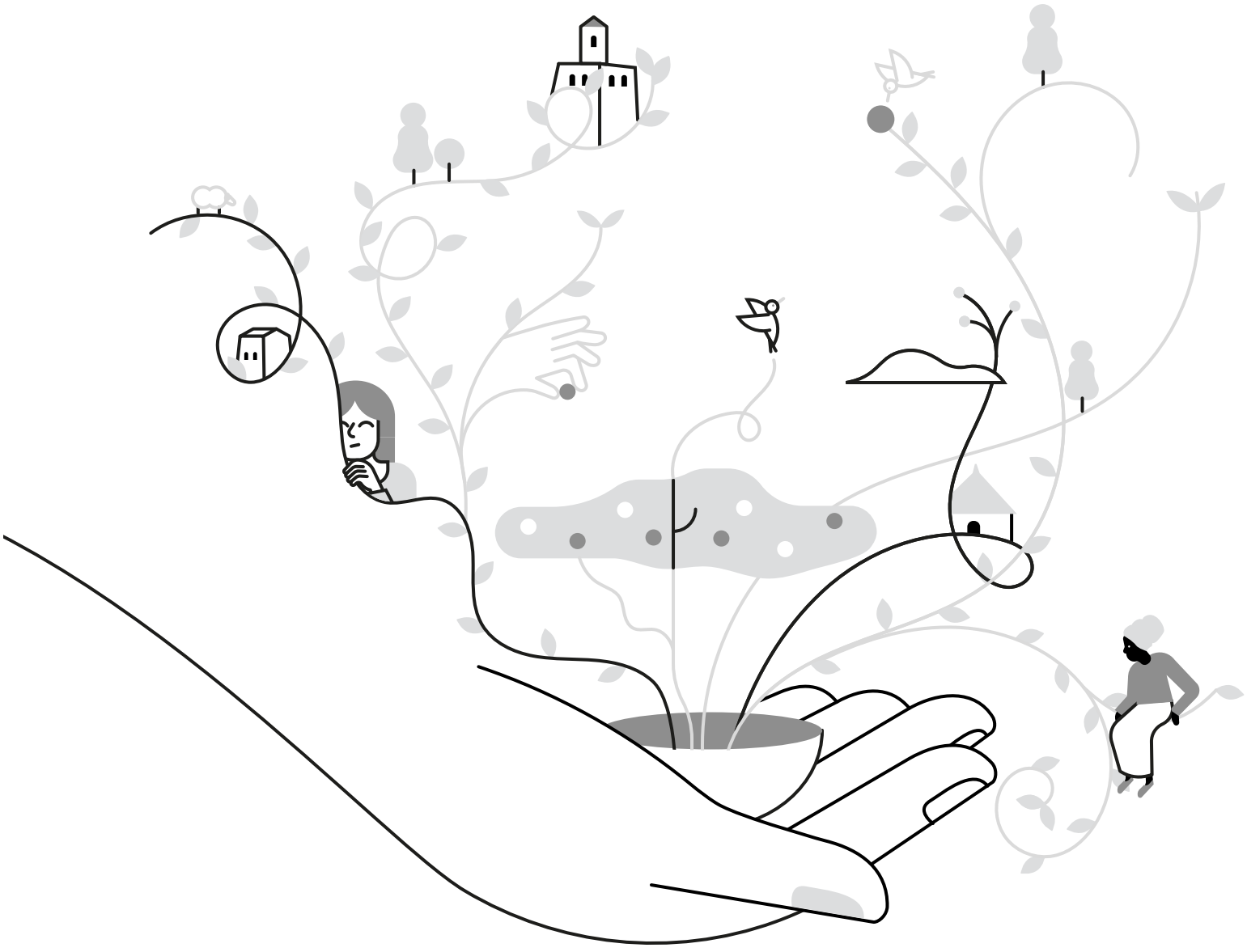
DO: Give the client time to reflect and respond. Then, based on what they have shared, help them to develop concrete next steps over the next week or other relevant time frame according to the client's needs and/or situation(s). Write down or ask the client to write down the agreed upon goals and next steps in their action plan

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we practiced today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.



Annex 4.4.7.2: Circles of Control

Objective	To identify areas within the client's control and outside of their control, and to identify coping mechanisms to assist in managing feelings arising from areas outside of the client's control.
Time	25 min
Materials	Paper, pens/pencils
Participant(s)	Client
Preparation	The caseworker should practice leading this exercise with another caseworker and / or supervisor and receive feedback before using with clients.

Instructions

SAY: We often feel flustered and out of control when we experience long term, unrelenting stress. It can be very hard to take care of ourselves during these times. However, one thing that can be helpful is to identify what we can and cannot control when experiencing stress.

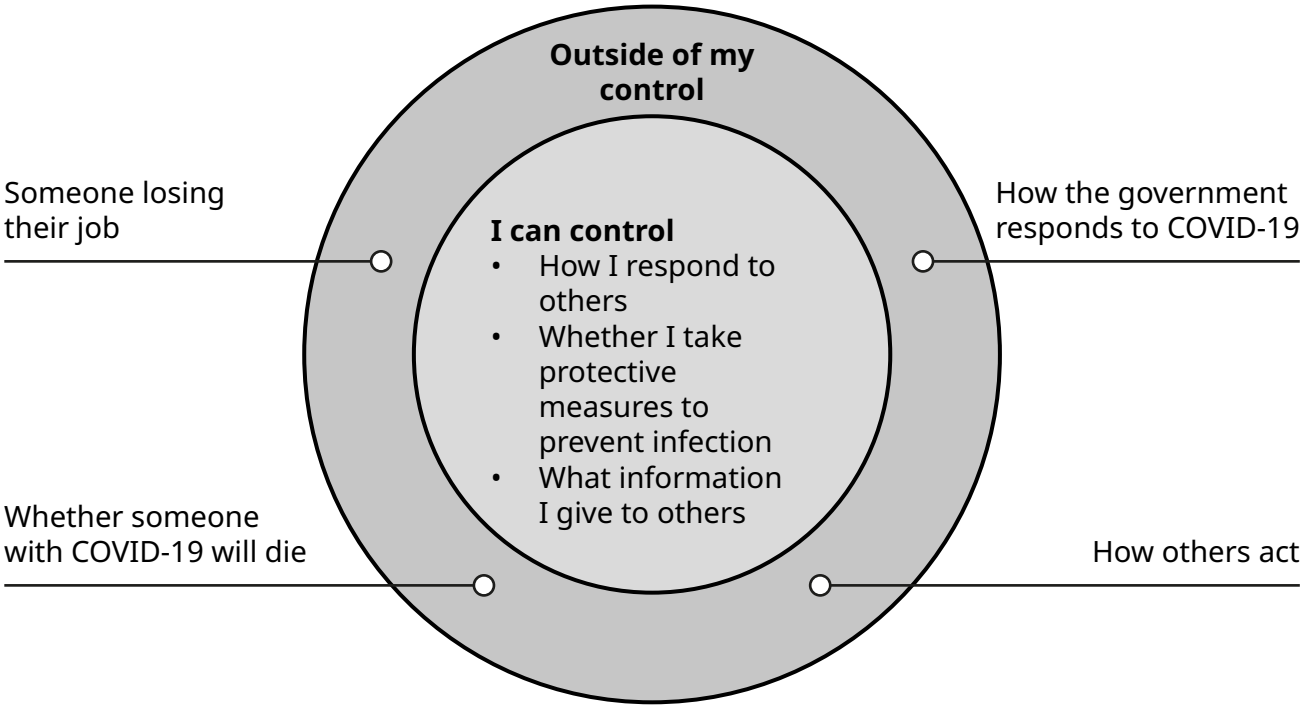
SAY: If you are feeling overwhelmed by everything you cannot control, knowing what you can control and taking actions to impact things you can control can be helpful. It can also help you identify where to focus your actions and effort.

DO: Bring out a sheet of paper and draw a circle in the middle of the paper that is big enough to write in. Label it "I can control." Then draw a circle bigger than the first circle around it. Label it "Outside of my control".

ASK: What are the things or people or other sources of stress that are currently impacting you?

DO: Give the client time to answer.

ASK: Of these, which can you control or have influence over?



DO: Give the client time to name what they feel they have control over.

DO: Challenge and question some of the client's answers if they do not have control over them. Focus on control being centred on the client's actions, thoughts, and feelings, rather than anything outside of or external to them.

Facilitators note: For example, if someone says "I can control having a job" you may say, "You can control how much effort and time you put into a job, but if the organization loses funding, the jobs may go away."

DO: Ask the client to put the different sources of stress they name into one of the two circles. Continue to discuss each of the things they have identified. Once you have placed everything in one of the two circles, focus on what they have identified as things they can control. It should be largely their actions and reactions to circumstances.

SAY: In your circle of control you have _____ and _____ (use two examples from their circle of control).

ASK: What can you do to support yourself so that you can influence what is in your control?

DO: Take some answers from the client. Highlight any that seem particularly supportive or useful for the client – if they seem excited about a particular few, note those.

Facilitators note: If the client is struggling to come up with a response, suggest the examples below to help them.

- *Eating well, getting enough sleep, taking walks or other forms of exercise*
- *Doing an activity you enjoy each day (reading, art, prayers, talking to a friend, etc).*
- *Engaging in communal and familial activities (dinner, family games, community football)*
- *Listing things you did that you are proud of accomplishing or doing at the end of each day*

DO: Validate the client after they have come up with some ideas for supporting themselves.

EXPLAIN: There are several different exercises and tools the client and caseworker can practice and decide if they will also be helpful.

SAY: We can continue to work on supports you identified as well as additional exercise and tools as we move forward.

DO: Update the client's coping plan as needed to help them remember this activity.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we worked on today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.

Annex 4.4.7.3: Mapping Sources of Support

Objective	The client identifies sources of support in their relationships and relationships that may cause tensions, stress, or feel unsupportive.
Time	20 min
Materials	Paper, pens/pencils
Participant(s)	Client
Preparation	The caseworker should practice leading this exercise with another caseworker and / or supervisor and receive feedback before using with clients.

Facilitators note: This activity is not appropriate to use with clients who are presenting with signs of acute distress. Use this activity when a clients seems to be or expresses to you that they are struggling with not feeling supported, have tension with their family, or have difficulty navigating relationships.

Instructions

DO: Introduce this activity by referencing conversations you have had with the client about family tension, navigating difficult conversations, or feeling unsupported within their relationships.

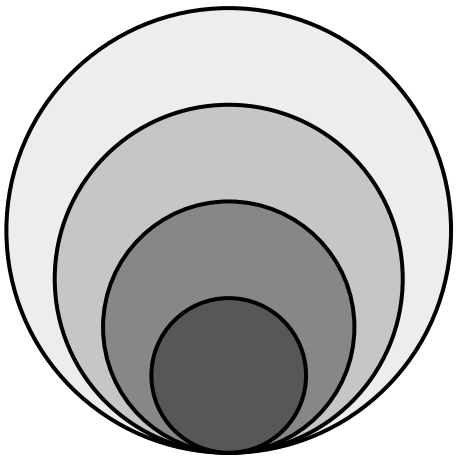
SAY: We are going to do an activity to help identify who in your life feels like someone you can rely on and who may feel less supportive or are people you have strained relationships with. We will explore what makes the supportive relationships feel supportive and what makes strained relationships feel strained.

DO: Draw on the piece of paper the circles of relationships and show it to the client.

SAY: Please take some time to share or list each person in your life at the different levels (i.e., circles) who impact your life either negatively or positively. In the outer levels, it may be fewer

people that really impact your life. That's typical of most relationships.

Facilitator's note: The client can write or the caseworker can write as they name different people.



Friends/family living in other places (no day-to-day in-person contact)

Community members

Neighbors, friends, extended family

Family/others you live with

SAY: As you write down people in each of the circles, think about how the interactions you have with them make you feel. Think about what and how you speak to each other, how you are similar and how you are different.

DO: Give the client time to think of different people at each level.

SAY: Now that you have listed each person, think about if that person largely feels like a positive, supportive relationship or a relationship that has tension or feels less supportive to you. For the supportive relationships, just put a star by them. Put an X by those that feel less supportive.

DO: Give the client time to complete this next step.

ASK: Now that you have identified the people and relationships that feel supportive, what do you think makes those relationships feel supportive?

DO: Give the client time to answer. Ask follow-up questions as needed to explore further.

ASK: Who, if anyone, feels the most supportive in your life? Can name more than one, maybe 2-3 that feel especially supportive?

SAY: Circle those people. We will come back to them.

ASK: Now, thinking about the relationships where you feel tension or less supported, what makes you feel this way? What are some specific issues that you'd like to address?

DO: Give the client time to answer. Ask follow up questions, as needed, to explore.

ASK: Which of the relationships and / or issues you have identified here feel most important to focus on and gain strategies around them?

DO: Give the client time to answer.

SAY: We can add this to your coping plan and begin to identify strategies and tools that can help address this issue.

ASK: Of the people you identified as most supportive, can any of them be of support with this person/these people and this issue?

DO: Give the client time to answer.

ASK: In what ways can they (i.e., the people who the client has described as most supportive) be supportive or helpful to you?

DO: Give the client time to answer.

DO: Validate the client's responses and update the client's coping plan as needed to help them remember this activity and the supports they identified.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we worked on today and discuss what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.
DO: Select an emotional regulation activity (different from the one just practiced with the client) and implement with the client before they leave to close the session.

Annex 4.4.7.4: Positive Journaling

Objective	To help clients focus on positive experiences, achievements, and things they are grateful for, thereby fostering a positive mindset and improving overall well-being. Additionally, to support clients in reflecting on past challenges and identifying strategies to overcome current challenges.
Time	15-20 minutes (once or daily)
Materials	Paper/journal or notebook and pen or pencil
Participation	This activity can be done individually by the client after introduced by the caseworker. It can also be shared with the caseworker or a trusted person if the client is comfortable. This journal exercise should be completed by clients who express they are able to and enjoy reading and writing (in any language they prefer).
Preparation	The caseworker should practice leading this exercise with another caseworker and/or supervisor and receive feedback before using with clients.

Facilitator's Note: Avoid this activity with clients who may be unable to maintain a journaling routine due to cognitive impairments or severe emotional distress. Adjust the prompts based on cultural context, literacy level, and specific client needs. Ensure the client understands that the focus is on positive experiences and gratitude, not on minimizing or ignoring distressing emotions.

Instructions

EXPLAIN: The objective of the activity.

SAY: This structured and clear positive journaling activity helps clients focus on the positive aspects of their lives, promoting a more positive mindset and enhancing their overall mental health and psychosocial wellbeing.

DO: Ensure the client has a piece of paper, journal or notebook and a pen or pencil.

SAY: Today, we are going to start a positive journaling activity. This involves writing about positive experiences, achievements, and things you are grateful for. This can help you focus on the positive aspects of your life and improve your overall mood. Are you comfortable trying this activity?

If the client agrees, proceed. If not, offer an alternative activity.

SAY: I'd like you to reflect on and write down a few sentences about something positive that happened, something you did well, and/or an challenge that you overcome or are working to overcome. You can also write about things you are grateful for. Here are some prompts to help you get started:

SHOW: Provide the client with the following prompts:
- "Today, I am grateful for..."
- "A positive experience I had today was..."
- "Something I did well today was..."
- "A happy moment I experienced today was..."
- "I felt proud of myself today when..."
- "A challenge I overcame today was..."
- "In the past, I faced [describe a situation or challenge] and I overcame it by [describe how]."
- "When I face challenges, I can remind myself to [describe a helpful strategy or mindset]."
- "A time when I used my strengths to overcome a difficulty was..."
- "If I encounter a challenge tomorrow, I can handle it by..."

SAY: Take a few minutes to reflect on these prompts and write in your journal. You can choose any prompt that feels right for you or come up with your own positive thoughts.

DO: Give them time to start their first journal entry. Offer support and encouragement as needed. Encourage journaling moving forward if they enjoy writing.

ASK: How do you feel after writing about these experiences? Did any specific memories or feelings come up for you?

DO: Give them time to reflect and share their responses.

EXPLAIN: Focusing on positive experiences and things we are grateful for can help us develop a more positive outlook on life. Thinking about challenges we've overcome in the past and ways we can overcome challenges in the future can help us develop solutions to the challenges we

are facing. It's important to acknowledge and celebrate these moments, no matter how small they might seem.

ASK: Would you like to add this activity or any of what we discussed today to your coping plan?

DO: Update the client's coping plan as needed.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity and if so, discuss what the client should do to practise at home. Examples include:

- *Writing in the journal daily for a week.*
- *Reflecting on how journaling about positive experiences impacts their mood and outlook.*
- *Identifying any patterns or recurring themes in their positive experiences.*

SAY: Next time we meet, we can review what we learned today and discuss what was most helpful for you.

ASK: Do you have any questions before we do our closing activity?

Closing Exercise

DO: Select an emotional regulation activity and implement it with the client before they leave to close the session.

Annex 4.4.7.5: Exception Questions

Objective	To help the client identify times in their life when they have overcome challenges, and to create a sense of hope by recognizing their strengths and resources.
Time	30 minute
Materials	flipchart with paper or regular paper, markers, pens or pencils
Participant(s)	Client
Preparation	The caseworker should familiarise themselves with the exception questions and adapt or contextualize as needed. Not all of the questions need to be asked; the caseworker can select 1-3 questions that would be helpful for the client. The caseworker should also be prepared to guide the client through reflective thinking. The caseworker should practice leading this exercise with another caseworker and / or supervisor and receive feedback before using with clients.

Facilitators note: This activity is not appropriate to use with clients who are presenting with signs of immediate or active distress / crisis.

Instructions

DO: Create a comfortable and safe environment for the client. Ensure you are both seated comfortably and without distractions.

SAY: We are going to explore some questions that will help us understand times in your life when you weren't experiencing some of the same challenges/issues you are experiencing now. This can help us to recognize strengths and supports, and help us develop solutions to address the challenges.

Facilitators note: You can name some of the client's prioritized issues or challenges as you explain the activity using the language provided above.

ASK: How does this activity sound to you?

DO: Give the client time to reflect and respond.

Facilitators note: If the client says they are unsure of the activity, explore their concerns and address them the best you can. Encourage the client to try the activity, explaining that the client can choose to stop the activity at any time.

SAY: Before we begin the questions, let's do a quick exercise to calm our bodies, minds, and emotions.

DO: Lead the client in a quick grounding exercise such as deep belly breathing. Take 5 deep breaths with the client before beginning the questions.

Facilitator's note: You can use '1. Emotion Regulation - Deep Belly Breathing' in Annex 4.4 for guidance, if needed.

SAY: Now that our minds, bodies, and emotions are a little calmer, we can start the activity.

ASK: Are you ready to begin?

DO: Give the client time to respond.

Facilitators note: You do not have to go through all of the questions below with the client. You can start and stop at any time, or you can select a few to do with the client. Be sure to pay attention to how the client is doing and check-in with them as you go along, taking pauses and breaks or stopping as needed.

SAY: First, I'd like you to tell me about times when you don't get angry. If helpful, you can think of specific situations where you have handled things calmly.

DO: Give the client time to reflect and respond.

ASK: What helped you to stay calm during those times?

DO: Give the client time to reflect and respond. Write down the things they share that helped them to stay calm.

ASK: Now, can you tell me about the times when you felt the happiest?

DO: Give the client time to reflect and respond.

ASK: What contributed to your feelings of happiness during those times? For example, what were you doing, who were you with, and what made these times special?

DO: Give the client time to reflect and respond. Write down the activities, people, and other things that the client shared that contributed to their happiness.

ASK: Now, can you tell me the last time where you feel you had a better day?

Facilitators note: If needed, guide the client to think about a recent day within their current circumstances/situation that felt better than other days, rather than having them choose a day that was in the past or a long time ago before the emergency, crisis, etc. happened.

DO: Give the client time to reflect and respond.

ASK: Can you describe what happened that day and how it was different from other days?

DO: Give the client time to reflect and respond. Write down the things they share that helped the day to be better than other days.

ASK: Now, can you think about a time when you felt happy in one of your significant relationships?

Facilitators note: A significant relationship could be any relationship that is important to the client. For example, this could be a relationship the client has with their child, a friend, another family member, spouse, etc.

SAY: Think about moments of joy or connection in this relationship. What were the circumstances?

DO: Give the client time to reflect and respond. Write down the things they share that helped them to feel joy or connection.

ASK: Finally, can you think of a time when your prioritized issue/challenge was not present in your life or less severe/problematic?

DO: Give the client time to reflect and respond.

ASK: What was different then?

DO: Give the client time to reflect and respond. Write down what was different for the client.

SAY: Thank you for answering all of those questions and for sharing your responses with me. Now, let's take a look at activities, people, factors, circumstances, and other things that contributed to some of these positive moments in your life.

ASK: Which of these are you able to access in the present moment?

DO: Give the client time to reflect and respond. Circle the things that they name they are able to access. If they are struggling, select one you think they can access and suggest it. Then encourage them to take another look to try and identify at least one or two more they can access in the present.

SAY: Great. Now let's think through how we can incorporate the things you've selected over the next week.

Activity Homework / Follow-up

Facilitators note: Decide with the client if they would like any homework or follow-up for this activity.
SAY: Next time we meet, we can review what we discussed today, including what was most helpful for you.
ASK: Do you have any questions before we do our closing activity?

Closing Exercise

SAY: Now, we are going to do a grounding exercise to help us close our time together. Our meetings can bring up emotions and memories, so it is important to do an exercise to help us relax and feel calm in our body, mind, and emotions.

Annex 4.5

Working with Clients in Severe Distress, Self-harm and Suicidal Ideation

Introduction

This document provides essential information, templates, and resources for caseworkers managing clients in distress and severe distress, including instances of self-harm and suicidal ideation. Caseworkers must be trained in assessing and discussing difficult topics, including suicidality. These conversations should not be avoided due to personal discomfort or biases. Preparation is key; caseworkers must be ready to address challenging subjects and seek support when needed. This support should come in the form of supervision, ongoing capacity building, peer support, and mental health and psychosocial support (MHPSS) services for staff. By doing so, caseworkers can effectively and compassionately assist clients experiencing severe distress.

Key terms[1]

The terms used to discuss MHPSS services and needs are not always consistent within or across sectors, so for the purposes of the Protection Case Management (PCM) Guidance and this annex document, it is important to define key terms based on global standards, such as the IASC Guidelines on Mental Health and Psychosocial Support in Emergencies.

Distress: A state of emotional suffering that can occur when a person is overwhelmed by stressors that are difficult to cope with in daily life. Distress can be the result of a one-off event such as a traumatic life event or crisis, or can be from stress that has been building over time[2].

Harm to others: When someone hurts another intentionally, by inflicting physical or emotional harm.

Self-harm: When a person injures or harms themselves to cope with or express extreme emotional distress and internal turmoil. It most frequently takes the form of cutting, burning, non-suicidal self-injury or other high-risk behaviours (WHO).

Severe distress: A heightened state of emotional suffering where symptoms are extreme and debilitating. Individuals in a state of severe distress may experience extreme sadness, hopelessness, exhaustion, and thoughts of self-harm or suicide.

Stress: Strain or tension that is a normal part of life and is a reaction to both negative and positive events.

Suicide ideation: Thoughts, ideas, or ruminations about the possibility of ending one's own life, ranging from fleeting considerations to detailed strategies (WHO).

Suicide: The act of deliberately killing oneself (WHO).

Window of tolerance: A term used to describe the "zone of arousal" or the right amount of stimulation in which a person is able to function most effectively. (Refer to Annex 4.5 for additional information on the window of tolerance.)

Supporting Clients Experiencing Severe Distress Reactions, Self-Harm, and Suicidal Ideation

Protection caseworkers play an essential role in identifying and providing life-saving MHPSS services (levels 1-3 of the MHPSS pyramid) to clients experiencing severe distress. They also provide an invaluable service by referring clients to specialised MHPSS service providers (level 4 of the MHPSS pyramid). When working with clients experiencing severe distress, key actions and considerations include: (1) preparation, (2) identification (inclusive of recognizing signs of severe distress and assessing client needs), (3) provision of MHPSS Services, and (4) follow-up.

Preparation

The preparation phase is essential and must be completed before caseworkers engage with clients. This phase lays the foundation for

building trust, ensuring effective communication, establishing referral pathways, and providing tailored MHPSS services throughout the case management process.

Key actions for caseworkers and supervisors/program managers include:

- Complete onboarding and training.
- Establish a schedule and set expectations for ongoing supportive supervision and peer support.
- Review organisational protocols and the scope of practice for caseworkers.
- Coordinate with key sectors and stakeholders including national and local coordination groups (e.g. MHPSS Technical Working Groups).
- Collaborate with community stakeholders, non-governmental organisations (NGOs) and individuals from affected communities, including those with lived experience of mental health conditions.
- Complete or update stakeholder mapping and service maps.
- Develop clear referral pathways and complete the High-Risk Referral Contact List Template (refer to page 639), including identifying emergency referral contacts and pre-programing phone numbers.
- Conduct an assessment of the context, client needs, and current resources to guide programming.
- Complete Managing Severe Distress Checklist (refer to page 639).

The form section of this annex includes the following key resources to prepare caseworkers to work with clients experiencing severe distress, self-harm or suicidal ideation.

- *High-Risk Referral Contact List Template (refer to page 639)*:[3] This template is to be completed and updated regularly by caseworkers or supervisors to ensure caseworkers have the contact information of the appropriate focal points within their organisation on hand to refer clients who are experiencing severe distress or at urgent risk of suicide (*refer to page 185 for important information on consent for referrals*). In addition to organisational focal points, the template includes space for country and location specific resources and referral agencies such as contacts for medical emergencies. This template should be completed and kept up to date before engaging with clients.
- *Managing Severe Distress Checklist (refer to page 639)*: This checklist supports caseworkers, supervisors, and organisations to provide

support to clients experiencing severe distress, particularly clients who are at risk of self-harm or suicide. The checklist provides a minimum standard; organisations may add additional steps to enhance support for clients in severe distress or at urgent risk of suicide. Caseworkers should contact their supervisor if any items on the checklist are missing within their program/organisation. Key considerations are included for: prior to engaging with clients in severe distress or at urgent risk of suicide, while providing services to these clients, and after referring these clients to specialised/ additional services to support their needs.

Mental Health Case Management (MHCM)1 integrates elements of clinical social work and human service case management practices. The MHCM approach primarily focuses on supporting the MHPSS needs of the service user. Mental health case management is based on the "biopsychosocial" framework for treatment and focuses predominantly on restoring mental health and normal functioning for individuals. International Medical Corps (IMC), is the lead agency working in MHCM and authored the seminal resource MHCM Training package (field-test version). Importantly, MHCM does not and should not replace GBV, CP, or Protection Case Management services; the reverse also holds true. Mental Health Case Management is an important service in providing a comprehensive MHPSS response and can be provided through health, protection or other relevant actors.

Seminal Resources, Guidelines and Tools:

- IASC Minimum Service Package Mental Health and Psychosocial Support (2022)
- IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007)
- IASC Guidelines on Mental Health and Psychosocial Support: Checklist for Field Use (2008)
- IASC Handbook, Mental Health and Psychosocial Support Coordination (2022)
- IASC Guidelines on Mental Health and Psychosocial Support: What should Protection Programme Managers Know? (2010)

- IASC: Who is Where, When, doing What in Mental Health and Psychosocial Support (2012)
- IASC Reference Group Mental Health and Psychosocial Support Assessment Guide (2013)
- Review of the Implementation of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. How are we doing? (2014)
- IASC Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings (2014)
- A Faith-Sensitive Approach in Humanitarian Response: Guidance on Mental Health and Psychosocial Programming, 2018
- IASC Guidance on Basic Psychosocial Skills – A Guide for COVID-19 Responders (2020)
- IASC Guidance, Addressing Suicide in Humanitarian Settings (2022)
- LIVE LIFE: An implementation guide for suicide prevention in countries (2021)

Identification

Identifying the MHPSS needs of clients presenting with signs of severe distress, self-harm, or suicidal ideation is vital for providing individualized care and support. Addressing these specific challenges promotes holistic recovery while adhering to 'do no harm' principles. Caseworkers must be able to recognize potential warning signs of distress, severe distress, self-harm, and suicidal ideation through observation in order to identify clients needing assistance. In addition to observation, caseworkers must be able to effectively complete assessments and utilise the information gathered to formulate a comprehensive case action plan together with the client and make necessary referrals with the client's informed consent. By thoroughly assessing for these challenges, caseworkers can tailor interventions and referrals to meet the unique emotional, psychological, and social needs of each client, fostering a more empathic and effective approach to case management.

Key actions for caseworkers include:

- Observe client behaviour and recognize potential warning signs that they may be experiencing severe distress, self-harm, or suicidal ideation.
- Complete Protection Risk Assessment (Form 3) and understand risk

and protective factors for severe distress, self-harm, and suicidal ideation.
- Complete Basic MHPSS Assessment and Suicide Risk Assessment (Form 5).
- Complete Psychosocial Wellbeing Assessment (Form 4) (optional).
- Engage in ongoing discussions with the client.

Signs of severe distress, self-harm, and/or suicidal ideation may be identified at any time and during any step of the case management process. It is important caseworkers are prepared to identify and respond to clients who are presenting with signs of severe distress at any point in time, and not wait until a situation occurs to receive training on how to identify and support these clients.

Seminal Global Resources, Guidelines and Tools:
- IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With means of verification (Version 2.0) (2021)
- IASC Guidance, Addressing Suicide in Humanitarian Settings (2022)
- Click here to enter text....

Distress & Severe Distress

Psychological distress reactions are commonly experienced by people affected by humanitarian emergencies. They are normal reactions to abnormal life events. Distress reactions are to be expected in emergencies and for most individuals they will improve over time once they are safe, have their basic needs met, and have access to community support.

It is important that caseworkers do not assume that everyone who has experienced an adverse or terrifying event, such as a humanitarian emergency, is traumatised or unable to access and use existing or emerging coping mechanisms. Caseworkers must take a strengths-based approach and be able to recognize resilience at the individual and collective levels rather than make assumptions about others' experiences. Each individual has protective factors and risk factors

that affect the way they experience an event and the impact it has on them. Care must be taken to avoid terminology that could lead to disempowerment and stigmatisation of people in distress. For example, instead of using “trauma” and “traumatic events” it is recommended to use alternative terms like “distress”, “severely distressed individual”, and “terrifying event”.

How to recognize signs of distress

It is common for caseworkers to work with clients who are experiencing varying levels of stress and distress. Stress, whether from negative or positive events, is a normal part of life. Stress can be helpful or harmful. Helpful stress – e.g., excitement for a forthcoming birthday or nervousness for an upcoming exam – is short-term, increases our focus and performance, and allows our bodies to return to a typical state after a productive period. Harmful stress occurs when stress is chronic or prolonged, preventing the body from returning to its typical state.

Individuals facing significant challenges or adversity may experience heightened levels of harmful stress. If harmful stress accumulates over time without opportunities for relief, this can lead to a state of distress. Distress can also be the result of a one-time terrifying life event or crisis, and can also arise suddenly due to difficult or stressful events such as the death of a loved one or the rejection of an asylum claim. Individuals experiencing distress may struggle to perform daily tasks.

Severe distress is a heightened state of distress where the symptoms are extreme and debilitating. Individuals in a state of severe distress may experience extreme sadness, hopelessness, exhaustion, and thoughts of self-harm or suicide. Daily functioning is significantly impaired, including the ability to carrying out simple daily tasks.

Stress, distress, and severe distress manifest in physical, behavioural, emotional, and/or cognitive signs and symptoms. Whether a client is experiencing stress, distress, or severe distress depends on the frequency at which the client is experiencing the signs and symptoms and the extent to which the experience disrupts their daily functioning. Below are some common signs and symptoms with examples to help differentiate stress from severe distress reactions. Cultural and contextual presentation should also be kept in mind when considering these reactions, as they present differently across cultures, contexts, and individuals.

Physical reactions: headaches, muscle aches, stomach aches, nausea, rapid heartbeat or palpitations, shortness of breath, lack of energy, extreme fatigue or exhaustion, chronic pain.

Example: If an individual is experiencing stress they may have the physical reaction of fatigue which manifests in feeling tired or slightly drained, often alleviated by rest or relaxation. However, if an individual is experiencing severe distress, fatigue can escalate to an overwhelming and persistent state of exhaustion with symptoms such as profound lethargy, difficulty concentrating, and a sense of chronic depletion that significantly impairs daily functioning and is not easily alleviated by typical self-care measures.

Emotional reactions: intense feelings of sadness or fear, anxiety or excessive worry, feelings of hopelessness or helplessness, emotional numbness or detachment, irritability or anger.

Example: If an individual is experiencing stress, they may have the emotional reaction of anger which can manifest in irritability, frustration, and tension in their muscles, chest, and/or head, often alleviated by relaxation techniques such as deep belly breathing or progressive muscle relaxation and/or emotional expression through journaling, talking to a friend or another supportive person, etc. However, if an individual is experiencing severe distress, they may no longer feel in control of their anger, manifesting in outbursts and other behaviours that may harm themselves and others such as shouting, cursing, throwing or breaking things, isolating, self-harm, and doing or saying things they regret that negatively impacts their relationships with others.

Behavioural reactions: socially withdrawn or isolated, changes in eating habits (e.g., overeating or loss of appetite), increased use of substances (e.g., alcohol or drugs), difficulty maintaining daily routines or responsibilities, erratic or 'unusual' behaviours outside of the norm for the client, risk-taking behaviours, observable actions such as shaking or pacing, self-harm or suicidal behaviours.

When someone is overwhelmed by emotions such as sadness, fear, or hopelessness and has difficulty calming down, this is primarily categorised as emotional distress. However, it can also manifest as behavioural distress due to the observable actions (e.g., crying, shaking, pacing, screaming uncontrollably) that result from their emotional state.

Example: Crying is a natural human response to a wide range of emotions, offering benefits such as self-soothing, pain and stress relief, and mood enhancement. Individuals experience crying at varying levels of severity for different reasons. If an individual is experiencing stress, crying is a common reaction that can serve as a healthy outlet for emotions and may occur in response to sad or stressful events, providing temporary relief when facing adverse situations (e.g., grieving the loss of a loved one or loss of work or home). However, crying uncontrollably is more often associated with severe distress. While grief and loss are common amongst most people, uncontrollable crying without reason is not. Bouts of uncontrollable crying differ from feelings of sadness in that crying won't stop and the feelings don't go away and are often not easy to explain. While crying is normal and may be a sign of stress or distress, uncontrollable crying may be an indication of severe distress.

Cognitive reactions: difficulty concentrating or focusing, racing thoughts, memory problems, fixation on a problem, trouble making decisions, confusion or disorientation, hallucinations and delusions, or intrusive thoughts or flashbacks.

Example: If an individual is experiencing stress, they may have the cognitive reaction of intrusive thoughts or memories that briefly disrupt their train of thought or the activity they are engaged in. Individuals experiencing stress or distress can usually re-focus on the thought or activity they were engaged in without significant effort or negative impact. Individuals experiencing severe distress are usually not able to re-focus as easily or quickly and are often stuck in ruminative cycles that disrupt their daily functioning.

Individuals experiencing severe distress can also experience the cognitive reaction of flashbacks where they are pulled from the present moment into the past and re-experience/re-live a previous distressing event.

When clients are experiencing severe distress, caseworkers must be vigilant in recognizing if a client is at risk harming themselves or others, indicating a potential safety risk. Signs and symptoms indicating severe distress which could pose a safety risk include:

- Extreme hopelessness, social isolation, withdrawal, or severe depression
- Medical emergencies such as visible wounds, bleeding, or intoxication, whether self-inflicted or otherwise
- Unresponsive, incoherent, comatose, or unconsciousness
- Physical or verbal aggression towards oneself
- Physical or verbal aggression towards others, animals, or objects in the environment
- Uncontrollable disruptive behaviour
- Threats to harm themselves or others
- Statements like, "Everyone would be better off if I were dead"
- Previous suicide attempts or expressions of self-harm, with prior attempts being the most significant risk factor for suicide

If the client is exhibiting these signs and symptoms, the caseworker should promptly seek additional support from their supervisor and refer clients to specialised MHPSS services. Additional information on clients at risk of self-harm and suicide, as well as when to seek additional support and refer can be found later in this annex.

Clients often experience distress due to extreme and prolonged stress from exposure to humanitarian emergencies, often inclusive of displacement, violence, and loss. Expressions of distress and severe distress can manifest differently across individuals based on their culture, age, sexual orientation, gender identity, and other demographics. Caseworkers should work with their supervisors and colleagues to understand what these expressions might look like for their clients before implementing case management services and on an ongoing basis during supportive supervision sessions. This understanding is crucial when working with clients and contextualising materials.

How to use assessments to identify clients experiencing severe distress

The primary purpose of the Basic MHPSS Assessment (Form 5) is to help caseworkers identify signs that a client may be experiencing distress, objectively assess the severity, and monitor changes over time. This form supports caseworkers in identifying challenges the client is facing and action items the caseworker and client can include in the action plan to support the client's mental health and psychosocial wellbeing. This form also aims to identify clients who may require referrals for additional and/or specialised MHPSS services (e.g., MHPSS, GBV, Health, Protection).

This form should be completed as part of the Protection Risk Assessment or after it. If the caseworker observes any changes in the client's distress level or the client reports problems related to their mental health and psychosocial wellbeing, the caseworker may want to complete this form again. Additionally, this form can be used during the mid- and end-line stages of case management to assess progress. Please be aware that this form contains sensitive information that may cause distress to some clients. Caseworkers should be prepared and ready to support a client in distress.

The Basic MHPSS Assessment (Form 5) includes nine questions and the Suicide Risk Assessment. This form also includes an 'open-response' section where caseworkers should write additional comments and observations about the client, including their appearance and behaviour, which could indicate their level of distress and mental health and psychosocial wellbeing. After the client has responded to all nine questions, the caseworker will add up the client's total score.

Total scores will range from 0 to 27. The client's total score can be grouped into five severity levels, described further in the table below.

Minimal *Score range: 0-4*	Clients experience few or no symptoms. They may occasionally feel down, but these feelings are infrequent and fleeting. They continue to perform well in their work, social interactions, and other daily activities without significant issues. Daily functioning is generally unaffected. They might not require any specific treatment but should maintain healthy lifestyle habits to prevent escalation.

Mild *Score range: 5-9*	Clients experience more frequent feelings of sadness or lack of interest, but these symptoms are still manageable. Tasks may feel a bit more challenging, and there might be a slight drop in productivity or social engagement. There is a minor impact on daily life. It might be beneficial to incorporate lifestyle changes such as exercise and/or better sleep to address these mild symptoms.
Moderate *Score range: 10-14*	Clients have symptoms that are more pronounced and persistent, such as frequent sadness, significant loss of interest in activities, and fatigue. Work performance, relationships, and social activities may suffer. Daily functioning is moderately affected. Individuals might struggle with maintaining their usual level of productivity and could benefit from a structured support plan.
Moderately severe *Score range: 15-19*	Clients experience symptoms such as intense sadness, persistent fatigue, and feelings of worthlessness or excessive guilt. Individuals may find it hard to perform at work, maintain relationships, or take care of daily responsibilities. There is a considerable impact on daily functioning. Focused intervention is typically necessary at this stage.
Severe *Score range: 20-27*	Clients experience symptoms that are debilitating. Individuals may experience extreme sadness, hopelessness, lack of energy, and thoughts of death or suicide. It becomes difficult to carry out even simple daily tasks, and there is a high risk of self-harm or suicide. Daily functioning is significantly impaired; clients find it difficult to carry out simple daily tasks. Referrals to focused specialized MHPSS services is needed.

The Basic MHPSS Assessment (Form 5) includes detailed instructions for implementing and scoring this form. If caseworkers are not comfortable completing the Basic MHPSS Assessment with a client, approaching and discussing specific topics of concern with their clients, worried that the client may be at risk of harming themselves or others, or are unable to obtain informed consent from the client to proceed with the referral, they must reach out to their supervisor for additional support on how to address the situation.

Importantly, caseworkers are NOT responsible for diagnosing clients with mental health conditions and SHOULD NOT attempt to do so. If at any time the caseworker has concerns regarding the safety or mental

well-being of clients, it is crucial for the caseworker to promptly notify their supervisor to determine the safest way forward.

When to seek additional support and refer

Caseworkers must seek additional support from their supervisor and refer clients to specialised MHPSS services if:

- The client scores in the "moderately severe" or "severe" range on the Basic MHPSS Assessment;
- The client shows signs of being in severe distress;
- The client indicates risk of self-harm or harming others; and/or
- The caseworker and supervisor feel the client's MHPSS needs are beyond their scope of practice.

If the client scores in the "severe" range (severity level 20-27) of the Basic MHPSS Assessment, caseworkers should approach the client with concern and discuss options for specialised MHPSS services in the area and obtain their informed consent before making the referral. If the client refuses to be referred to a specialised MHPSS service provider, the caseworker should inform the client that they would like to further discuss with their supervisor on the safest way forward and request the client to stay with them while they make the call. If a client is grouped in the moderately severe level (15-19), the caseworker should also discuss with the client options for specialised MHPSS services in the area and continue to provide focused MHPSS services within their scope of practice.

Self-Harm

Self-harm refers to behaviours that intentionally cause harm to oneself to cope with difficult emotions. It often manifests as cutting, burning, non-suicidal self-injury, or other high-risk behaviours. Importantly, most individuals who engage in self-harm do not intend to end their lives.

Everyone encounters stress and anxiety. While many people manage these feelings by talking to friends and family, some find these difficulties overwhelming. When emotions are not expressed and feelings of distress, anger, or sadness are bottled up, the pressure can become unbearable. Some individuals turn this inward, using their bodies to express thoughts and emotions they cannot verbalise, leading to self-harm.

Self-harm is most prevalent among adolescents and young adults, though it can occur at any age. The reasons for self-harm vary. Known triggers include:

- Significant life changes such as a death, displacement, divorce
- Livelihoods stress, extreme pressure, or fear of failure
- Witnessing or experiencing abuse at school, home, or in relationships
- Witnessing or experiencing a severely distressing or traumatic incident
- Loneliness, feelings of guilt, or feeling unloved
- Low self-esteem or body image issues
- Criticism from family, friends, or community members
- Exposure to violence, including but not limited to gender-based violence

When several of these issues converge, they can become overwhelming. Instead of finding ways to express their feelings, some individuals turn their pain and anger inward. The motivations behind self-harm are diverse and can vary even for a single individual. People may self-harm to express distress, regain control, escape troubling situations, distract from painful memories, feel something when they are otherwise numb, and/or gain a sense of relief. Regardless of the reason, self-harm generally indicates intense emotional pain and distress. Sometimes, for some individuals, it is a way to punish themselves due to feelings of guilt.

It is crucial to understand that if a client is self-harming, they are not doing it for attention. It may be a sign they need support and reassurance to adopt safer coping mechanisms. Self-harm has many causes and varies from person to person; open communication with the client and finding the right support is essential for managing self-harm and aiding recovery.

How to recognize signs of self-harm?

Self-harm manifests in various ways and its frequency varies among individuals—some may engage in it once, while others may do so for many years. Common methods include:

- Cutting, burning, biting, or scratching the skin
- Picking at wounds or scabs to prevent healing
- Pulling out hair, punching, or hitting the body
- Ingesting harmful substances (such as poisons, or misuse of over-the-counter or prescription medications)

Self-harm behaviours come with significant risks. Some prevalent warning signs include:

- New marks on the body, such as bruises, cuts, or burns
- Withdrawal from friends, family, school, and work
- Decline in performance at school, work, or in activities
- Changes in mood, sleep, and eating patterns
- Avoiding activities once enjoyed or places where injuries may be exposed, like a lake or ocean
- Wearing inappropriate clothing to hide wounds
- Making excuses for injuries or behaviours
- Being secretive, hiding sharp or dangerous objects

While these warning signs might suggest self-harm, it's crucial to understand some of these warning signs may also signal other serious issues, such as gender-based violence or intimate partner violence (IPV).

When to seek additional support and refer

If a caseworker notices signs of self-harm in a client, it is crucial that the caseworker handle the situation with empathy, explore support options – in particular MHPSS services specialized in harm reduction, if available – with the client and refer accordingly, and notify and discuss with their supervisor. Caseworkers can also continue to provide MHPSS services within their scope of practice, such as psychoeducation on self-harm and identification of additional, safer coping strategies. If uncomfortable discussing self-harm with their clients, caseworkers should seek guidance from their supervisor. People who self-harm require care, understanding, and support for recovery. Stigma and simply stopping or not allowing the client to harm themselves without identifying and agreeing to try additional, safer coping strategies can be highly detrimental and prevent them from getting the help they need.

Suicidal Ideation

Suicidal ideation includes thoughts or plans about taking one's own life, ranging from fleeting considerations to detailed strategies. Although not everyone experiencing these thoughts will attempt suicide, they are significant indicators of distress and must be taken seriously.

Identifying clients experiencing suicidal ideation is a critical skill for caseworkers. There are many reasons why it might feel difficult or uncomfortable to ask someone if they have thought about or tried to harm themselves or take their own life, but it is important to know that talking about it can bring comfort to the individual and help them to feel less alone. It can also help the caseworker to know how best to support them.

Talking about suicide

There is a common misconception that talking about suicide can increase the likelihood of someone taking their own life. In reality, the opposite is true.[4] Studies have shown that talking about suicide does not increase risk of suicide or cause suicides to happen.[5] Talking about suicide and being heard in a non-judgemental, compassionate way can help a person to access support and decrease their feelings of being all alone in their pain, depression, and fear. By not talking about suicide, feelings of hopelessness and distress can become amplified and the person may feel they have no options or support available to them.[6]

The language to talk about suicide is important. Phrases like "commit suicide" should be avoided as it is connected with the idea that suicide is a criminal or immoral act. While it is possible that suicide is criminalised in certain contexts, it is important that caseworkers do everything they can to help reduce the stigma around suicide to help create a safe environment for people to seek help. According to those with lived experience, the following phrases are more appropriate: attempted suicide, died by suicide, took their own life.[7]

How to recognize warning signs of suicidal ideation?

Recognizing signs of suicidal ideation and supporting clients requires sensitivity, understanding, and prompt action. By identifying the signs and assessing the risk, protection caseworkers can play a crucial role in preventing suicide and providing the necessary support to those in crisis. Warning signs can be categorised into three main types: verbal, behavioural, and situational. Each type provides different clues that, when identified, can help caseworkers intervene appropriately.

Verbal Warning Signs: Individuals experiencing suicidal thoughts may express their distress through verbal cues, whether directly or indirectly.

Direct statements: Explicit mentions of self-harm or suicide such as "I want to die" or "I'm going to kill myself."

Indirect statements: Subtle hints or less direct comments such as "I can't go on," "Everyone would be better off without me," "What's the point of living?", or "no one cares what I do".

Behavioural Warning Signs: Changes in behaviour can sometimes signal that someone is struggling with suicidal thoughts.

Withdrawal: No longer participating in regular activities and isolating from friends, family, or social activities.

Changes in sleep patterns: Either sleeping too much or experiencing insomnia.

Risk-taking behaviours: Engaging in reckless actions, substance abuse, or self-destructive activities.

Giving away possessions: Distributing valued belongings, which may indicate preparations to no longer exist in this world.

Sudden improvement: An unexpected shift from deep sadness to apparent calm or happiness; this might be due to the person deciding to end their struggle by ending their life.

Situational Warning Signs: Certain life circumstances or events can increase the risk of suicidal ideation.

- Recent loss: Experiencing the death of a loved one, a breakup, job loss, or other significant losses.
- Chronic illness or pain: Dealing with prolonged physical or mental health issues.
- High-stress events: Facing overwhelming stress from situations like financial problems, legal issues, or academic pressures.
- History of exposure to adverse life experiences and/or severely distressing events: Previous experiences, including abuse, neglect, or other forms of violence.

A caseworker's vigilance about these warning signs can make a significant difference in the lives of clients. Early identification and intervention can provide individuals with the help they need.

How to assess the risk of suicide?

Risk of suicide can be assessed by: (1) recognizing the warning signs, (2) directly observing the client, (3) reviewing risk and protective factors, and (4) completing the suicide risk assessment with the client. It is also important to be aware of any trends of suicide within the community to understand most commonly used means, availability of means, locations, and specific populations that might be more vulnerable.[8] Assessing risk of suicide can happen at any point when working with a client.

1. *Warming signs that indicate heightened risk:* Recognizing warning signs can be challenging, as each client is unique. It is important to understand the individual and what might not be normal for them. Examples of verbal, behavioural, and situational warning signs have been provided above.
2. *Direct Observations:* Notice signs such as extreme hopelessness, erratic behaviours, impact from chronic illnesses, depressed or anxious mood can be beneficial when assessing for risk. Each individual is unique; some may appear visibly agitated or distressed and verbalise their desire to take their own life, while others may appear apathetic or calm and give no indication at all that they are suicidal.
3. *Protective and Risk Factors:* Protective and risk factors can be at the individual, relationship, community, and societal levels. What can be a protective factor for one person can be a risk factor for another (e.g. closeness to family or religion). It is important to explore the meaning of risk and protective factors with the client rather than make assumptions. Examples of factors that that may increase risk of suicide include:[9]
    - *Individual:* previous suicide attempt, mental conditions, job or financial loss, chronic pain, genetic and biological factors, harmful alcohol or substance use
    - *Relationships:* feelings of isolation and lack of support, violence or conflict within relationships
    - Community: Discrimination, barriers to accessing healthcare, access to means for suicide easily available, exposure to potentially traumatic events, such as abuse, disaster, war and conflict, dislocation

- *Society:* Media reporting sensationalises suicide, stigma towards mental health seeking behaviour

4. *Suicide Risk Assessment:* The Basic MHPSS Assessment (Form 5) includes key questions and guidance on use of the Suicide Risk Assessment.[10] The Suicide Risk Assessment should be completed immediately as a follow up if the client responds "several days", "more than half the days" or "nearly every day" to question nine (9) of the Basic MHPSS Assessment, "Had thoughts that you would be better off dead or of hurting yourself in some way". A copy of the Suicide Risk Assessment, including a script for caseworkers and guidance information can be found in the forms section of this annex.

Key Resource: The EQUIP Platform "Assessing and Supporting People with Suicidal Behaviours"
The EQUIP Platform provides a self-guided course on assessing and supporting those with suicidal behaviours. Within this course, caseworkers can learn more about how to ask about suicide, and how to assess suicidal behaviours, how to determine level of risk, and safety plan for those at risk of suicide. Sample scripts are provided as well as a video to support caseworkers and teams in their learning. To access this course and additional key resources and courses for caseworkers and supervisors, visit www.equipcompetency.org; registration is required and free. To access this course directly, visit https://equipcompetency.org/en-gb/node/929#page-1.

When to seek additional support and refer?
If at any time a caseworker observes warning signs of suicidal ideation in a client, whether through verbal admission or other indicators, or the client indicates risk of suicide when completing the Basic MHPSS Assessment and the Suicide Risk Assessment, it is crucial for the caseworker to take immediate action. The caseworker should inform their supervisor, refer the client to specialised MHPSS services if available with their consent, and continue to provide support within their professional scope of practice. If caseworkers feel uncomfortable discussing suicidal ideation with their clients, it is important they reach out to their supervisor for additional support on how to address the

situation. Additional guidance, including required timeline for the referrals of clients experiencing suicidal ideation, can be found in the Basic MHPSS Assessment (Form 5).

Provision of MHPSS Services

Caseworkers play an essential role in providing MHPSS services to clients and referring clients who are experiencing severe distress, self-harm, and suicidal ideation. Training on how to provide MHPSS services to clients should not be delayed; instead, caseworkers must be prepared and trained in how to provide MHPSS services in advance. Knowing how to support clients, refer when needed, and engage emergency services effectively can significantly reduce stress and complications for caseworkers and ultimately, this preparedness can save the lives of clients.

Key actions for caseworkers include the following:

- *Use Basic Psychosocial Support Skills:* Hold space for the client without immediately trying to fix the issue.
- *Address Acute Distress:* If a client shows signs of acute distress, immediately select and engage in an appropriate focused MHPSS activity to support them.
- *Make Key Referrals:* Inform clients about specialised MHPSS services and other relevant providers (e.g., health, GBV), refer them to the services they consent to, and continue to provide support services within scope of practice.
- *Create a coping plan:* Work with the client to create a coping plan and update the coping plan regularly during the case management process.
- *Provide Focused MHPSS Activities:* During case management sessions, provide focused MHPSS activities that meet the needs of the client.
- *Case Conference:* Caseworkers should actively organize and participate in case conferences with MHPSS service providers to address the client's MHPSS needs. Coordinate with health teams, doctors, psychiatrists, counsellors, and other caseworkers (e.g., GBV) to address bottlenecks (e.g., barriers to accessing care, quality issues, etc.), assign follow-up responsibilities and monitor the client's progress and risk status. Caseworkers are not and should not be the sole source of support for clients experiencing severe distress or at risk of self-harm or suicidal ideation.

- *Create a Suicide Safety Plan:* For clients at risk of suicide, develop and complete a Suicide Safety Plan together.
- *Emergency situations:* If concerned that a client may harm themselves or others, or is in immediate danger, follow pre-established procedures (e.g., do not leave the client alone, complete referral to specialised MHPSS service providers or health provider, contact supervisor, etc.).
- S*eek support from supervisor:* Caseworkers should continuously engage in capacity-building activities and individual and peer-support sessions with their supervisors. Seek immediate guidance from supervisors when questions or concerns arise; waiting to discuss concerns could put the client or caseworker at risk of more harm.
- *Prioritise staff-care and wellbeing:* Caseworkers and their supervisors should ensure that staff-care and wellbeing services are available and prioritised.

The safety of the caseworker is a top priority; prior to implementing services, supervisors and caseworkers should establish a plan to ensure that caseworkers know what to do in situations where they do not feel safe for any reason.

Using **basic psychosocial support skills** can go a long way in supporting someone who is experiencing severe distress. Often when a person feels like they are heard and not judged for their reactions, they will calm naturally. **Psychological First Aid** is a set of skills that can support case workers when working with those in distress or who are at risk. The principles of Look, Listen, and Link will give a structure to follow when things may seem chaotic. Remembering that challenging behaviours are usually coming from a place of hurt, hopelessness, and pain can help to remain empathetic if someone is being difficult.

Tips for working with clients experiencing severe distress

Below are some tips for working with someone who is experiencing distress or severe distress.

1. Stay grounded and calm: Take deep breaths and remain composed. Remember that the client may not have experienced much safety or care from others.
2. Use de-escalation techniques: The use of de-escalation techniques (examples can be found in following section of annex "managing clients experiencing severe distress").
3. Provide appropriate space: Maintain a safe distance where the client does not feel threatened or confined, yet not too far to seem distant or scared.
4. Use empathy and a neutral tone of voice: Acknowledge and name the emotions the client is exhibiting (e.g., "I can see that you're very upset right now") and validate the client's experience without judgement.
5. Offer water or a walk: If it is safe and appropriate, suggest taking a walk or offer a glass of water to help the client calm down.
6. Engage in emotion regulation activities: If the client has previously practised emotion regulation activities such as grounding or relaxation techniques, suggest doing one of these activities together.
7. Ask neutral questions: Once the client appears to have calmed down a bit, ask neutral questions to ground them in the present moment (e.g., "Can you tell me about your favourite place to relax?"). Continue to build rapport by showing understanding and patience.

Below are some key 'Do's and Don'ts' for when working with someone who is experiencing distress or severe distress.

Do's	Don'ts
Remember to stay calm. Use a calming tone of voice and speak slowly and clearly.	Avoid appearing upset or anxious (even if that is the reality!). There is a higher chance of the distressed person picking up on heightened emotions and becoming more distressed themselves.

Do's	Don'ts
Treat the person with respect and dignity, even if their behaviours are frustrating or challenging.	Don't try to handle the situation or support the client alone. Always have a plan in place to ensure you can ask for backup support.
Keep open body language and maintain eye contact as appropriate. Try to match the distressed client's level, so if they are sitting on the floor, ask if you can join them.	Avoid standing over the person, as this may feel threatening.
If not a risk to the caseworker, invite the distressed client to a calm, safe environment – ideally a place that feels comfortable and away from others' watching eyes.	Do not stay alone in a room with someone if you are at risk. Immediately activate escalation protocol.
See that basic needs are attended to; perhaps the client needs a drink of water, or to take a deep breath, or would like to have a blanket to warm them up.	If you are not at risk, do not leave the person alone.
Ask permission and give choices where possible. This can give the client a sense of control over the situation and their distress reactions.	Don't attempt to introduce or implement focused MHPSS activities, especially more complex activities, if the client is in acute distress or has expressed they do not want to participate.
Explain what is going on as much as possible in clear and simple language. *"We are going to go to a room that is more private, would that be ok for you?", "I am going to invite my supervisor into the sessions so we can work together to support you. Their name is _____ and they are very helpful in situations like these."*	Don't immediately ask the person to stop being distressed, if possible. It is important to understand why they are distressed, and often beneficial for them to have a non-judgmental space to have their feelings.

Do's	Don'ts
Remember that emotions, while sometimes intense and difficult to watch, are important and valuable. It is important that the person be able to have space to express their emotions without judgement.	Don't wait until a difficult situation emerges to be aware of your organisational protocols in case of urgent situations.
Use basic psychosocial support skills the entire time. Once the person has calmed, continue to use these skills to understand causes of distress.	
After some time, the caseworker can take steps to support the distressed client to feel calmer and more in control of the situation including completing focused MHPSS activities, such as short breathing exercises or a coping strategy of their choice. Knowing what works for the client will work best.	
Ask the client if they would like to invite someone into the space with them who is supportive and that they trust. This can be a relative or friend or anyone they are comfortable with.	
Once calmed, work with the client to understand what is in their control and out of their control, and jointly come up with a coping plan or action plan to address what is in their control.	
Provide continuous follow up and check-ins within the caseworker's scope of practice.	

Do's	Don'ts
Complete a referral for specialised MHPSS services and additional MHPSS services as needed and with the informed consent of the client.	
Engage in case conferences to ensure appropriate support and address any barriers the client is facing in accessing quality services	

De-escalation techniques for caseworkers[11]

De-escalation for caseworkers is an important skill to have. Natural reactions that happen when we are confronted with aggressive behaviours can be to freeze, walk away, or fight back and argue with the person. It is important for caseworkers to practise de-escalation techniques regularly when faced with difficult situations to be able to manage their own reactions before attempting to manage the distress reactions of the client.

- Remember: safety first! It is essential that the caseworker is physically and psychologically safe. It is important to be in an open space with clear exits. If the client is displaying aggressive behaviours, the caseworker should maintain a safe and comfortable distance from the client and always be ready to activate their organisation's safety protocol.
- Take a deep breath! It can be difficult in the moment to not react, especially when feeling threatened. Taking a deep breath and then doing a quick grounding exercise such reminding oneself of the organizational safety protocol can help to respond calmly to the situation at hand.
- Awareness of physical reactions and body language are always important when working with clients and especially so when de-escalating a situation. Using a calm tone of voice and simple, clear language is important. Be sure to keep hands out in the open and to not turn your back on the client. If possible, stand at an angle so not directly opposing the client. Smiling or laughing may be perceived as a threat, as can direct, consistent eye contact.
- Consider word choice. Be sure to not try to rationalise with a client who is displaying aggressive behaviours or defend yourself. When

clients are experiencing distress or sever distress, they are often not able to be persuaded or convinced. Even if the client says or shouts insults, it is important to stay calm. Do not tell the client to 'calm down' as this may escalate rather than de-escalate the situation.

- Be respectful and treat the client with dignity. Do not shame or judge the client if they displaying aggressive behaviours. Remember their humanity and that there is something that has made them act this way. When connecting to the organizational safety protocol or other support, continue to treat person with dignity and respect, and inform them of what is going on as appropriate.
- It is important caseworkers receive support for themselves after a tense or stressful situation. They may need to take a break from work and talk to a supervisor or a peer. Organisations should make every effort to ensure support is readily available.

Tips for Clients Under the influence of Drugs or Alcohol

A client may also come to session under the influence of drugs or alcohol. For some clients, this may increase their likelihood of displaying aggressive behaviours. If this happens, it is important to immediately use organisational safety protocols to receive assistance and use de-escalation techniques as needed while awaiting assistance.

Tips for Clients in "Fight Mode"

When a person is experiencing distress or severe distress, they may go into "fight" mode (e.g., shouting, swearing, using harsh language, being physically aggressive towards property or people, appearing tense or agitated, etc.). They may have unmet MHPSS needs, situations in their life that feel unmanageable and overwhelming, and have levels of frustration that push them to feel out of control. It is important for caseworkers to remember that a client in 'fight mode' is likely experiencing something distressing and displaying these behaviours/emotions to try and keep themselves safe. The use of de-escalation techniques (examples can be found above or in the following section of annex "managing clients experiencing severe distress"), psychological first aid, and other calming and non-judgmental approaches can often lessen disruptive behaviours so that caseworkers can understand

the cause for the behaviours and make appropriate linkages for support. The caseworker's objective in this situation is to help the client feel safe.

Tips for Clients Who Express the Desire to Harm to Others

If you are working with a client who expresses that they would like to harm another person, it is important to understand the risk level. Even if the client says something like this jokingly, caseworkers are encouraged to explore with the client their meaning and intent. Expressions of harming someone might include:

- *"I am going to kill that person"*
- *"Sometimes I want to strangle them"*
- *"I am going to beat them up"*

If a client uses this kind of language, you can use basic helping skills to explore the meaning and intent behind their words. For example:

- *"I can understand your frustration with that person. It sounds like you have been feeling very hurt and frustrated by them the past few weeks. You mentioned that you would like to kill him. I wanted to check in to see if you have had any thoughts or plans to hurt this person?"*

Caseworkers should follow their organisation's protocols for harm to others, as well as legal and ethical guidance on mandated reporting requirements. Caseworkers should always escalate this to their supervisors.

If a situation feels dangerous or unsafe to the caseworker, it is important to prioritise physical safety. If necessary to leave the room or space to ensure safety, caseworkers should follow their organisation protocols for staff safety and contact their supervisors immediately. Organisation protocols should include information on follow up and next steps for the caseworker and client.

Tips for Working with Clients Experiencing Self-Harm

If the caseworker suspects that a client is self-harming, it is important to approach them with concern and discuss options for referrals for specialised MHPSS services, if available. Caseworkers should avoid trying to force clients to stop the self-harm, as it can exacerbate the situation. Talking about self-harm in a supportive manner can be both safe and beneficial. In addition, caseworkers can support clients to identify additional, safer coping strategies. Caseworkers trained specifically in harm reduction can also support the client with harm reduction techniques. If caseworkers are not comfortable approaching and discussing self-harm with their clients, it is important that they reach out to their supervisor for additional support on how to address the situation.

Tips for Working with Clients Experiencing Suicidal Ideation

If the caseworker has identified a client is at risk of suicide, it is important to know how best to manage that risk. The form section of this annex includes a table called 'Levels of Risk of Suicide and How to Respond' to support caseworkers in understanding the level of risk of suicide and how to respond. Prior to working with clients, caseworkers should be trained on and understand the levels of risk and recommendations on how to respond. When working with clients who are presenting with signs of suicidal ideation, it is important to involve the client by providing them with information and telling them what they can expect along the way to help them feel supported and more comfortable and confident about what is happening. Involving the client can also support the client to feel a sense of control over their life. In medical emergencies this might not always be possible. It is essential that organisational protocols are in place to manage risk, and that all caseworkers have a working knowledge of how to use those protocols.

Sample script for supporting clients at high risk of suicide

The following is a sample script that can be used for supporting clients who are at risk of suicide. Specific actions taken should always reflect organisational protocol, and the script should be contextualised to fit the language and culture that it is being used in. Examples of things that can be adapted include the language used to talk about suicide (while remembering to still ask directly!), and normalisation that suicide is often stigmatised and how the caseworker is not there to judge, but rather support.

Sample script:
I am glad you feel comfortable sharing with me how you are feeling right now. I really appreciate you being open with me. You are not alone. It is common for people to feel this way sometimes and I want to make sure you have the help you need.

You may remember that when we started working together, we talked about the limits of confidentiality and how everything we talk about is kept private unless you or someone else is in immediate danger. This means I won't talk to anyone about you without your permission unless I am concerned for your or someone else's safety.

Given what we talked about today, I think it is important to have other people involved so that we can keep you safe. This is because I care about you and I don't want you to take your own life. I will need to let my supervisor know that you are thinking of taking your life and that you have a plan, and we will need to get you the best kind of care and help we can. I know this all probably sounds very overwhelming, but it is to help keep you safe.

Is there someone who you would like to call who can support you? Perhaps a friend or a family member? They can join us in the session and together we can make a plan to keep you safe.

Suicide Safety Plan
A Suicide Safety Plan can support clients in reducing suicidal thoughts and actions and can be used with anyone who is experiencing risk of suicide, with the exception of those who need to be medically stabilised or are at urgent risk of suicide. Safety plans should be personalised, and are only effective when the information is meaningful to them.

When developing a Suicide Safety Plan with a client, it is important to explore both the warning signs of when the client might be feeling at risk of suicide, and the supports they have in their life to reach out for help. Caseworkers should also explore with the client ways to limit access to means of harm as this is an evidence-based way to prevent suicide.

Developing a Suicide Safety Plan should be as conversational as possible, allowing for the client to explore for themselves what is most meaningful to be included. The Suicide Safety Plan usually takes about 30-45 minutes to complete and caseworkers should not rush through the process with the client. A physical copy should go with the client. The caseworker should keep a copy on file and revisit it regularly with the client. A template for the Suicide Safety Plan can be found at the end of this annex.[12]

Following the completion of the Suicide Safety Plan with the client, caseworkers should help the client to contact one of the supports identified in their Suicide Safety Plan to request accompaniment home or to a calm, safe environment void of any potential means for suicide. When the client's support person arrives, the caseworkers should help the client to explain the client's need for support and inform them of the Suicide Safety Plan. It is important to ensure that the client is not left alone after their disclosure.

Support for loved ones of those at-risk or who have died by suicide

Caring for someone who is at risk of or who has died by suicide can take a heavy toll on wellbeing. In some cases, it can increase risk of suicide for the carer themselves. It is important for caseworkers to also support carers of clients at risk of suicide. Examples of support that can be provided to carers include:

- Psychoeducation on suicide, how to help make an environment safe by restricting means to suicide and self-harm, and how to have healthy boundaries with the person who is at risk of suicide.
- Information on communication skills that can create a supportive space for the person who is at risk of suicide (e.g. validating their feelings and not the desire to end their life, responding in a non-judgemental manner, etc.).
- Psychoeducation on self-care (i.e., care for the carer).
- Information and referrals for additional supports, including counselling, support groups, bereavement and grief groups

Key Resources for more information:

- WHO Instruction on how to start a survivors' group
- WHO messaging for family and friends
- Alliance for Hope: for suicide loss survivors

Follow-up

Follow-up is a vital phase in the case management process, serving as a cornerstone for ensuring the ongoing well-being and safety of clients. This step is critical for several reasons. First, it provides an opportunity to assess the effectiveness of the interventions and support services that have been implemented, allowing for adjustments as needed to meet evolving needs. Second, regular follow-up helps build trust and rapport between caseworkers and clients, fostering a sense of stability and continuity. It also enables early detection of any new or recurring issues, ensuring timely and appropriate responses. By maintaining consistent contact, follow-up strengthens the accountability of all parties involved and reinforces the commitment to achieving long-term positive outcomes for the clients being supported.

Key considerations for follow-up include:

- *Team approach:* Caseworkers should not be the sole providers of support for clients in distress, severe distress, or at urgent risk of suicide. Caseworkers should regularly discuss clients in distress, severe distress, or at urgent risk of suicide with their supervisors in individual supervision. Caseworkers may also seek support from other caseworkers during group supervision, case management meetings, or peer support sessions without sharing any of their client's identifying information.
- *Maintaining contact:* Caseworkers should maintain regular contact with the client for the first two months, following organisational protocols (e.g., home visits, phone calls, scheduled appointments). Caseworkers should continue follow-up as long as risk is present, adjusting the frequency as needed.
- *Making referrals:* If specialised MHPSS providers and other practitioners are available and not already part of the client's care team, discuss these service options as relevant with the client and obtain their informed consent before making the referrals. If the client does not consent to working with specialised MHPSS providers and other practitioners, the caseworker must discuss with their supervisor on the safest way forward.
- *Case conference:* Collaborate and convene case conferences as needed with other service providers involved in the client's care such as doctors, nurses, psychiatrists, counsellors, and other caseworkers (e.g., GBV) with the consent of the client to troubleshoot barriers to accessing care and/or meeting client goals, and to monitor the client's progress and risk status.

- *Routine assessments:* At each point of contact during the first two months, the caseworker should ask the client about thoughts of suicide and explore their risk. If the client is not improving, refer them for specialist support and maintain or increase regular contact until improvement is seen.

By incorporating these considerations into the case management process, caseworkers can ensure comprehensive support for and continuous monitoring of clients in distress, severe distress, or at urgent risk of suicide.

If the Client Does Not Return
There are some situations in which the client may not return to services. This can happen for a number of reasons: perhaps they have chosen not to or they are receiving support in other places. The caseworker should reach out as usual for missed appointments. If an emergency contact person is on file, they should reach out to that person. If that person has not previously been involved in care, it is important to maintain the client's privacy while still checking in on their safety. Case conferencing with other practitioners will also help to understand the situation and if there is cause for concern.

Staff Wellbeing
Caseworkers need to have access to their own support services when working with clients in distress, severe distress, and/or at urgent risk of suicide. This is especially important if a client has died by suicide or if there was an incident of aggression or hostility. This type of work adds pressure and responsibility, and it is important to have time and space to reflect, and to process with a supervisor and other trusted providers. Supervisors should regularly check-in with their caseworkers to offer emotional support and help strengthen skills to work with clients in distress, severe distress, and/or at urgent risk of suicide.

For additional key information on follow-up, caseworkers should refer to case closure in Module 4.

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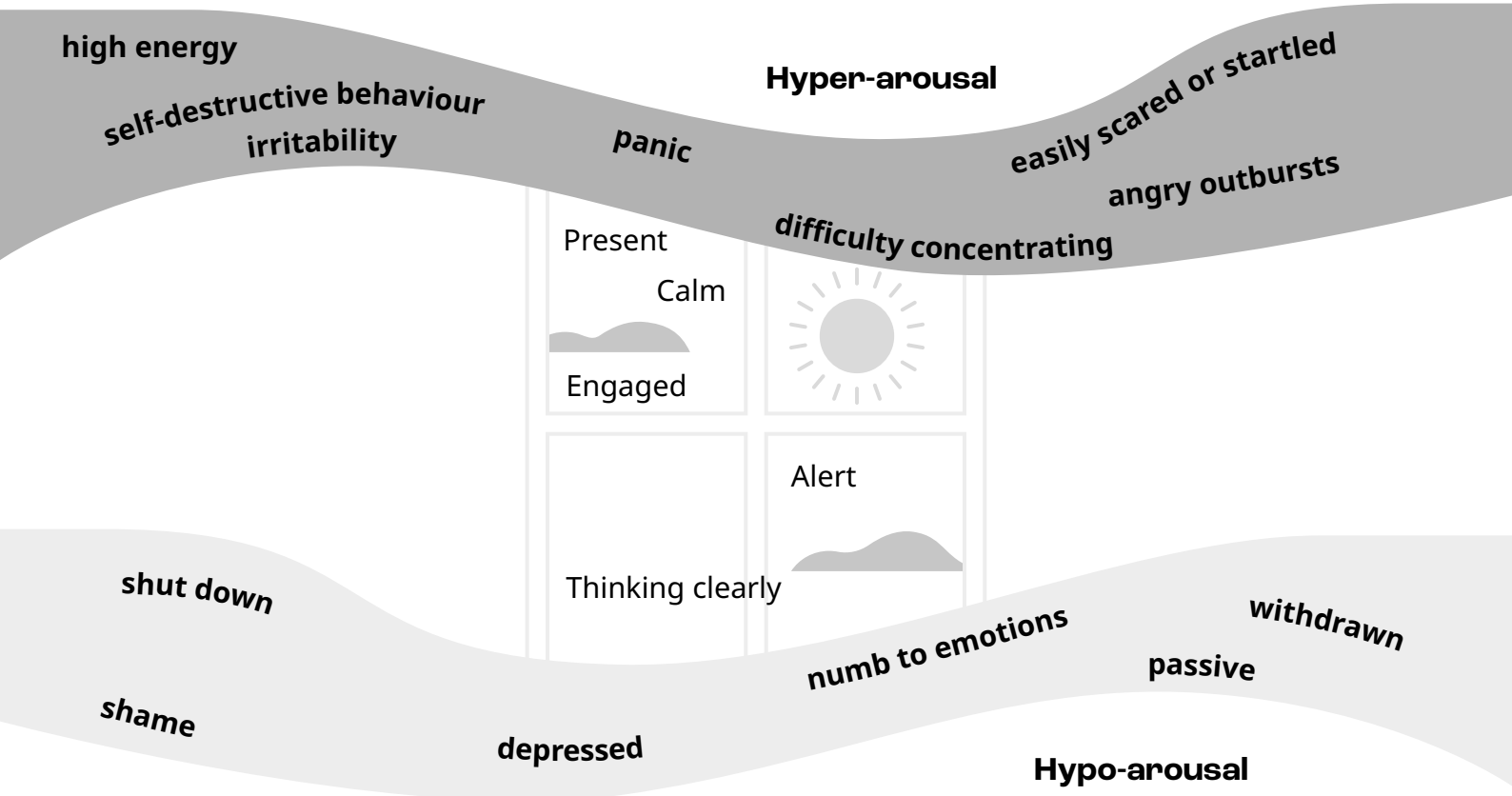
Handouts & Forms

Handout 1: Window of Tolerance

The window of tolerance is a term used to describe the "zone of arousal" or the right amount of stimulation in which a person is able to function effectively. When someone is within their window of tolerance, they can handle the ups and downs of daily life while remaining relatively stable, and process information and respond to the demands of everyday life without too much difficulty. Their brain functions well, allowing them to think rationally and make decisions without feeling overwhelmed or withdrawn.



When someone is operating outside of their window of tolerance, this indicates a problem. Extreme stress can push someone outside this window, leading to hyper-arousal (increased responsiveness to stimuli) or hypo-arousal (decreased responsiveness to stimuli), compromising their ability to cope and respond appropriately. Hyper-arousal and hypo-arousal are forms of self-protection and are also considered 'survival mode'. In either of these states, an individual may become unable to process stimuli effectively.

Hyper-arousal: When someone is above their window of tolerance, they are experiencing hyperarousal or overactivation of the nervous system. Hyper-arousal, otherwise known as the "fight/flight" response, is often characterised by hypervigilance, feelings of anxiety or anger and/or panic and racing thoughts.

Hypo-arousal: When someone is below their window of tolerance, they are experiencing hypo-arousal or under-activation of the nervous system. Hypo-arousal is a state of shut down where an individual has stopped acting or reacting. This state may cause feelings of emotional numbness, emptiness, or paralysis, as well as restricted functioning and social withdrawal.

Each individual's window of tolerance varies. Those with a narrow window of tolerance may find their emotions intense and difficult to manage, while those with a wider window of tolerance can handle intense emotions or situations without significant impact. The window of tolerance can also be affected by the environment: people are generally more able to remain within their window when they feel safe and supported. Distress or severe distress can push someone into hyper-arousal or hypo-arousal, especially for those who have experienced exposure to adverse life experiences such as war, displacement, or famine, resulting in a smaller window of tolerance.

Caseworkers can support clients to expand their window of tolerance and support clients in distress or severe distress to move back into their window of tolerance by providing MHPSS services.

Template for High-Risk Referral Contact List

To be completed by caseworker and regularly updated to include safe referrals for those who are in distress or severe distress and for emergency situations (e.g., urgent risk of suicide).

Location	Focal point/ organisation, resource	Contact information	Language(s)
Organisational focal points and supervisors			
On-site	Jane Smith, supervisor	555-55555 jane@smith.com	Dari, Pashto, English
Medical emergency services for immediate risk			
Main street hospita	Dr. Brown	454-5544 drbrown@hospital.com	Dari, English, Arabic
Ambulance service			
Emergency Room			

Location	Focal point/ organisation, resource	Contact information	Language(s)
Mental health and psychosocial support resources			
Main street community health centre	Aysha Brown	444-7777 Aysha@cmh.com	Dari, Pashto, English
General emergency/other			
Other important info			

Checklist for Managing Severe Distress

This checklist supports caseworkers, supervisors, and organisations to provide support to clients experiencing severe distress, particularly clients who are at risk of self-harm or suicide. The checklist provides a minimum standard; organisations may add additional steps to enhance support for high-risk clients. Caseworkers should contact their supervisor if any items on the checklist are missing within their program/organisation. Key considerations are included for: prior to engaging clients experiencing severe distress, while providing services to clients experiencing severe distress, and after referring clients experiencing severe distress to specialised/ additional services to support their needs.

Table 1: Prior to engaging clients experiencing severe distress

Caseworkers	✔	Supervisors	✔	Organisations	✔
Participate in trainings on managing risk, de-escalation, and suicide prevention Engage in supervision to ensure confidence in identifying and managing risk Confirm organisational safety policies for managing risk and clarify anything that is unclear Complete High Risk Referral Contact List template (see page 636)		Ensure completion of risk management training and how to manage risk within supervision Confirm duration, frequency, modality, and timing of supervision with caseworkers Ensure organisational safety policies, tools for assessing and responding to risk of suicide, and referral pathways are in place and understood by caseworkers		Ensure access to risk management training for all caseworkers Ensure that risk management is part of induction process for all new staff Ensure availability of staff trained to identify and manage risk Ensure availability of supervision for caseworkers with those experienced in managing risk	

Caseworkers	✔	Supervisors	✔	Organisations	✔
Ensure awareness of referral pathway and how to establish contact				Ensure service mapping and referral pathways exist and are regularly updated Establish feedback mechanism for caseworkers and supervisors about risk management	

Table 2: While providing services to clients experiencing severe distress

Caseworkers	✔	Supervisors	✔	Organisations	✔
Be able to identify risk through MHPSS assessment and follow up questions Be able to identify and assess risk at any point of case management process (not just at assessment) Be aware of levels of risk and actions to take for each level Know how to follow organisational safety policies		Ensure regular supervision for those working with clients experiencing severe distress Ensure organizational safety policies are in place and the availability of immediate support for clients experiencing severe distress and/ or at urgent risk of suicide		Ensure safety policies and protocols in place for managing emergency situations Ensure availability of supervision for all caseworkers Ensure availability of regular training and refresher trainings on managing risk Ensure staff care mechanisms in place to support staff working with those at-risk including referral pathways for those affected by loss	

Caseworkers	✔	Supervisors	✔	Organisations	✔
Be aware of referral pathways for those who are at risk and how to make safe referrals Keep High Risk Referral Contact List up to date Be able to complete Suicide Safety Plan for those at risk of self-harm and suicide Ensure continuous check-ins with clients experiencing sever distress, including regular review of Suicide Safety Plan for those at risk of suicide Participate in case conferences as applicable and needed		Ensure referral pathways are up-to-date and maintain relationships with external service providers		Ensure that relationships are established and maintained with primary healthcare centres and other healthcare facilities who can work with those who are high risk Maintain feedback mechanism for caseworkers and supervisors about risk management; revise protocols as needed	

Table 3: After referral to specialised/ additional services to support clients experiencing severe distress

Caseworkers	✔	Supervisors	✔	Organisations	✔
Engage in case conferences as needed and take action according to what is agreed upon in the case conference		Provide ongoing supervision		Ensure referral pathways are functioning, safe, and effective	

Caseworkers	✔	Supervisors	✔	Organisations	✔
Participate in supervision and reflect on clients and impact on self, and if additional skills are desired Access Duty of Care support as needed to manage impact of working with clients experiencing severe distress		Support caseworkers in facilitating case conferences as needed Determine if caseworkers need or desire additional skills to support continuous growth in ability managing risk Engage in own supervision on regular basis		Ensure access of supervision and Duty of Care supports for all caseworkers and their supervisors	

Suicide Risk Assessment

This form includes the Suicide Risk Assessment. These questions can also be found included at the end of the Basic MHPSS Assessment (Form 5); they should be completed as a follow-up if client responds 'several days', 'more than half the days', or 'nearly every day' to the suicide ideation question (i.e., question 9) of the Basic MHPSS Assessment (Form 5).[13]

Introduce the Suicide Risk Assessment (i.e., optional script): *"Oftentimes when people have been experiencing challenges or emotional difficulties in their life, they can begin to feel sad or hopeless, and have thoughts of ending their own life. It is important to know that this is not uncommon, and that people often feel better after talking about it. I will ask you some questions on the thoughts you have been having. The reason I am asking these questions is because your responses will help me to connect you to the right type of support. Would it be ok if we continued?"*

If the client does not want to continue with the Suicide Risk Assessment questions, inform them of specialized MHPSS services if available and request their consent to refer them to the specialized MHPSS provider

for assessment and support. If the client does not consent to the referral or if no specialized MHPSS provider exists, the caseworker must contact their supervisor immediately to discuss the safest way forward. The caseworker should inform the client of the need to call their supervisor and ask the client to stay with them as they call.

If the client answers 'several days', 'more than half the days', or 'nearly every day' to question 9, continue with the Suicide Risk Assessment	
A. In the past month, have you had serious thoughts or plans to end your own life? *Guidance: If the client responds 'no' to Question A, thank them for answering your question and inform them of specialized MHPSS services if available. Request their consent to proceed with a referral to the specialized MHPSS provider for further assessment and MHPSS service provision. This should also be done if the client declines to complete the suicide risk assessment because without further information, the client should be categorized as a high-risk client and be referred for specialized MHPSS services. If the client does not consent to the referral, you must contact your supervisor immediately to discuss the safest way forward.*	☐ Yes ☐ No
B. If yes, what plans have you made or actions have you taken to end your life? *Guidance: Plans or actions could mean the client has plans to or has obtained items (e.g., poison, a knife) to aide in ending their own life, or has previously attempted to end their own life.*	Write response here:

C. Do you have plans to end your life in the next two weeks? *Guidance: If 'yes' or 'unsure', ask the client to describe their plan to you. The aim is to understand whether the client is planning on ending their life in the immediate future. If the answer is yes, and/or the client has a plan to end their life in the immediate future, or you are unsure, then inform the client that you would like to conduct a referral to a specialised service provider. If the client does not provide consent to be referred, inform the client that you must contact your supervisor for additional guidance and ask the client to remain with you as you call.*	☐ Yes ☐ No ☐ Unsure Write response here:

Table 4: Levels of risk of suicide and how to respond[14]

Level	Indicators	Response
Low	Thoughts of suicide, but no plan or access to means to self-harm Thoughts or plans to self- harm in past month, or an act of self-harm in the past year.	Provide immediate psychosocial support services (e.g., psychoeducation about suicide, use basic psychosocial skills to normalise client's feelings, create safe non-judgemental space) Create Suicide Safety Plan (refer to Annex 4.3) Activate social supports that are meaningful to client (e.g. family member, friend, trusted member of community) Connect with supervisor

Level	Indicators	Response
Low		Provide ongoing psychosocial support services as a part of your case management services (e.g., regularly check- in about thoughts of suicide, continue to educate about suicide, use psychosocial skills to promote trust and safety) Refer with client's consent to additional support services to address key needs/ risks highlighted by client (e.g., livelihoods, GBV, health, food distribution, etc.) Refer with client's consent to additional MHPSS services, including but not limited to specialized MHPSS supports, as needed Follow-up and check-in regularly with the client about their own safety
High	Has thoughts of suicide and plans for suicide in the last two weeks Access to means to end their own life Previous attempt to take their own life in past year or thoughts and plan in past month	Do not leave the client alone Connect with supervisor immediately Complete the Suicide Safety Plan with the client (refer to Annex 4.3) Remove any means for harm (e.g. consider windows if on top floor, sharp objects, ingestible toxins)

Level	Indicators	Response
High		Move to safe supportive environment that allows for privacy and easy access to support if needed Invite supportive person of the client's choice to join Invite supportive person to be with client and provide psychoeducation on steps that can be taken to help to ensure safety of client Provide psychoeducation to client and support person (e.g., about how to promote safety, how to connect to support, how to care for the carer) see accompanying text box for additional resources Refer with client's consent to specialist mental health providers who are equipped to support those at risk of suicide (e.g., medical support, specialised mental health provider) Engage in regular follow- up during the first two months and continue to ask about risk Continue to provide psychosocial and suicide management support during follow up

Level	Indicators	Response
High		Case conference with providers engaged in supporting the client (e.g. members of health team, doctors, psychiatrist, psychologist/ counsellor)
Emergency	Physical indicators such as signs of poisoning, bleeding from wound that is self-inflicted, loss of consciousness	Activate organizational safety policy immediately to access medical services to medically and/ or psychologically stabilise the client. Assist person to be brought to a secure and supportive environment in a healthcare setting that is equipped to support those who are at risk of suicide. Ensure client is told what is going on in way that ensures their dignity, and give choices when possible. Do not leave person alone. Stay with person until you have passed care to another individual. Provide psychosocial support to client's support person(e.g. carers). Continue to provide support after stabilised and case conference as needed.

Endnotes

1 For more information about terminology, see: McBride, K., Engels, E. Suicide Prevention. IFRC Reference Centre for Psychosocial Support, Copenhagen, 2021.Suicide Prevention. IFRC Reference Centre for Psychosocial Support, Copenhagen, 2021. Padmanathan P, Biddle L, Hall K, Scowcroft E, Nielsen E, Knipe D. (2019) Language use and suicide: An online cross-sectional survey. PLoS ONE 14(6): e0217473. https://doi.org/10.1371/journal.pone.0217473. Retrieved from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0217473

2 Definitions adapted from https://pscentre.org/wp-content/uploads/2019/07/PFA-Intro-low.pdf

3 This template has been adapted from IRC's template escalation protocol for acute protection concerns

4 Inter-Agency Standing Committee (IASC). Guidance Note: Addressing Suicide in Humanitarian Settings. IASC, Geneva, 2022.

5 Dazzi T, Gribble R, Wessely S, Fear NT. Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? Psychological Medicine. 2014;44(16):3361-3363. doi:10.1017/S0033291714001299 Live life: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.

6 Lindsay Sheehan, Nathalie Oexle, Silvia A. Armas, Hoi Ting Wan, Michael Bushman, LaToya Glover, Stanley A. Lewy, Benefits and risks of suicide disclosure, Social Science & Medicine, Volume 223, 2019, Pages 16-23, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2019.01.023.(https://www.sciencedirect.com/science/article/pii/S0277953619300231)

7 Nielsen, E., Padmanathan, P., & Knipe, D. (2016). Commit* to change? A call to end the publication of the phrase 'commit* suicide'. Wellcome open research, 1, 21. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5341764/

8 Inter-Agency Standing Committee (IASC). Guidance Note: Addressing Suicide in Humanitarian Settings. IASC, Geneva, 2022.

9 Adapted from: World Health Organization (2014). Preventing suicide: A global imperative and Inter-Agency Standing Committee (IASC). Guidance Note: Addressing Suicide in Humanitarian Settings. IASC, Geneva, 2022.

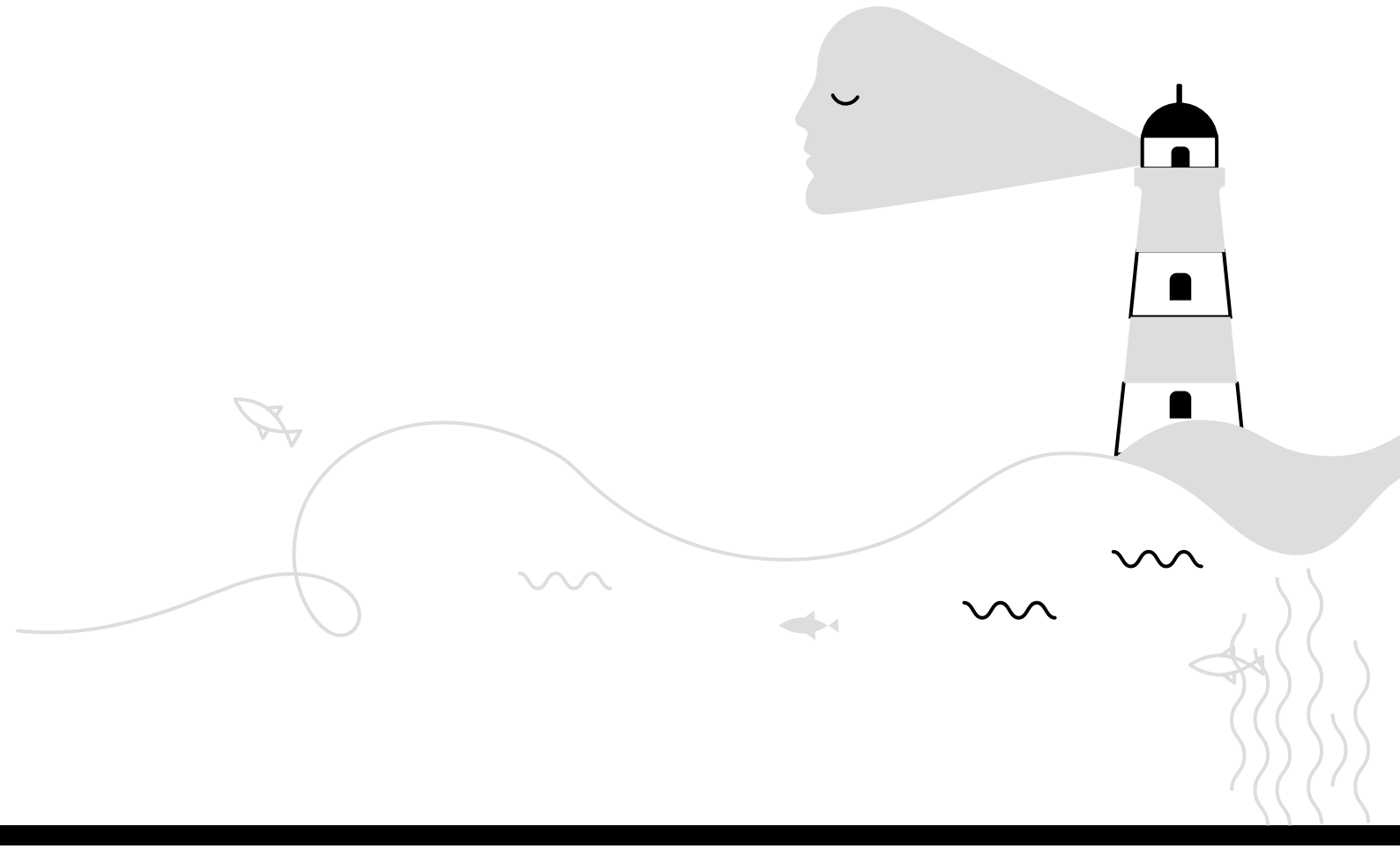
10 Questions adapted from: Ensuring Quality in Psychological Support (EQUIP) Assessing and Supporting People with Suicidal Behaviours, McBride, K., Engels, E. Suicide Prevention. IFRC Reference Centre for Psychosocial Support, Copenhagen, 2021.Suicide Prevention. IFRC Reference Centre for Psychosocial Support, Copenhagen, 2021.

11 Adapted from INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM) (2023). *IOM CASE MANAGEMENT GUIDELINES*. IOM, GENEVA, Box 15. https://publications.iom.int/books/iom-case-management-guidelines

12 Adapted from IFRC Reference Centre for Psychosocial Support and Suicide Prevention, and Suicide Prevention during Covid-19

13 Questions adapted from: Ensuring Quality in Psychological Support (EQUIP) Assessing and Supporting People with Suicidal Behaviours, McBride, K., Engels, E. Suicide Prevention. IFRC Reference Centre for Psychosocial Support, Copenhagen, 2021.Suicide Prevention. IFRC Reference Centre for Psychosocial Support, Copenhagen, 2021.

14 MhGap, IFRC publication TBC after review



Supervisor Form 1
Caseworker Capacity Assessment[1]

Purpose of the form: This helps supervisors to understand the extent of newly recruited caseworker's attitude, knowledge and skills. It contains minimum competency standards for all caseworkers providing client-centred Protection Case Management services. The results of the assessment should inform the capacity building and development actions that a supervisor provides in individual and group supervision sessions.

How to administer the form:

Before

The Supervisor should
Step 1: Organise an individual supervision session in a comfortable and private space. The supervisor should set aside between 2-3 hours for this assessment or if it is preferred, this process can be broken down into 2 or 3 separate sessions.

During

The Supervisor should
Explain the purpose of the assessment to staff and ask staff to answer honestly and be self-reflective. This will be most helpful in identifying areas where staff can benefit from further coaching and staff development. **The supervisor can say:** *"This form has been developed to capture some of the key standards that are expected of a protection caseworker. We don't expect you to be an expert and have perfect answers from the very beginning. It takes time to understand Protection Case Management guiding principles and how to apply them with clients. During our first weeks together, this assessment will determine the areas where we can provide you with more technical support. After the assessment, we will continue working together to build your knowledge and skills. After a few months, we will revisit the assessment to see how you are progressing."*

Client code: _____

During

The Supervisor should

Step 3: Explain the form is divided into three sections (attitudes, knowledge and skills). Explain that **the attitude assessment is a self-administered assessment** where the caseworker will be given 20 minutes alone to answer these questions. Once this has been completed, **the knowledge and skills assessment will be administered through a verbal interview with the supervisor**. Explain that notes will be taken in order to remember their responses. Invite the caseworker to raise any questions about the form or the process to ensure they feel comfortable. **The supervisor should ask the questions on the questionnaire in order and give the caseworker time to explain/describe their answer.** Allow the caseworker to speak openly and ask clarifying questions. Supervisors are encouraged not to provide answers, but should respond if there are some alarming issues that require immediate discussion and direction. For the attitude scale, simply mark the scoring and don't ask for further elaboration.

Once the assessment is complete, the supervisor and caseworker should discuss what are the suggested priorities in each area for technical capacity building and development.

If the staff member does not meet, or only partially meets, the required attitudes, knowledge and skills, it may not be appropriate for them to work with persons at heightened risk until they undergo personal reflection of the harmful values and/or beliefs, or review the way Protection Case Management services should be delivered. If this is the case, supervisors will need to handle this conversation carefully and sensitively.

After

The Supervisor should

During regular individual supervision sessions, the supervisor should refer back to the capacity assessment in order to provide ongoing coaching to the caseworker. If several caseworkers need guidance in the same area, the supervisor can organise a training or development session during group supervision. The supervisor should also arrange shadowing sessions for the caseworker to observe the application of guiding principles in practice.

After approximately 3-6 months, the supervisor should re-assess the caseworker to determine their progress and continuous development needs.

Part one: Protection attitudes and scoring

This is made up of 15 statements to assess personal beliefs and values. The scale can measure their attitudinal readiness for working directly with persons at heightened risk and highlight areas for further learning and training.

Statements	Does the caseworker:				Caseworker's response and notes from discussion	Development priority?
	Strongly agree	Agree	Disagree	Strongly disagree		
1. People with developmental disabilities and mental health conditions have something to offer the community and should be able to move freely.	4	3	2	1		
2. Violence can sometimes be a person's own fault and is justified.	1	2	3	3		
3. People of all political and religious beliefs and values have the right to express them and live in safety and dignity.	4	3	2	1		
4. People who experience traumatic events cannot recover or become productive members of society.	1	2	3	3		
5. A caseworker should always consider a person's opinion and wishes when making a decision that will affect them.	4	3	2	1		

Part one: Protection attitudes and scoring

Statements	Does the caseworker:				Caseworker's response and notes from discussion	Development priority?
	Strongly agree	Agree	Disagree	Strongly disagree		
6. It is acceptable for caregivers to make decisions and provide consent on behalf of a person with developmental disability or an older person because they know best.	1	2	3	3		
7. Violence within a household is a family matter and should be handled within the family.	1	2	3	3		
8. Services should always be designed with persons with permanent disabilities in mind.	4	3	2	1		
9. Retaliation from community members against former combatants is acceptable.	1	2	3	3		
10. Men don't experience mental health concerns.	1	2	3	3		

Part one: Protection attitudes and scoring

Statements	Does the caseworker:				Caseworker's response and notes from discussion	Development priority?
	Strongly agree	Agree	Disagree	Strongly disagree		
11. It is my job to determine whether a client is telling the truth.	1	2	3	3		
12. Poor people often say that they have been excluded from assistance or don't have support so that they can get attention or money.	1	2	3	3		
13. If a person can't answer the question properly or needs time, he/she is making up the case.	1	2	3	3		
14. Locking someone up with a disability or mental health concern is normal in some situations.	1	2	3	3		
15. A former member of an armed group should not be accepted for Protection Case Management.	1	2	3	3		

Part one: Protection attitudes and scoring

Statements	Does the caseworker:				Caseworker's response and notes from discussion	Development priority?
	Strongly agree	Agree	Disagree	Strongly disagree		
Total score (supervisor should sum the total score in each column and then add these together for the total score)						

The below scores should be used as a guide but are not definitive:
50-60: Scores in this range indicate that the caseworker has a person at-risk friendly attitude – they have positive beliefs and values for working with people at heightened risk. However, you can still consider supporting the caseworker on certain issues as needed.
35-50: Scores in this range indicate some troubling attitudes that may be harmful to clients. Managers and supervisors should use their discretion in allowing staff to work on cases and may want to consider "coaching" the staff person before they work independently with the person at-risk.
34-0: Scores in this range indicate that an individual is not ready to work with person at risk. Managers and supervisors should work independently with an individual who scores below 34 to address negative beliefs and attitudes, and identify immediate actions to address these gaps.

Actions to be taken	Supervisor:	Caseworker:

Part two: Protection Case Management knowledge

Knowledge questions	Possible correct responses	Caseworker's response and notes from discussion	Development priority?
1. What are the guiding principles for working with people at heightened risk?	1. Respect confidentiality and its limitations 2. Promote client safety and security 3. Everyone is entitled to human rights equally and without discrimination 4. Participation: Clients should be supported to make their own decisions, their views and opinions should be respected 5. Empowerment: I should look to enhance a person's strengths and capacities for coping 6. Do not harm 7. Client-centred approach		
2. What can be possible consequences of violence for a person	1. Physical harm such as injury or disability 2. Psychological harm such as mental health problems (depression, anxiety, low self-esteem, isolation, hopelessness) 3. Difficulty trusting people and maintaining relationships 4. Difficulty accessing services 5. Stigma		

Part two: Protection Case Management knowledge

Knowledge questions	Possible correct responses	Caseworker's response and notes from discussion	Development priority?
3. What are the limits to confidentiality when working with persons at heightened risk?	1. If there are mandatory reporting laws in place 2. If the client is at risk of harming themselves 3. If the client is at risk of harming another person (possible homicidal) 4. If a person has been legally assessed to lack capacity for consent and all possible steps have been taken to support informed consent process with him/her 5. Where the client is a child and is at risk of harm we must act in the child's best interest		
4. Why might it be difficult for someone to leave an abusive situation?	1. Has nowhere safe to go 2. No economic resources of their own. Dependant on the abuser economically 3. Has hope that things will change 4. Is scared no one will provide care or support 5. Worried about breaking up the family 6. Worried what people in the community will say (stigma) 7. Unable to independently move or voice their concerns due to barriers		

Part two: Protection Case Management knowledge

Knowledge questions	Possible correct responses	Caseworker's response and notes from discussion	Development priority?
5. When and how should a caseworker obtain informed consent/assent?	When: 1. Before the identification meeting - prior to intake into Protection Case Management services for permission to hear the persons story, record and take notes 2. After the identification meeting - prior to intake into the Protection Case Management services to request for permission to participate in services 3. For referrals to other services providers How: 1. Address any barriers identified for informed consent with the client 2. Ensure the client fully understands the Protection Case Management process 3. Ensure that the client fully understands confidentiality - including how their information will be collected, stored and shared 4. Ensure the client fully understands the limits to confidentiality 5. Ensure the client fully understands their options and the potential risks and benefits of them 6. Provide time for any questions 7. Ask the client whether they wish to proceed by signing/ verbal consent		

Part two: Protection Case Management knowledge

Knowledge questions	Possible correct responses	Caseworker's response and notes from discussion	Development priority?
6. What are the possible consequences of sexual violence on men?	1. HIV/AIDS or other STIs 2. Mental health problems (depression, anxiety, other) 3. Stigma 4. Relationship problems 5. Isolation in community		
7. What are some of the reasons a client may not want to report violence or tell you their story?	1. Fear of retaliation from the perpetrator 2. Fear or worry that no one will believe them 3. Shame 4. Self-blame 5. Lack of transportation 6. Lack of money to pay service fees 7. Do not trust the authorities or service providers 8. Believe agencies only support certain people like children		
8. What are the steps of Protection Case Management?	1. Identification and registration 2. Risk assessment 3. Case action planning 4. Safety planning 5. Implementation of the case action plan 6. Follow up and monitoring 7. Case closure 8. Protection Case Management service evaluation		

Part two: Protection Case Management knowledge

Knowledge questions	Possible correct responses	Caseworker's response and notes from discussion	Development priority?
9. What body language can you use to make the client feel more comfortable (for example, how you are sitting)?	1. Sit face to face with client, but not at a desk 2. Make eye contact appropriately according to local customs 3. Keep a calm and relaxed body posture 4. Lean in toward the client as she/he speaks 5. Nod your head to show understanding 6. Keep a warm and friendly disposition		
10. What are some things you can do to create trust and show respect to a client during your meeting?	1. Give full attention to client e.g. don't take phone calls 2. Don't interrupt give time to talk and don't be in a rush 3. Use respectful language which mirrors the clients 4. Don't promise anything you cannot do 5. Give complete and honest information 6. Follow through - do what you say you will do 7. Don't tell them what they "should" do, give information to help them make their own choice		

Part two: Protection Case Management knowledge

Knowledge questions	Possible correct responses	Caseworker's response and notes from discussion	Development priority?
11. Describe how you should start your first meeting with the client (introduction, identification).	1. Greet the client 2. Introduce yourself, role and agency, as well as anyone else present 3. Create a private and safe space 4. Assess any immediate risk to personal safety and security 5. Address any barriers to participation 6. Explain the Protection Case Management process and the person's rights (can stop, refuse to answer, ask any questions) 7. Explain confidentiality and its limits, including data protection 8. Explain any potential risks or benefits 9. Understand the persons general situation 10. Identify whether the person is at risk of/has experiences a rights violation 11. Determine the risk-level 12. Ask permission to proceed either for intake into Protection Case Management services or to conduct a quality referral only		

Part two: Protection Case Management knowledge

Knowledge questions	Possible correct responses	Caseworker's response and notes from discussion	Development priority?
12. What are some key considerations when developing a case plan?	1. Develop within two weeks of the risk assessment 2. The client should drive the process of setting their goals 3. We should build on the client's strengths 4. Content of case plan should reflect the clients risk assessment 5. Should set specific, time-bound actions outlining who is responsible for what		
13. How can a caseworker support a client-centred approach to Protection Case Management ultimately support the client's empowerment process?	1. View people as rights claimants and support them to access their rights 2. Listen to the client's opinions and requests without judgement and action their wishes 3. Assess a person's individual and environmental risk-factors and protective-factors to a violation and address these 4. Support clients to draw on their protective factors e.g. resilience, strengths and resources inherent within them, as well as their household or community to build the action plan 5. Provide full information to the client of the types of services available, how to access them, and possible risks 6. Where appropriate, safe, and requested by the client, support the families/household's commitment to the outcomes, goals and tasks outlined in the case plan		

Part two: Protection Case Management knowledge

Knowledge questions	Possible correct responses	Caseworker's response and notes from discussion	Development priority?
14. What are key healing statements you can use with clients?	1. I believe you 2. You are not to blame 3. I am here to support you 4. What you are feeling is a very normal reaction to this situation 5. I am sorry you are in this situation/this happened to you		
15. What are the main criteria for knowing when to close a case?	1. Goals within the case plan have been met as much as possible and follow up is complete 2. The client explains that they are able to address on-going challenges now themselves 3. The child and family relocate and the case file can be closed or transferred as appropriate 4. The client is transferred to another case management stream e.g. due to relocation 5. No client contact for more than a specific period (i.e. 2 months) 6. The death of a client		

Part two: Protection Case Management knowledge

Where a caseworker is able to answer most of these questions with the possible correct responses or similar responses (such as 5 criteria per answer), it indicates that the member of staff meets the core Protection Case Management requirements and is able to work independently with persons at-risk (with ongoing supervision). If a caseworker provided 3 criteria or less and/or was completely unable to answer some of the questions, this indicates that a capacity building plan should be in place and, where necessary, one on one mentorship and training, and staff shadowing.

Overall final evaluation

Actions to be taken:	**Supervisor signature:**	**Caseworker signature:**

Part three: Protection Case Management skills

This form is intended to guide a **process** of learning, allowing a caseworker to put their knowledge and attitude to practise. It is not an evaluation of the caseworker's performance. These questions can guide a discussion or role play. It lists skills associated with good Protection Case Management practice and describes the correct answers/approach to look for. The form is for the supervisor only and is intended to help the coaching process as it provides a structured method to identify in which topics/issues caseworkers need support the most.
Please note: It is very important that the form itself and the written comments are not shown to the caseworker (so as not to make them nervous). Supervisor should take notes separately. Once the supervision session is finished, document their feedback on the form.

Skills questions	Listen & ñook for responses	Caseworker's response and notes from Discussion	Development priority/ continued support needed?
1. Show how you would introduce yourself to a potential client in your first meeting.	1. Introduces themselves warmly, indicating their role and agency 2. Asks the person what their name is 3. Checks the space and asks whether the client feels comfortable, private and safe 4. Checks whether there are any immediate safety concerns 5. Asks whether they need any support to fully participate in the meeting		

Part three: Protection Case Management skills

Skills questions	Listen & ñook for responses	Caseworker's response and notes from Discussion	Development priority/ continued support needed?
2. Show how you would use your body language to help a client feel safe and comfortable.	1. Uses appropriate eye contact 2. Mirrors the words and phrases you use 3. Stays calm and comforting throughout the interaction 4. Uses a short and gentle voice 5. Friendly facial expressions 6. Leans towards you when speaking		
3. Show how you would explain confidentiality and its limits to the client.	Explains that confidentiality means: the conversations together will not be shared beyond the discussions they have, except some exceptions e.g. for safety reasons if a client gives reason that they may hurt themselves or someone else.		
4. Explain what you would do if a client walks-in and starts to talk about what happened immediately.	1. Let the client finish what they are saying, but do not ask further questions 2. Politely let them know that you understand that they are in distress and that you would like to listen and help 3. Explain that before you can do that you need to explain a few things which are important for them to know.		

Part three: Protection Case Management skills

Skills questions	Listen & ñook for responses	Caseworker's response and notes from Discussion	Development priority/ continued support needed?
5. How should a caseworker respond if a client becomes hostile or angry during an interview?	1. Remain composed and calm 2. Do not raise voice 3. Attempt to calm the person down, attempting to determine what is causing the anger and recognise their feelings 4. Give the person space and time to think 5. Be alert for possible aggression and 6. leave the situation if it feels unsafe 7. Carry a cell phone and use it where appropriate 8. If needed and advised by a supervisor, conduct interviews with a colleague to mitigate risks		
6. What are some important considerations when interviewing a client who has experienced abuse?	1. Do not push the client to speak about their experiences 2. Tell the client they can take their time 3. Do not ask heavy questions that might re-traumatize the client - they should speak to you about these issues when ready 4. Tell the client that you are here to help		

Part three: Protection Case Management skills

Skills questions	Listen & ñook for responses	Caseworker's response and notes from Discussion	Development priority/ continued support needed?
7. How can a you demonstrate empathy and respect for clients	1. Pay attention to verbal and nonverbal cues 2. Determine what is important to the client 3. Show a genuine desire to understand their situation 4. Keep an open mind 5. Create an environment of respect and acceptance 6. Listen for an acknowledge difficult feelings and encourage honest discussions		
8. Can you demonstrate, with a few questions, how you would start a discussion with a client about their experience?	Use an open tell, explain or describe question. Examples: *Tell me about what brought you here today* *I'd like to hear about what brought you here today* *Would you like to tell me about what happened?*		
10. Can you show me how you would assess safety and create a safety plan?	1. Ask the client how safe they feel at home or in the community 2. With the client, identify strategies and resources in the client's life that can help reduce risk 3. Use safety assessment or suicide assessment as needed		

Part three: Protection Case Management skills

Skills questions	Listen & ñook for responses	Caseworker's response and notes from Discussion	Development priority/ continued support needed?
11. Can you explain to me how you would come up with a coping skills plan with a client?	1. Examples include asking the client who they talk to when they feel lonely or scared. Have the client, or yourself, write a list of the people they feel comfortable with. 2. Identify the activities the client enjoys and the feelings associated with those activities. Build on the information gathered from the psychosocial assessment. 3. Based on the client's answers, help them come up with a plan to talk and spend time with the people they identified, including doing the activities that make them feel better. Explain that they can use this plan whenever they feel [insert appropriate feeling]. 4. Ask the client if there is anyone they would like to share their plan with who can help remind them of it.		

Actions to be taken:	Supervisor signature:	Caseworker signature:

Endnotes

1 This form has been adapted from the Child Protection Case Management Supervision Package developed by the Child Protection Case Management Task Team

Supervisor Form 2
Session Observation[1]

Purpose of the Form: This should be used as a guide for the supervisors when observing the provision of Protection Case Management services by a caseworker. This form is part of the regular coaching and feedback should be provided in individual supervision sessions.

Before

The Supervisor should	The caseworker should
• Discuss the process with the caseworker so that they feel reassured about the exercise, allowing the caseworker to ask any questions and raise any concerns they have in advance of the scheduled observation exercise • Schedule an observation with an appropriate case in advance with the caseworker • Be familiar with the client's case file ahead of joining a meeting and any issues that may arise • Ensure that consent has been obtained for the visit	• Schedule the interviews or meetings with a client with an appropriate case. The caseworker should obtain the clients informed consent/assent • Eventual risks or concerns associated with the observation should be discussed with the client. If no concern is underlined and the client provides consent, then the observation can take place

Client code: _____

During

The Supervisor should	The caseworker should
• Allow the caseworker to take the lead • Don't interrupt the caseworker unless it is necessary • Explain that you will be taking notes about the caseworker's practice and let the client see the notes if they are interested • Take notes according to the observation tool, highlighting specific examples for areas of improved or good practice that can be praised afterward • Fill the observation tool, making sure that concrete examples are noted	• Introduce the client to the supervisor and remind them why the supervisor is joining the visit • Lead the session with the client as though the supervisor is not present

After

The Supervisor should	The caseworker should
• Complete the observation tool, including constructive and positive feedback • Shortly after the session, have an individual supervision session with the caseworker to provide feedback from the observation	• Participate in an individual supervision session with the supervisor and share reflections/feelings about the observation • Ask any questions that may exist from this specific session or technical areas that the supervisor can provide more guidance on

Case number

Date

Caseworker code

Supervisor

Mark which stage of the CM process you are observing:

Identification & registration	
Risk assessment	
Action plan	
Implement action plan	
Follow up, monitoring	
Closing	

Areas of Observation	Examples (Did the caseworker...)	Examples observed and comments for the caseworker
1.**Preparation** Demonstrate proper planning and organization for the session including making any adjustments for participation	• Ensure the available background information was gathered and adjustments/considerations were made prior to the session to ensure full participation of the client • Select an accessible, comfortable, safe and private location based on the client's preference • Have a clear objective/goal for the session	

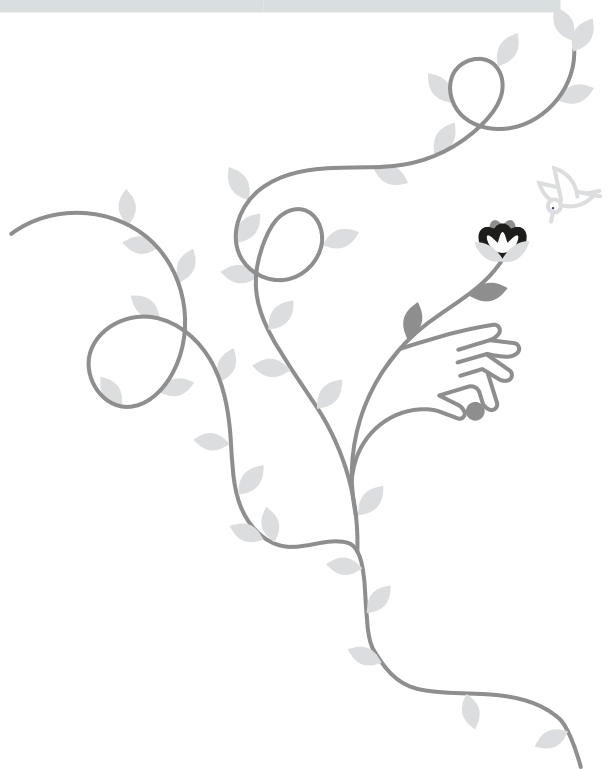
Areas of Observation	Examples (Did the caseworker...)	Examples observed and comments for the caseworker
2. **Introduction** Introduce the session appropriately to the client, create a comfortable and safe space	• Introduce themselves by name, role and organisation in a way that the client could understand • Explain to the client the purpose of the interaction in a simple and clear way	
3. **Address barriers** Makes adjustments to overcome barriers if not already done so/new barriers identified	• Assess the any barriers to the client's full participation including for informed consent • Involve the client to agree upon ways to address barriers including for communication	
4. **Confidentiality** Protect the client's confidentiality through data protection and their informed consent	• If completing an intake or referring the case, obtain the clients informed consent/assent by explaining the Protection Case Management/referral process and the client's rights, as well as confidentiality, including data protection protocols, and limits of confidentiality (e.g. mandatory reporting policies, potential risks and benefits) • Keep all documents secure • Take notes and document the case only once obtained informed consent	

Areas of Observation	Examples (Did the caseworker...)	Examples observed and comments for the caseworker
5. **Communication** Engage using effective communication techniques that are age, gender, disability and diversity appropriate	• Body posture remains open and facing the client, keeping eye contact but remaining respectful of local customs • Use active listening skills • Mirror language used by the client and keep eye contact • Stay calm and comforting throughout the interaction • Ask open-ended questions • Use reframing and summarising • Reflect on what the client has shared • Check-in regularly with the client to ensure that they're accurately understanding	
5. **Trust** Seek to establish or maintain trust, create a healing relationship	• Greet the client warmly • Give full attention • Use healing statements such as: *you for sharing your story with me, you can take your time, I understand you are feeling (frustrated, angry, sad, etc.), it is a very normal reaction for someone in your situation etc.* • Avoid interrupting the client • Listen before asking questions • Provides relevant and accurate information in response to questions • Avoid making promises that cannot be fulfilled • Not distracted by forms and note taking	

Areas of Observation	Examples (Did the caseworker...)	Examples observed and comments for the caseworker
6. **Client-centred** Seeks to draw on the client's strengths, promotes client's participation and seeks to understand their wishes	• Give full attention • Invite the client to express their own opinions and feelings throughout the session • Communicate with the client using non-judgmental language • Respect the clients wishes • Support the client's strengths and capacities through the development on the action plan and its implementation • Be sensitive when arranging services, speaking and listening, and acknowledge the client may have experienced trauma • Give the client time to make decisions and allow them to pause or stop the session at any time • Develop the action plan together	
7. **Safety** Assess the client's safety and other immediate needs	• Assess the immediate safety needs (if applicable) • Assess the client's sense of personal safety in the home and community • Review the safety plan (if applicable) with the client	

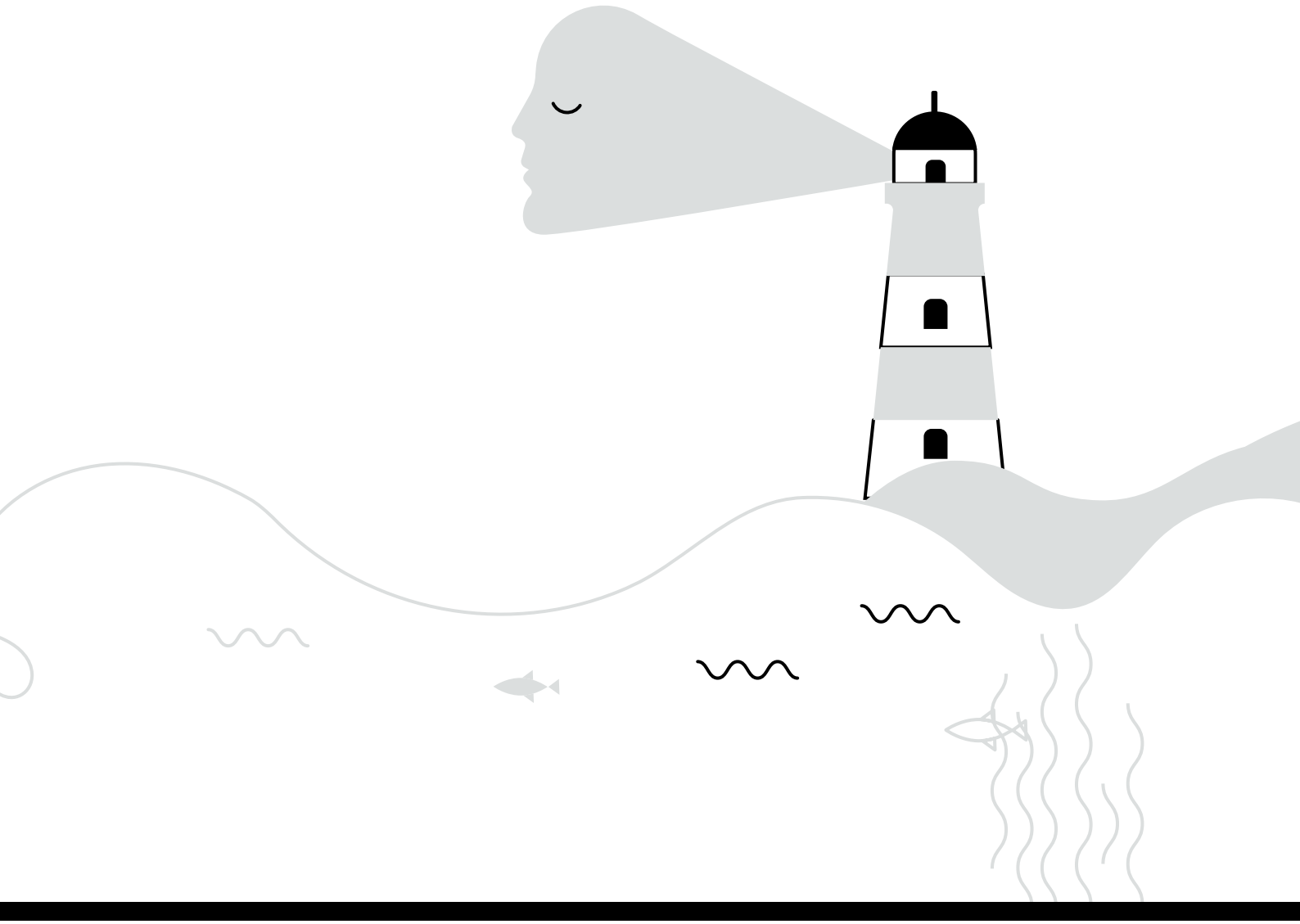
Areas of Observation	Examples (Did the caseworker...)	Examples observed and comments for the caseworker
8. **Closing** Close the session appropriately	• Summarise what happened during the session with the client and thank them for their participation • Ask if the client has any questions • Agree with the client in a simple and clear manner what will happen next and when • Ensure that the client is aware of how to contact the caseworker (if necessary)	

Actions to be taken:	Supervisor signature:	Caseworker signature:



Endnotes

1 This form draws heavily from the observation form in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task Force



Supervisor Form 3
Shadowing[1]

Purpose of the Form: To be used by a caseworker as a guide while watching an experienced caseworker or supervisor interact with a client. Reflections and discussions of shadowing sessions should occur in individual supervision sessions.

Before

The Supervisor should	The caseworker should
• Discuss the shadowing process with the caseworker so that they understand the purpose of the exercise, allowing the caseworker to ask any questions and raise any concerns they have in advance of the scheduled shadowing exercise • Arrange a shadowing visit with an appropriate case and ensure that informed consent occurs with the client • Ensure that consent was obtained for the visit	• Attend Protection Case Management training. • Be familiar with the client's case file ahead of joining a meeting

During

The supervisor/senior caseworker should	The caseworker should
• Introduce the client to the caseworker and remind them why they are joining the visit • Explain that the caseworker might be taking notes about the supervisor's practice and let the client see the notes if they are interested	• Not interrupt the supervisor/senior caseworker • Take notes to apply theory to practice • Fill the shadowing tool, making sure that concrete examples are noted

After

The Supervisor should	The caseworker should
• Shortly after the session, have an individual session with the caseworker to discuss the shadowing session • Some questions that the supervisor should ask include: hat did you observe during the session?;; What did you learn?; What went well?; What might you do differently?; Do you have any questions?	• Complete the shadowing tool, including questions for the supervisor • Participate in an individual supervision session with the supervisor, and share reflections and observations from the shadowing session • Ask any questions that may exist from this specific session or technical areas that the supervisor can provide more guidance on

Date

Caseworker code

Supervisor

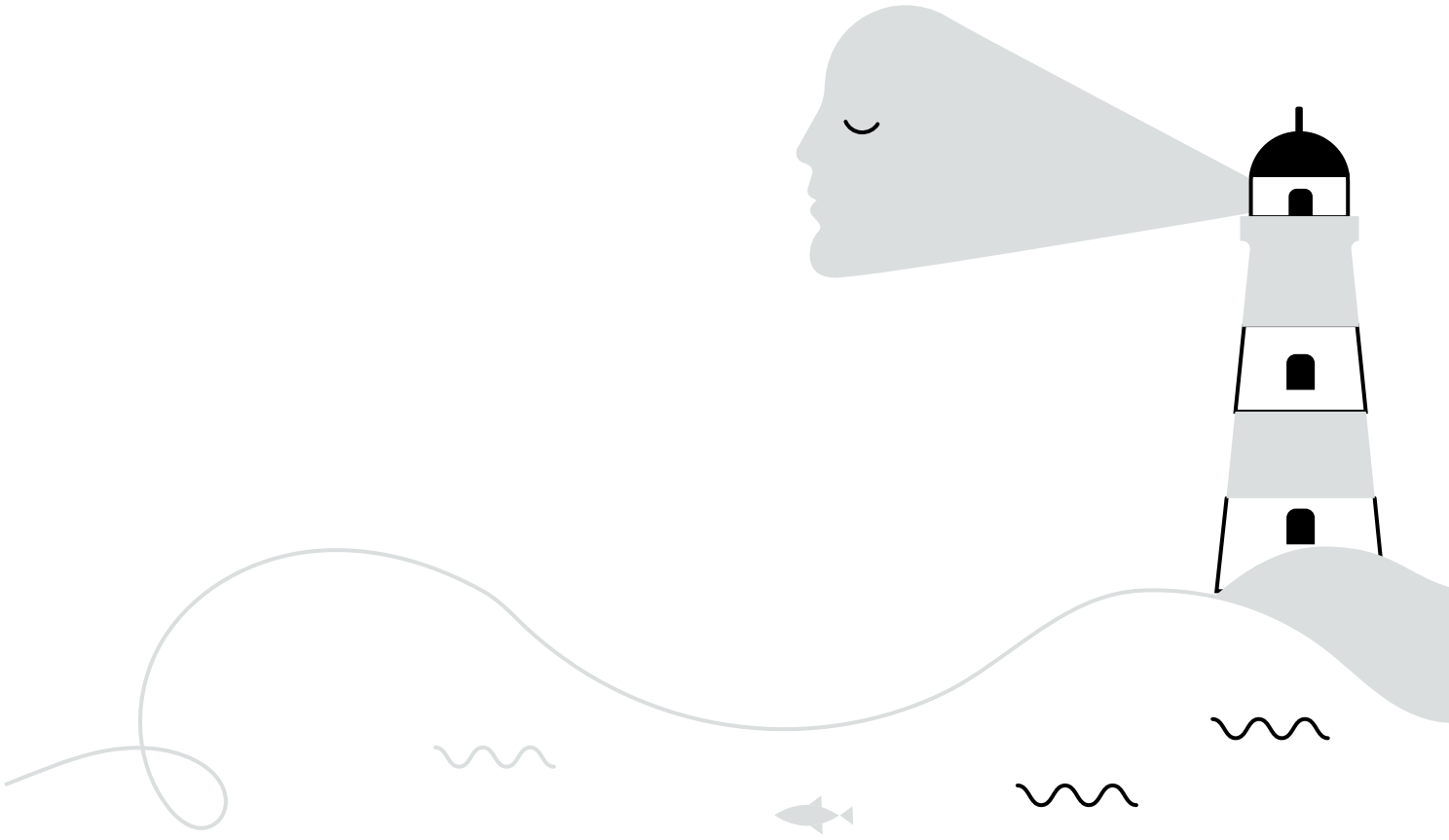
Identification & registration	
Risk assessment	
Action plan	
Implement action plan	
Follow up, monitoring	
Closing	

Areas of observation during the meeting	List examples observed and questions for the supervisor
1.**Preparation** Demonstrate proper planning and organisation for the session including making any adjustments for participation	
2.**Introduction** Introduce the session appropriately to the client, create a comfortable and safe space	
3. **Address barriers** Makes adjustments to overcome barriers if not already done so or new new barriers have been identified	
4. **Safety** Assess the clients safety and other immediate needs	
5. **Confidentiality** Protect the clients confidentiality through data protection and their informed consent	
6. **Communication** Engage using effective communication techniques that are age, gender, disability, and diversity appropriate	
7. **Trust** Seek to establish or maintain trust, create a healing relationship	
7. **Client-centred** Seeks to draw on the client's strengths, promotes clients participation, and seek to understand their wishes	

Areas of observation during the meeting	List examples observed and questions for the supervisor
8. **Closing** Close the session appropriately	
Actions to be taken	**Caseworker**

Endnotes

1 This form draws heavily from shadowing form in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task Force



Supervisor Form 4
Case File Checklist Tool[1]

Purpose of the Form: This tool should be used as a guide for supervisors to review a single case. This tool is part of regular coaching, and feedback should be provided in individual supervision sessions. It can also be used to review multiple case files independently and, where common trends are observed (i.e. mistakes or misunderstandings), these can be addressed in group sessions.

Identification & registration	
Risk assessment	
Action plan	
Implement action plan	
Follow up, monitoring	
Closing	

	General documentation	Y/N/NA	Comments/recommendations
1	Paper documentation for each case is stored in its own individual file		
2	Case files are clearly labeled with the individual case code		
3	Each step in the case management process that occurred thus far has a corresponding form		
3	All relevant sections of the forms are filled out completely and accurately according to the status of the case		

Identification		Y/N/NA	Comments/recommendations
1	The clients age, gender and disability bio-date have been correctly captured		
2	Barriers to participation have been assessed and measures are in place to address these		
3	Information captured in the identification demonstrates correct identification of the violation type(s)		
4	The risk level determination appears correct		
5	Informed consent/assent to collect, store and share information has been obtained from the client		
Assessment		**Y/N/NA**	**Comments/recommendations**
1	The risk assessment was carried out within 1 week of the identification (or based on the risk level or in accordance with timelines agreed upon in country)		
2	The assessment comprehensively described the risk factors and protective factors for the client		
3	Both immediate risks and longer term needs are captured		

Case action planning and safety planning		Y/N/NA	Comments/recommendations
1	The case plan was completed within 2 weeks from the completion of the assessment (or based on risk level or according with timelines agreed upon in country)		
2	The actions within the case plan are realistic and address the identified risks in the assessment		
3	The case plan was developed with the client		
4	Goals are specific, measurable, action-oriented and time-bound (SMART) as much as possible		
5	Roles and responsibilities of different actors required to reach the goals in the case plan are clearly defined		
6	If a client indicates they are at risk currently, there is a complete safety plan		
7	Safety plan was realistic and aligns with identified risks		
8	Safety plan was complete within 24-48 hours of the risk being identified		

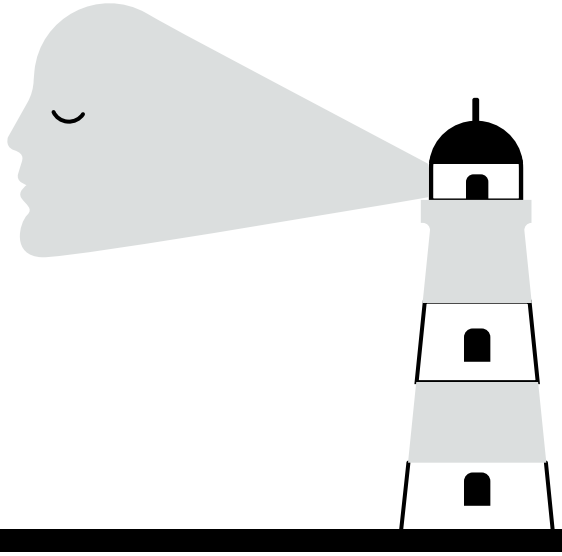
Implementation of the case plan		Y/N/NA	Comments/recommendations
1	Client has been linked with relevant and available services according to their case plan and informed consent/assent has been taken		
2	Appropriate steps taken to ensure referrals are safe and only include 'need to know' information		
3	Where required, mental health and psychosocial support (MHPSS) has been provided and referrals completed		
Follow up and review		**Y/N/NA**	**Comments/recommendations**
1	Follow up was conducted regularly according to case plan		
2	Review of case plan was carried out at least once every three months with client		
3	Based on the review, the case plan is adjusted accordingly		
Case closure		**Y/N/NA**	**Comments/recommendations**
1	The reason for the closure is clearly documented		
2	Documentation indicates that: • The client discussed readiness and agreed to close the case • Contact information was given in the event the client wants to re-access services		

Case closure		Y/N/NA	Comments/recommendations
3	Approval of the supervisor was sought prior to closing the case		
4	A client feedback survey was requested/conducted		
4	A follow up visit was planned with the client to conduct a visit within 3 months after the case was closed		

Actions to be taken	
Supervisor:	**Caseworker:**

Endnotes

1 This form has been adapted from the case audit file in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task



Supervisor Form 5
Case Discussion[1]

Purpose of the Form: This should be used by a supervisor to facilitate a collaborative dialogue with a case worker during an individual or group supervision session to analyse a case and explore potential options and ways forward.

If a case is discussed in a group setting, it is important that the supervisor ensures the caseworker is prepared and comfortable sharing in front of their peers. In order to maintain confidentiality, the discussion should occur in a private space without using identifying information and according to the "need to know" principle. No details related to the case should be discussed externally.

The questions under each header are suggested, but can be adapted. At times, it could be helpful to use a flipchart to draw out the client's situation as presented by the caseworker.

Identification & registration	
Risk assessment	
Action plan	
Implement action plan	
Follow up, monitoring	
Closing	

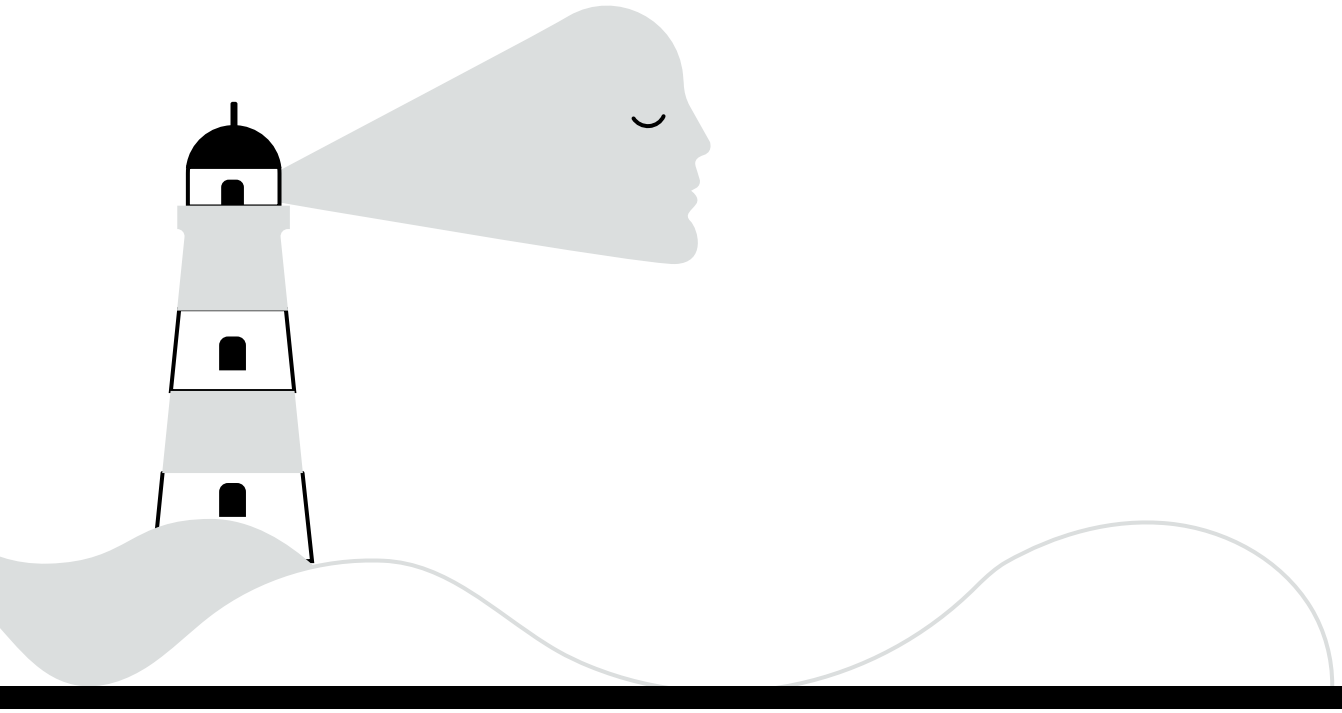
Background: client Information – prompts	Notes from discussion
• Referral source and date • Clients gender, age, nationality, disability status • Protection status (i.e. IDP) • Type of residents (i.e. urban/rural) • Living arrangement (i.e. living with whom)	
Current situation/protection concerns	
• Describe the main protection issue in the case, including any specific abusive or violent incidents, if applicable. • Are there immediate safety concerns? If yes, from where/who? Who can provide immediate protection to the client (explore network and resources)? • How does the client view their situation? What are the client's priorities? • What are the roles and attitudes of their close social circle? Are they supportive? How is the relationship with the client? Is anyone implicated? • Is the client at risk of further abuse or violence? • Are other household, community, group members experiencing, or at risk of, abuse? • Does the client have other needs and/or risk-factors that make the case higher risk? • What are the strengths or resources for the client? Do they have access to, either internally or through their family, or broader community? • What does the client see as possible ways forward?	

Background: client Information – prompts	Notes from discussion
Actions taken/challenges	
• Briefly describe the work done on the case so far • Describe the safety plan, including the measures çput in place • What services have been provided directly? • What referrals have been made? Has the client received those services? What was the quality of those services? • What have been some of the particular challenges (e.g. concerns, referrals, engagement)? • Questions to open a discussion – supervisor questions • What are the possible options to respond to the challenges with the case? • What are potential positive and negative effects of the options? • Are there contingencies that should be considered? • What are ideas and tips for bringing in people involved in the client's life (if consent given), to lead to a positive change?	
Good practices/learning points	**Notes from discussion**
• Highlight any particular good practices or successful approaches (e.g. client-centred, finding ways of enhancing collaboration, and motivations to change) • Highlight similar cases and responses taken	

Identify next steps	Notes from discussion
• Agree on a way forward including any services to be provided, discussions to hold with the clients, or follow-up to be conducted by agencies (note the person responsible and timeline) • Highlight any broader advocacy issues	
Actions to be Taken	
Supervisor:	**Caseworker:**

Endnotes

1 This form is adapted from the case discussion form in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task Force



Record Form 1

Individual Supervision Meeting Record[1]

Purpose of the Form: This should be used by a supervisor to facilitate a collaborative dialogue with a case worker during an individual or group supervision session to analyse a case and explore potential options and ways forward.

If a case is discussed in a group setting, it is important that the supervisor ensures the caseworker is prepared and comfortable sharing in front of their peers. In order to maintain confidentiality, the discussion should occur in a private space without using identifying information and according to the "need to know" principle. No details related to the case should be discussed externally.

The questions under each header are suggested, but can be adapted. At times, it could be helpful to use a flipchart to draw out the client's situation as presented by the caseworker.

Identification & registration	
Risk assessment	
Action plan	
Implement action plan	
Follow up, monitoring	
Closing	

Supervision practices conducted this period		
# Shadowing visits	**# Observation visits**	**# Case files reviewed**

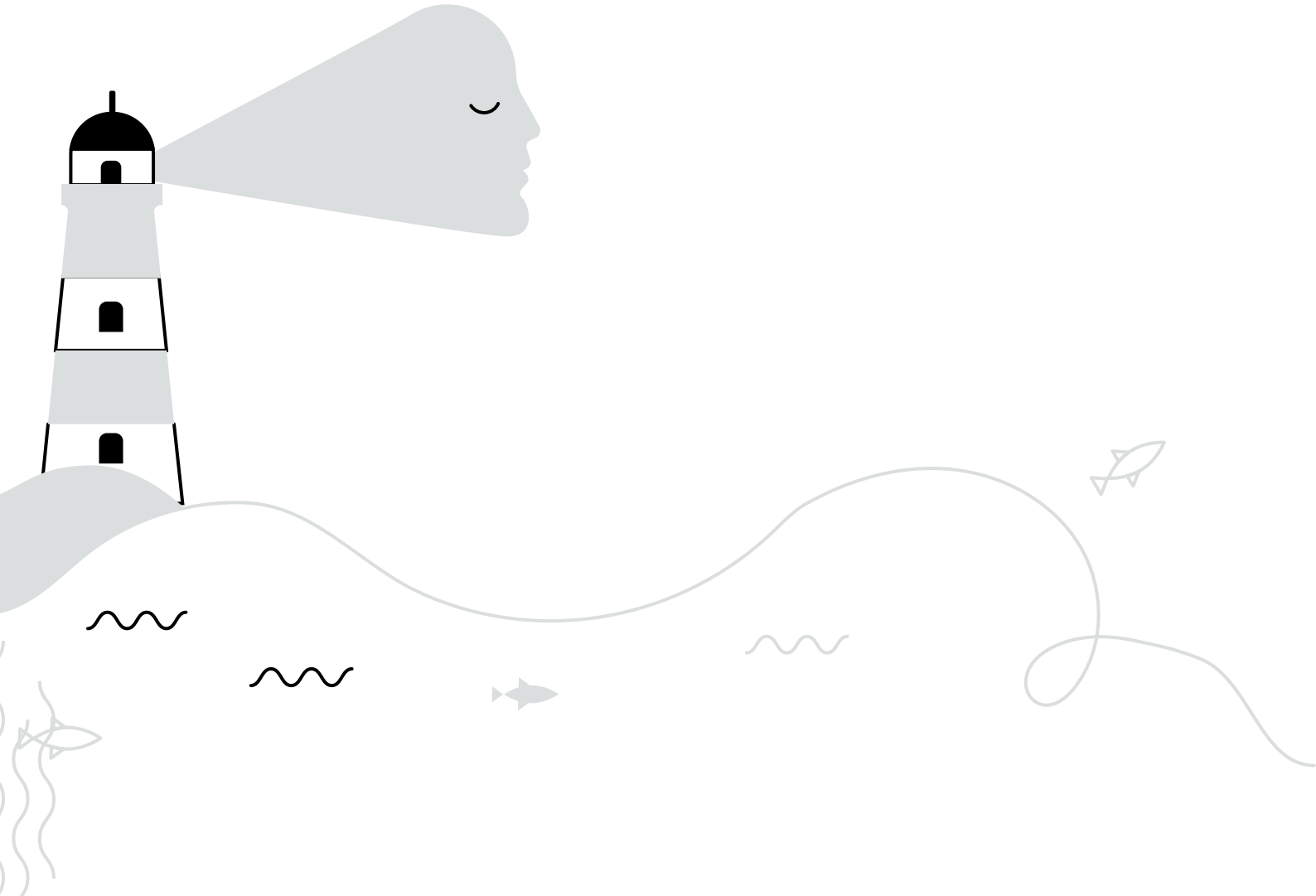
Agenda	Sample discussion questions	Notes from discussion
Opening and check-in: • Review action points from the previous meeting and any challenges faced • Set and agree upon agenda	• *How was the week/period for the caseworker? Are there issues that they would like to add to the agenda?* • *What are the caseworker's priorities within the hour?*	
Administrative: • Review of current caseload *If appropriate use **Supervisor Form 5: Case Discussion Tool*** • Other logistics, human resource, operations points for discussion	• *Are there any personal HR issues that should be discussed?* • *How many new cases the caseworker has registered and the number of high-risk cases or cases requiring intensive actions or response?* • *Are there any operational or logistical challenges that need to be addressed?* • *What are some particular challenges the caseworker is facing?Would they like some feedback or guidance?* • *What are some accomplishments with cases to be celebrated?*	
Development: • Attitudes • Knowledge • Communication Skills • *Refer to ***Supervisor Form 1: Caseworker Capacity Building Assessment***	• *Are there any skills or information that the caseworker would like to work on?* • *What application of CM knowledge/skills from training or coaching is the caseworker implementing in their daily work?*	

Agenda	Sample discussion questions	Notes from discussion
Supportive: • Check in with caseworker • Explore possible self-care strategies or support needed	• *How is the caseworker feeling in their work?* • *Are there any triggers/ red flags that may be an indication of needing extra support or of potential burnout?* • *Any impact on self or personal life related to specific, high risk cases in particular?*	
Discussion of supervision practices utilised in the past week/period: • Concrete and detailed feedback for caseworker on the exercise - positive and constructive	• *What does the caseworker think about the shadowing, observation session or the case files selected and reviewed?* • *Does the caseworker have any questions or concerns?*	
Closing and action points: • Agree on the main action steps to be taken, following the meeting and the agreed upon time frame for accomplishing these tasks.	• *What are the caseworker's main priorities for improving practice and outcomes for the clients?* • *What are the supervisor's main priorities for the caseworker to improve practice and outcomes for the client?*	

Actions to be taken:	
Supervisor:	**Caseworker:**

Endnotes

1 This form is adapted from the Individual supervision record in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance For Child Protection In Humanitarian Action, Case Management Task Force



Record Form 2

Group Supervision Meeting[1]

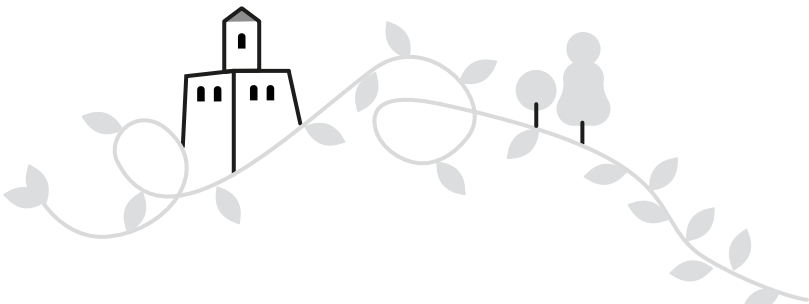
Purpose of the Form: The supervisor can use this form to take minutes of meetings and to track progress made with caseworkers during group supervision meetings. It also assists the supervisor to facilitate a discussion with caseworkers about the functions of supervision.

Date

Caseworker code

Supervisor name

Agenda	Notes from discussion
Welcome, opening and check-in • The supervisor greets the team (can use an icebreaker or energiser). • Agenda is reviewed and agreed upon by the team. • Establish or briefly review meeting "agreements" especially related to sharing of information.	



Agenda	Notes from discussion

Administrative
• Supervisor shares reflections from the past week and provides updates on logistics, reporting, recruitment, etc.
• Supervisor invites caseworkers to ask questions or share if they are facing any administrative or operational challenges in their work.
• Caseworker check-in (each team member shares the following):
  • A success or positive experience from the week
  • Challenges that they have been experiencing
  • Anonymous review of:
  ◦ Number of open cases
  ◦ High-risk cases and some medium-risk cases [stagnating cases, complex protection issues, etc.]	

Development • Based on the capacity building plans of the caseworkers, the supervisor can suggest potential topics for a team learning event (such as teach-back, guest speaker, or special events). • Caseworkers should be asked to share any learning opportunities they are aware of, or if they have a topic they wish to teach-back to the team.	
Supportive • Track progress towards the goals. Discuss if the goals are still relevant. • Supervisor or caseworker can propose team-building activities or address team wellness issues they have noted since the last meeting.	

Agenda	Notes from discussion
Closing and action points • Summary of the meeting, highlighting the action points raised and the expected timeframe. • Schedule for the following week.	
Actions to be taken by the supervisor:	**Actions to be taken by caseworkers:**

Endnotes

1 This section draws heavily from the Case Meeting Record Form used in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task Force