

TOOL 3.2.0 GUIDANCE ON BASIC CASE MANAGEMENT AND BASIC REFERRAL PATHWAY

This section has the following 3 objectives:

1. To explain what basic case management is (and what it is not)
2. To explain the principles of basic case management
3. To describe the steps of the basic case management process

This guidance and the accompanying tools are not for professional case workers who will have more expert knowledge than outlined herein. Detailed case management is out of the scope of this document.¹

The target audience is PGI delegates and/or focal points working in preparedness, emergencies or recovery with professional experience in the domain of protection.

This tool is relevant from the outset of an emergency, and aims to build resilience and contribute to recovery by allowing for protection follow-up and referral of individuals in the community who face protection concerns; and through establishment of basic case management in emergencies where needed and feasible.

- Not all Movement actors are able to implement all stages of the case management process (due to resources, focus of operations or lack of protection expertise)
- All actors should, however, strive to implement a **referral pathway**, which should be known by staff, and staff should be supported to sensitively and appropriately offer this information within the community (“response to disclosure” and “referral” skills)

BASIC CASE MANAGEMENT

1. What is basic case management?²

Basic case management is a way of identifying an individual’s protection needs in an appropriate, systematic and timely manner, and then coordinating services in order to meet those needs.

This is usually achieved through direct support to the individual, offering of information and safe referrals in accordance with a programme’s objectives, and follow-up on whether services have the capacity to manage cases. It can be provided in emergency or development settings to address a range of concerns and issues, such as child protection concerns or sexual and gender-based violence (SGBV) related issues (including rape, domestic violence, and sexual assault), and is an important aspect of recovery as it helps ensure that protection needs exacerbated by an emergency can be managed in the aftermath of a crisis.

Basic case management should:

- Support the needs of an individual and their family, ensuring that concerns are addressed systematically, with sensitivity and in the best interests of the individuals concerned
- Be provided according to the **key steps of the basic case management process**, involving the individual’s meaningful participation throughout the process
- Involve the coordination of services and supports within an interlinked or referral system

¹ For an overview of case management in the specialized area of sexual and gender-based violence (SGBV), please see the Inter-agency Gender-based Violence Case Management Guidelines: https://reliefweb.int/sites/reliefweb.int/files/resources/interagency-gbv-case-management-guidelines_final_2017_low-res.pdf. For an overview of child protection cases in emergencies, please see the Inter-Agency Child Protection Network Case Management Guidelines: http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf

² Adapted from IASC Guidelines for Case Management and Child Protection, p.13-16

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- Ensure there is a **clear and competent focal person within the operation** (e.g. PSS delegate, PGI delegate, PGI focal point, Social Welfare Officer when applicable) who is responsible for updating referral pathways, explaining the system, and ensuring that cases are managed according to the established steps.

In some contexts, you will be able to have several case workers within the operation. A case worker will possess the following key skills:

- Ability to use case management principles in their interactions
- Ability to use active listening skills
- Ability to communicate non-judgementally, and cross-culturally
- Ability to demonstrate empathy
- Ability to communicate essential information about care options
- Ability to identify key protection issues and needs related to client/survivors case
- Ability to solve problems related to the client/survivor's care
- Ability to coordinate with internal programmes, project and/or departments as well as external partners
- Ability to report and refer appropriately

Basic case management is not:

- A type of 'standalone' programme or intervention – it is a service for identifying individual's needs and coordination services to meet those needs that can be integrated into any programming
- A quick and easy fix solution – it requires well trained staff supported by appropriate supervision and is often medium to long-term work in progress.

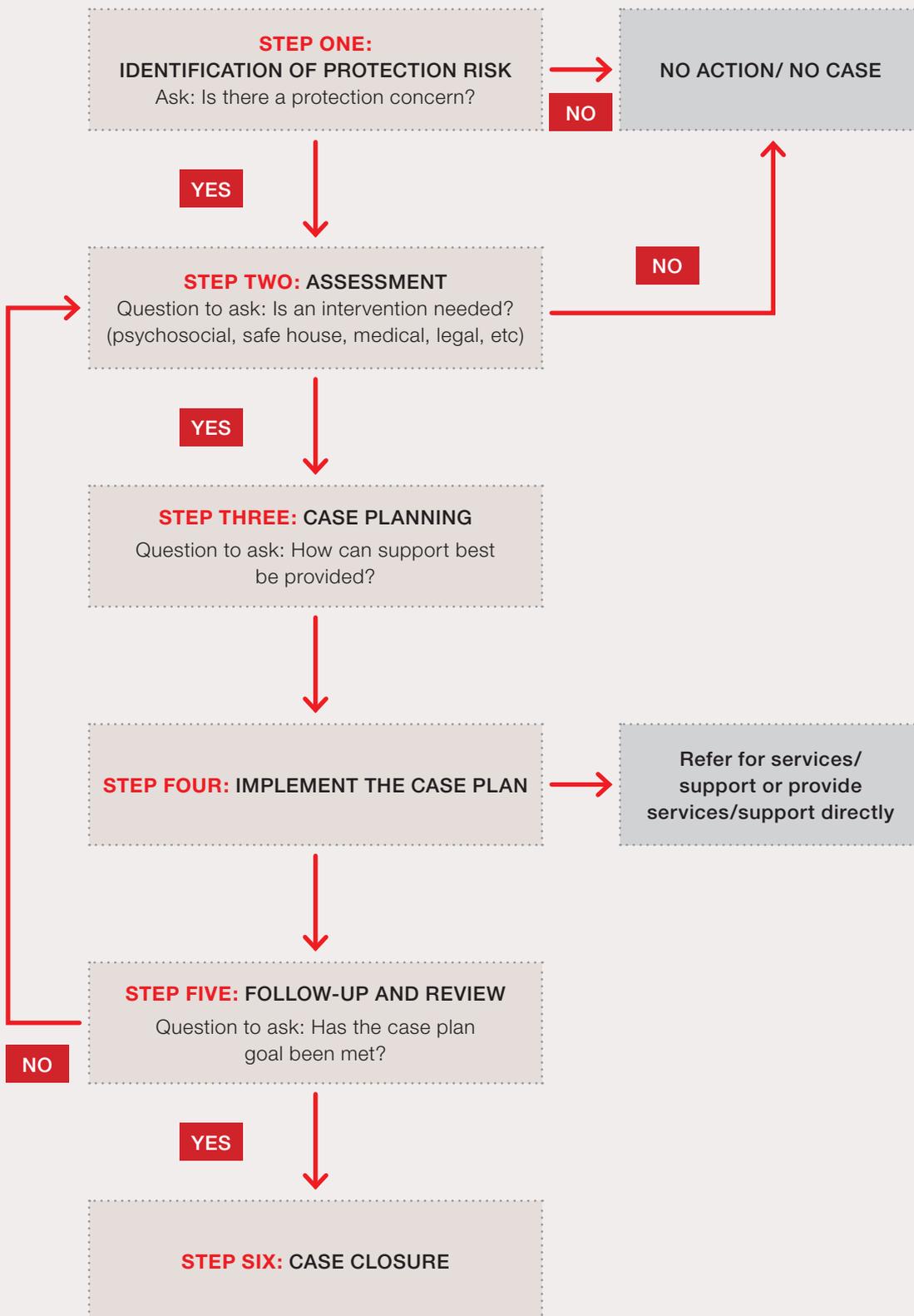
What are the key things a PGI person in an emergency operation needs to do to establish the basic case management process³:

Regardless of whether a strong or limited case management system is in place, PGI delegates/focal points and trained volunteers should:

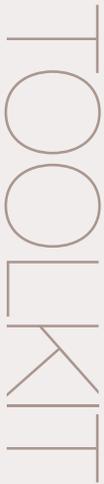
- Understanding the cultural context, the legal rights of the population of concern and their access to services, and understand which protection services are available to different groups of people including women, men, girls, boys, people of other genders, people with disabilities, migrants, asylum seekers, refugees, and others (context specific)
- Coordinate with other agencies and organisations through local working groups to set up some referral pathways, and to list any National Society services on those pathways (this may sometimes be done through clusters if an emergency results in the activation of clusters)
- Map referral services or become part of an existing referral pathway (by seeking a copy of the referral pathway through local child protection, SGBV or other working groups)
- Check the quality and eligibility criteria of services in a referral pathway regularly
- Understand how to make a safe referral that is culturally sensitive and train others within the operation how to do this (according to the Survivor-Centred Principles) and sensitive to the ethics of child protection

³ Adapted from IASC Guidelines for Case Management and Child Protection, p.51. For caseworker competencies see Appendix 1, p.73.

BASIC CASE MANAGEMENT FLOW



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During each step, it is also crucial to remember, that supervision is required at every stage. This is especially important if a group of volunteers are working together with the PGI delegate/focal point to check for service quality in the referral pathway, to train others on how to handle disclosures or handling disclosures themselves, to make referrals and following up on the case if necessary.

Supervision has a particular meaning in this context, and can be carried out in a number of different ways, including but not limited to:

- (1) **Hold regular meetings** to update each other on cases, challenges with referrals, updated information or concerns about services.
- (2) **Train and support professional competence** for case identification, assessment and being able to refer the affected individual and their family to the appropriate support or service. Primarily, continuous support to ensure all staff have an understanding of the cultural context and norms will support teams to: implement the

principles of basic case management at all times; understand protection risks; to adequately handle disclosures.

- (3) **Share and discuss internal and external referral pathways and how to safely refer cases** on a regular basis. By sharing information on where to refer cases, any referral issues, and on new services or overloaded services will assist teams to support the community.
- (4) **Visits and direct supervision of activities** to best understand issues and provide support to staff to improve systems or processes.

2. What are the principles of basic case management?

In addition to the Seven Fundamental Principles of the Red Cross Red Crescent Movement, the following principles are crucial for basic case management implementation during emergencies. Staff and volunteers should embody these values, and act according to them in interactions with community members.

PRINCIPLE	DEFINITION ⁴
Do no harm	Ensures that interventions designed to support the person and his/her family do not expose them to further harm. At each step of the case management process, care must be taken to ensure that no harm comes to them as a result of caseworker conducts, decisions made, or actions taken on behalf of the individual or family
Dignity	For the Red Cross Red Crescent, human dignity means respect for the life and integrity of individuals. Measures to respect, safeguard and promote the dignity of individuals in situations of extreme vulnerability are not limited to engaging with them in a respectful manner.

⁴ Adapted from Turkish Red Crescent Standard Operating Procedures on Individual Protection Assistance AND The Minimum Standard Commitments to Protection, Gender and Inclusion in Emergencies (p12-16)

PRINCIPLE	DEFINITION ⁴
Prioritization of the interests of individuals⁵	The interests of the persons should provide the foundation for all decisions and actions taken, and for the way in which service providers interact with persons and their families.
Non-discrimination/ access	Ensures that persons are not treated unfavourably (discriminated against) because of their individual characteristics or a group they belong to (e.g. gender, age, race, religion, ethnicity, disability, sexual orientation or gender identity).
Adhere to ethical standards	Professional ethical standards and practices should be developed and applied. Please see the WHO Ethical and Safety Recommendation for Researching, Documenting and Monitoring Sexual Violence in Emergencies for some practical guidance.
The survivor-centred approach (for all sexual and gender-based violence and human trafficking related cases)	A survivor-centred approach creates a supportive environment in which the survivor's rights and wishes are respected, their safety is ensured and they are treated with dignity and respect. This approach has 4 guiding principles: 1) Safety, 2) Confidentiality, 3) Respect and 4) Non-discrimination.
Ensure accountability	Accountability refers to being held responsible for one's actions and for the results of those actions. Institutions and staff involved in case management are accountable to the person, the family and the community.
Empower persons and their families to build according to their strengths/ empowerment	All persons and their families possess resources and skills to help themselves and contribute positively towards finding solutions to their own problems.
Participation	Participation refers to the full, equal and meaningful involvement of all members of the community in decision-making processes and activities that affect their lives.
Coordinate and collaborate	Protection programmes are more effective when institutions work together, and involve communities, families and persons in their efforts. Principally, international organisations have a responsibility to coordinate their activities with national governments and non-governmental organisations to ensure that existing systems are strengthened and not duplicated ⁶ .
Seek informed consent	Please see detailed description below.
Respect confidentiality	Please see for detailed description below.

⁵ **A special note on protection cases with children.** The United Nations Convention for the Rights of the Child outlines that all child protection related activities should be guided by the following principles:

- 1) Non-discrimination: There shall be no discrimination against any child. This means that all children, at all times, in all circumstances are equal and all have the right to protection.
- 2) Best interests of the child: The best interests of the child shall be a primary consideration in all action affecting children. This means that when a course of action affecting a child is taken, that course of action should reflect what is best for the child.
- 3) Right to life, survival and development; Each child has a fundamental right to life, survival and development to the maximum extent possible.
- 4) Child Participation: Children should be assured the right to express their views freely and their views should be given "due weight" in accordance with the child's age and level of maturity.

⁶ Interagency guidelines for Case Management and Child Protection, January 2014.

The importance of informed consent⁷

Informed consent means telling an individual concerned all of the relevant facts about what options are available and what will happen if they choose to follow each course of action. It must be disclosed at the time consent is given and the affected person must be able to evaluate (by asking questions and receiving information) and understand the consequences of an action. Informed consent can be given by a person 18 years or older. A child 17 years or younger may require informed consent

to be given through a guardian or another party.

The below steps will assist in ensuring informed consent. Ensure that that individuals have opportunities to ask questions and that they fully understand what they are signing up for.

Remember, age, gender, religious and cultural issues may mean that extra steps would be needed to get the consent of some groups.

STEPS TO ENSURE INFORMED CONSENT (VERBAL)

Step 1: Provide all information	<ul style="list-style-type: none"> • Provide all possible information and options available to the concerned individual • Explain to concerned individual what will happen to him/her after the referral • Explain to concerned individual that s/he has the right to refuse or decline any part of the services
Step 2: Ensure the concerned individual understands the implications of any referral	<ul style="list-style-type: none"> • Explain the benefits and the risks of the service to the concerned individual • Concerned individuals should understand the implications of their case information being shared with other agencies or individuals within the referral pathway
Step 3: Explain the limitations to confidentiality	<ul style="list-style-type: none"> • Explain to concerned individuals that their case information may need to be shared with others within the Red Cross Red Crescent or external? who can provide additional services (if external: only if they consent or when there is a danger)
Step 4: Ask for consent	<ul style="list-style-type: none"> • Ask concerned individual if s/he give consent to contact other services and pass on their name • For non-specialised providers, this process can be done verbally. A written document is not advisable, especially if confidentiality are not known or cannot be followed • During case management, written consent should be obtained as much as possible
Step 5: Check limitations of consent	<ul style="list-style-type: none"> • After being made aware of risks or implications of sharing information about their case, the concerned individual has the right to place limitations on the type of information to be shared and to specify, which organisations can or cannot be given the information. (If case management data in use, record such information for future)

⁷ Adapted from "Standard Operating Procedures For Gender-based violence and response," GBV Sub-Cluster, Turkey and Syria, November 2018.

When there is a language barrier between the person disclosing and the person listening, it is advisable that an interpreter is used. Be aware that the age or gender of the interpreter may be relevant to the giving of consent and the person giving consent should be able to choose the age and gender of their interpreter if possible. The interpreter should be briefed on the concept of informed consent and confidentiality in order to accurately explain it, and in order to ensure there is no miscommunication or harmful communication. In addition, the interpreter should sign a confidentiality agreement and be informed of the risk of harm of sharing what they have heard. Interpreters may also require debriefing to reduce the harmful impact of vicarious trauma.

Informed consent/assent for children⁸

As a general principle, permission to proceed with providing assistance is sought

from both the child and their caregiver (e.g. parent) unless it is deemed inappropriate to involve the caregiver (e.g. when there is suspected sexual violence perpetrated by the caregiver). Permission to proceed with case management and other care and treatment actions, such as referrals, is sought by obtaining “informed consent” from caregivers of older children and/or “informed assent” from younger children.

Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent (which can vary according to laws in different countries). To provide “informed consent” the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent.

Informed assent is the expressed willingness to participate in services.

AGE GROUP	CHILD	CAREGIVER	IF NO CAREGIVER OR NOT IN THE CHILD'S BEST INTEREST	MEANS ⁹
0-5	-	Informed consent	Other trusted adult or caseworker's informed consent	Written consent
6-11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, written consent
12-14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight	Written assent, written consent
15-18	Informed consent	Obtain informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

⁸ ibid

⁹ Asking for a signature may not always be appropriate, especially if the existence of such a form (or section in a form) signed by the concerned individual poses risk to their safety. Alternative options are for the provider to sign a form confirming consent was given. For those who cannot sign, a thumbprint or “X” may be appropriate, otherwise verbal consent must be obtained.

Informed consent for concerned individuals with disabilities¹⁰

Individuals with disabilities may have physical, sensory, intellectual and/or psycho-social types of disabilities, which may be short-term or long-term. Gaining informed consent from persons with disabilities can sometimes be difficult depending on the type and extent of their disabilities. The Convention on the Rights of Persons with Disabilities (2006) states that an individual cannot lose their legal capacity to make decisions simply because they have a disability. It is therefore, important to assume initially that all concerned individuals with disabilities can provide informed consent, and to follow the same steps as table 2. Additional procedures include:

- Asking the concerned individual if s/he want some support to help them give informed consent
- Adapting communication methods to match those preferred by and effective for the concerned individual
- Taking more time to ask questions to ensure the concerned individual understand everything, including consequences of accessing services
- Checking to ensure they are not being coerced or forced to make decisions

The importance of confidentiality¹¹

An ethical principle associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. All written information is kept in locked files and only non-identifying information is written down on case files. Maintaining confidentiality about abuse means service providers never discuss details with family or friends or with colleagues, whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children or clients who express intent to harm

themselves or someone else, or clients who disclosed information leading to a concern that a third party will seriously harm them or others.

Role of PGI focal point in debriefing a staff member or volunteer who reports or responds to a protection incident

1. Move the staff member to a quiet or confidential space
2. Commend the staff member for taking action
3. Let them know you will keep the information shared confidential
4. Help them to offer referral to the community member, or you should follow-up and refer the community member (or group of people) to the relevant entity
5. Refer staff member to the operation's or National Society's PSS team in case they wish to debrief further
6. Be aware of self-care and existing resources for support, both for yourself and the staff member/volunteer

3. What are the steps of establishing a basic case management system?

- (1) Understand the Red Cross Red Crescent role as an organisation and your role as a PGI delegate/focal point during an emergency

Understand the mandate, comparative advantages and constraints of your own organisation in relation to protection concerns. Some National Societies may be able to implement a full-fledged case management programme or may have lots of expertise (a history of programming, strong PSS and other programming) or they may only be able to administer referrals to other specialised agencies who provide relevant

¹⁰ Ibid. For more detailed information please see p.139-146.

¹¹ Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, p.324.

case management services (which is the bare minimum action in the IFRC Minimum Standards for Protection, Gender and Inclusion in Emergencies 'Safety' chapters).

Understand also your role as a PGI delegate/focal point within the emergency context, especially your limitations in providing case management. **Without adequate resources, it can pose harm to take on more case management than the basic steps because it will create unreasonable expectations that cannot be fulfilled.** Therefore, it is important to coordinate with other actors working on protection related services and partner with local organisations who are experienced in providing protection related services, such as child protection, SGBV prevention and response, human trafficking, internal displacement and refugee issues to create a more lasting system of protection, rather than starting a new system in an emergency which cannot be sustained with limited resources

(2) Understand rights and access to services of the affected population

Understand the rights of the population of concern and their access to services. Also understand cultural practices. Having rights (to access certain services) is not a pre-requisite for referral or assistance, however, the lack of rights can be a life-threatening barrier and poses additional challenges to mapping a referral pathway. Depending on the population of concern, their rights and access to services can vary greatly. Men, women, boys, girls including gender and sexual minorities, (irregular) migrants, persons with disabilities, the elderly, ethnic minorities, religious groups may all have varying levels of access depending on the legal framework. For example, "unaccompanied and separated children, survivors of torture, violence or abuse, persons in detention, and those who have experienced human trafficking might be especially vulnerable and have specific needs and rights".¹²

You should consult local health, legal and community organisations to understand what rights people have to access services. You should also directly collect information from the affected community members about what they can access, and what legal rights they have (de facto or de jure) or to understand persistent myths, rumours and misinformation in the community, and correct it.

It is also common for admission and administration staff in some services to have the wrong information about who can access their service, often resulting in people being turned away. Discrimination also can play a role in this.

(3) Map relevant services for referral pathway and coordinate with organisation, agencies and NGOs through the cluster and sub-cluster system.

When identifying the appropriate service providers, it is important to be aware of both governmental and non-governmental actors including civil society groups and community-based organisations, existing referral pathways which do no harm (for example where there is no discrimination) and what their procedures and eligibility criteria are, how survivors are referred to the receiving agency in practice and how the service in question **fills a gap or complements services being offered by a Red Cross Red Crescent Movement actor.**

Before starting your mapping of service providers, it is important to coordinate with other agencies who are also working on PGI issues. In some emergency contexts there will be an active cluster system (either a national cluster system, or a UN System-wide cluster activation).

As a PGI delegate/focal point, it is important to reach out to the following clusters and sub-clusters, as they may have already established a referral pathway or mapped the services, necessary for your program activities:

- Protection cluster (often led by UNHCR)

¹² ibid.

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- Gender-based Violence (GBV) sub-cluster (often led by UNFPA)
- Child Protection sub-cluster (often led by UNICEF and Save the Children)
- Prevention of Sexual Exploitation and Abuse (PSEA) working groups

Depending on the context you are working in, and in cases where there is no cluster, there will be national or local working groups such as an SGBV Working Group, a Protection Working Group, a child protection committee, and you should contact those working groups. Even when no emergency response referral has been established, there are community-based groups that are the most important services that will need to be linked to, these are: women's groups, domestic violence support groups, child protection agencies and other local organisations with a track record of providing protection related services, and you should contact those to ask what services they are providing in the emergency and whether they wish to coordinate with you and other agencies to form a referral pathway for this emergency or crisis (they will be provided support in their own community anyhow, and may not be aware of the emergency response pathways to coordinate with).

- Tool 3.2.1 provides a list of relevant questions to consider when evaluating services on an existing referral pathway or for a new one.
- Tool 3.2.2 Provides a format for mapping services.

(4) Establish referral pathways¹³

Talk to other organisations about creating a referral pathway (ideally linked to expert organisations with expertise in case management, health, psycho-social support, legal aid and safe house services). Agree on clear and precise procedures with referral partner organisations on how referrals should be made – this may include simple telephone referrals, or submission of case forms to the referral organisation.

In order to decide whether your team will make referrals to an agency, ensure that you have the following information and that details of how to make a referral are agreed in the SOPs:

- Where is the service provider located, which location areas do they cover, and what time are they open and available? Is there a specific referral focal person within their organisation that referrals should be addressed/made to?
- To whom do they provide services (age, gender, impairments etc.)?
- Do specific referral forms need to be filled?
- How will the confidentiality of referral information be ensured (e.g. through password protected forms attached to emails, limited number of persons copied on referral emails, not mentioning identifying information about the survivor in emails, ensuring that referral phone calls cannot be overheard, etc.)?
- Expectations in terms of the action to be taken by the service provider (what sort of support do they offer and how do they follow-up?)
- How will the payment for the service be covered, if payment is required?
- In what languages are their services available?
- Are there trained male and female translators available?
- Who does the service provider cooperate with? (e.g. other organisations and authorities) and will informed consent of the client be obtained before sharing information with third parties (especially police)?
- Is there transportation available to the service provider? Is there transportation available between service providers along the referral pathway?
- Will the person referring the survivor receive an update on the case from the service provider? If yes, within

¹³ Please see sample referral pathways in Annex H.

which timeframe and how (via phone, by email, case conference, etc.)?

When establishing the referral pathway or coordinating with other agencies and organisations on an existing referral pathway, it is important to monitor and **evaluate service providers according to the basic case management principles defined in section 2.**

If you receive feedback that an organisation is not meeting the principles defined, then you should cease making referrals to that organisation until the issue has been resolved. This is because the service providers in the referral pathway should not increase risk to the population of concern.

Continuous monitoring and verification of complaints on service providers can occur in the following ways:

- Use feedback and complaints mechanisms to understand community views on existing services
- Share concerns of service quality at (daily, or weekly) coordination meetings including the Operation's own meetings, and in meeting with other agencies and organisations to understand if they have been observing and/or receiving similar complaints
- Visit service providers on the referral pathway to assess if case management principles are being upheld
- Call service providers once a month to check for accuracy on contact information, eligibility criteria, quality of services
- Check for additional ways to (co-)monitor with agencies and organisations in the protection cluster and its sub-cluster (such as the International Rescue Committee, Save the Children, UNFPA and UNICEF for child protection organisations)

If a community member raises a complaint that a staff member at one of the referral agencies has committed acts of sexual exploitation and abuse against a member of the community, then referrals to that agency must stop immediately, and you should make

a confidential complaint to the relevant inter-agency PSEA focal point, or a relevant authority, if safe to do so. You should keep this information confidential and raise it confidentially with the head of operations to agree on a path of action. You should also notify the global IFRC PGI in Emergencies Coordinator.

(5) Disseminate referral pathway to staff, volunteers and communities.

- Once you have mapped and agreed to a referral pathway, you should put the contact details for referral organisations into an easy to understand format (a poster, Word document, Excel sheet) and disseminate it to staff, volunteers and communities. Ensure that community, staff and volunteers know the confidentiality requirements that staff must adhere to
- In order to disseminate the information in community, ensure it is in relevant community languages, and is distributed in relevant and appropriate ways (based on feedback from the community as to what those means may be)

4. What are the steps in implementing community focused case management?

(1) Identification of cases

Individuals who are at risk of being harmed or facing other protection related risks can be identified by a number of sources, depending on the situation and context. The sources can be:

- From community members
- Civil society
- Government authorities
- Protection cluster and sub-clusters (child protection and GBV)
- Self identified by the concerned individual
- Health services staff
- Law enforcement agencies
- Asylum seeker and refugee registration processes
- RCRC staff or volunteers
- General observation in the field



After case identification, the case will be screened and verified in order to assess whether it meets the vulnerability criteria agreed for the agency handling the case. If the concerned individual falls outside of the organisation’s eligibility criteria, it is important to know about the relevant services to refer the person to.

- Tool 3.3 can be used for referral to another agency/service (this is relevant in all emergencies)

- Tool 3.4 can be used to register/facilitate intake within your own organisation (this is relevant if you intend to establish case management services as part of your programming)

Below is a sample snapshot of case screening and verification by UNHCR in Jordan. This example showcases the eligibility criteria¹⁴:

Sample case-level snapshot/Severely vulnerable
38 year old widowed Syrian female with 4 children.

	Predicted expenditure 3	Predicted per capita 43 JOD			
	Documentation status 4	PA Documentation PA is missing MOI	Family Documentation Family registered		
	Coping strategies 4	1 emergency strategy being implemented			
	Dependency ratio 4	1 autonomous adult 4 children			
	Basic Needs 4	Coping strategies Emergency strategies	Dependency ratio Poor dependency	Economic state High debt per capita	
	Education 3	Attendance risks Finance main risk	3 school aged children 2 years missed education 2 children attending		
	Food 4	Social vulnerability High dependency ratio, Single headed	CARI score FCS = 103, 20% spent on food, Emergency		
	Health 4	Access to services Missing PA doc, not had problems accessing	Family composition No under 5's and over 60s in case	Existing conditions Existing disabilities present	
	Shelter 3	Housing conditions Missing essential items, showing poor signs	Security of tenancy Has contract but high debt	Family composition Female-headed house, high dependency ratio	
	WASH 3	Health No issues	Access to latrines Shared access with 1 house and safe access	Access safe water Municipality source 1 instances without	Waste management 0 instance water 3 instances solid

¹⁴ Vulnerability Assessment Framework Guidance Note, p.4: <https://data2.unhcr.org/en/documents/download/53708>

This eligibility criteria to access case management for the above example is based on a combination of 'Universal indicators' (document status, coping strategies, dependency ration) and 'sector indicators' (health, shelter, WASH, etc).

After identification, screening and registering, the next step in basic case management is the **assessment**.

(2) Assessment of need for action

This stage helps to assess the risk level of the concerned individual's situation and also establishes what strengths, resources

and protective influences the person has. Usually there is an **initial assessment and a comprehensive assessment**.

The initial assessment should ideally take place within the first 24-hours of case identification and should consider:

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

At this point a risk level should also be assigned to the case. Below is a guide:

RISK LEVEL	DESCRIPTION	TIMEFRAME
HIGH	Concerned individual needs serious medical attention, is likely to be harmed or injured or subjected to on-going sexual abuse, be permanently disabled, be trafficked or die if left without protective intervention	Intervention should be done ideally before leaving the concerned individual. Report immediately to supervisor. Or if you are the supervisor, make necessary referral immediately
MEDIUM	The concerned individual is likely to suffer some degree of harm without an effective protective intervention plan. However, there is no evidence that the concerned individual is at risk of imminent death or serious injury	Intervention should take place within 72 hours
LOW	The home/shelter area is safe for the concerned individual. However, there are concerns about the potential for the individual to be at risk if services are not provided to prevent the need for protective intervention	Intervention should take place within 1 week

After the initial assessment, **it could also be that the case can be closed if there are no concerns (e.g error in identification or registration)**.

The following Do's and Don'ts are important to keep in mind when assessing a disclosure and when speaking to/communicating with (at any point) the individual of concern:

**DO**

- Stay close and listen to the story
- Move the person to a safer place
- Use words that help the person feel understood and in control. Examples may include: “How can I support you?” “What would you like to see happen next?”/ “Please share with me whatever you want to share. You do not need to tell me about your experience in order for me to provide you with information on support available to you”
- If it is the wish of the client/survivor to be interviewed or examined by a person of their own sex, make sure that female/male staff is available
- Ensure safety and do not put the person in danger (e.g. by calling the police without their consent)
- Be very clear about the options that are available and the decisions that need to be taken.
- Give information that is accurate and age-appropriate
- When communicating through a translator or interpreter, look and talk to the person you are addressing, not at the translator/interpreter
- Maintain confidentiality as appropriate, e.g. explain limits to confidentiality (immediate threat to oneself or others, Prevention and Response to Sexual Exploitation and Abuse (PSEA), child survivor)
- Provide information about reliable referral systems, e. g. medical support
- Minimize the number of times a client/survivor needs to retell her/his story
- Pay attention to your own emotional and physical reactions and practice self-care

**DO NOT**

- Force a person to do anything
- Make assumptions based on physical appearance, age or sexual orientation
- Some clients/survivors of domestic violence (or human trafficking) decide to stay in the abusive relationship. Even in these situations, no action should be taken against the will of the person affected by domestic violence (unless there is immediate grave danger to themselves or others)
- Pressure the person to share/tell details
- Judge or blame the person by saying things like “You provoked your husband, that’s why he beats you”
- Give advice on what the person should do. You cannot judge what is best for them as you are not in their situation
- Draw conclusions or analyse by making statements like “You must hate him”
- Offer possibly inaccurate information

Special considerations for children:**DO**

- Provide accurate, up-to date information on available services to the individual who asked you for support
- Respect confidentiality, and let them know if you are obliged to tell someone (police for example) about what has happened, and how you will go about it
- Ask the child/adolescent if they want to find a quiet and private place to talk. Make sure it is a place where others can see you, but not hear you
- Ask girls and boys if they want to talk to an adult woman or man of the same gender
- Listen attentively and pay attention to non-verbal body communication
- Be calm and patient, accepting what is being said without passing judgement
- Let the child/adolescent express themselves and use their own words
- Respect the child's opinion, beliefs and thoughts
- Ask if there is someone the child/adolescent trusts
- Stay with the child/adolescent until s/he feels safe or are in the care of someone who s/he identifies as safe and trusted
- Provide the child/adolescent and adult s/he trusts with accurate, relevant information on services that are available and how to access them
- Say what you know and what you do not know

**DO NOT**

- Investigate/interview the child adolescent
- Discuss or share the details of what you learned with anyone
- Direct the child/adolescent to go to a quieter or private pace or isolate the child against their will
- Touch, hug or make physical contact as this can be traumatizing, uncomfortable and distressing
- Take pictures or verbally share information about the child/adolescent or their experience
- Display shock, disbelief, anger or any other reactions that may cause the child/adolescent distress
- Make promises you cannot keep
- Force the child/adolescent to continue talking with you if s/he does not want to



(3) Implementation of referral

For staff who do not have case worker experience or access to case workers during an emergency can formally refer the case (disclosure) to an appropriate service provider, by linking the concerned individual to an appropriate service provider (after receiving informed consent), and in the case of adults can also let a concerned individual know which services they can access when they wish to. Whenever possible, concerned individuals should be accompanied to the service (at least for the first time) to ensure the referral is understood by the agency receiving it.

What is a safe referral?

“A **referral** is the process of directing a client to another service provider because s/he requires help that is beyond the expertise or scope of work of the current service provider. A referral can be made to a variety of services, for example, health, psycho-social activities, protection services, nutrition, education, shelter, material or financial assistance, physical rehabilitation, community centre and/ or a social service agency.”¹⁵

Making a safe referral consists of the following 8 steps¹⁶:

1. Identify the needs and capacities of the client/survivor
2. In cooperation with the client/survivor, identify which organisation and/or agency can meet the most immediate needs
3. Contact the service provider to confirm the eligibility criteria for the client/survivor
4. Explain the referral process to the client/survivor
5. Document informed consent from the client/survivor
6. Make the referral according to the procedure agreed upon with the service provider
7. Follow-up with the client/survivor and the receiving agency according to the procedure agreed upon with the service provider
8. Store information in a safe, ethical and confidential manner

How to respond to someone from the community when they tell you of a protection concern, but when there is no protection actor¹⁸

Always Ask for informed consent, respect confidentiality, be clear and aware of your own limitations and follow the Referral Guidance*. Share information on all services that may be available, even if not protection specialised services and clarify what they can and cannot provide.

Never Give false information, refer without informed consent, refer to an actor or instance you do not know, one that does not respect people’s dignity, access, participation and safety, or one that directly contradicts the 7 fundamental principles.

Acknowledge the person’s situation and feelings

Understand the survivor’s decision: **give information on rights and services, do not give advice.**

¹⁵ Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, *Inter-Agency Referral Form and Guidance Note*, 2017. p.3.

¹⁶ For more detailed information please see the “Safe Referrals in Migration and Displacement Contexts” A Pocket Guide, Danish Red Cross

¹⁷ Adapted from “How to support survivors of gender-based violence when a GBV actor is not available in your area”, GBV AoR 2018

Carefully listen to what the person says

Comfort the person: ensure the individual is safe

Take notes: document what the person says and what is observed

Refer to the nearest Social Welfare Office for immediate support

For children and adolescents: In some cases, it may be unclear how to support the best interest of the child and his/her physical and mental well-being. If ever unsure about the safety of the child survivor, inform the child that you will need to confidentially speak to another service provider or team member that may have more knowledge on how to ensure his or her safety.

(4) Case planning

If experienced in case management or if case management is being implemented (above and beyond simple referral pathways) then the PGI or other case management focal point should make a case plan within one week of first encountering the disclosure. Such a case plan usually entails how to meet the identified needs of the concerned individuals, what actions to take, who is responsible to carry these out, within what time frames and a routing monitoring plan, with the frequency of the monitoring based on the concerned individual's risk levels and needs.

The plan should include short-term, medium-term and long-term actions, with contingencies for what will happen if the plan fails. Some examples may include developing a new plan or reconvening a case planning meeting.

(5) Follow-up and monitoring

Follow-up and monitoring involves checking whether the individual of concern and their family are receiving appropriate services and support to meet their needs, as outlined in the case plan.

For RCRC actors who are implementing a full case management programme, this means following up regularly. For PGI delegates and focal points who are operating in an emergency situation, it is recommended that follow-up on cases occur over a 3

month time period, based on agreements with the service providers.

Follow-up actions can entail:

- checking that the concerned individual has received necessary medical support
- checking that the concerned individual is feeling safe and well in the new temporary accommodation s/ he is currently in
- checking that (if it is a child) that s/he is registered for school and continues to attend it

The follow-up itself can take place in a variety of ways, including but not limited to:

- Meetings with the concerned individual and their family
- Scheduled home visits – if appropriate. These must be carefully considered as they could expose the concerned individual and their family to further harm (e.g. by drawing the attention of the neighbours/ community to the individual and family in question)
- Ad-hoc home visits- these can be important for volatile situations in which the levels of care are low
- Phone calls – these may be necessary for care placements that need follow-up in the initial stages, and can be useful for individuals and their families living in remote areas

- Confirmation from relevant service providers that the person referred to their service actually received it

For more information on **case reviews, case planning meetings, case management meetings and case conferences**, please see **p.65 in the *Interagency Guidelines for Case Management and child protection***.

(6) Case closure

How do you know when to close a case?

The length of time a case may be open will vary greatly depending on the individual person's needs and the context in which you are working.

Because of these variables, it is important to have criteria for case closure so that you know when it is time to close a case.

You can close a case as follows:

- When the client's/survivor's needs are met by checking:
 - Follow-up with the survivor and discuss their situation.
 - Review the final action plan and the status of each goal together.
 - Explain that it is time to close the case, but reassure the survivor that they can always return if they encounter new issues or experience violence again.
- When the survivor wants to close the case. Sometimes survivors may feel that they do not want to continue with you even if they haven't had all their needs met. Our goal is to respect the survivor's wishes, and thus the case is closed at their request.
- When the survivor leaves the area or is relocated to another place.
- When you have not been able to reach the person for a minimum of 30 days.

If you are not implementing a case management programme, as the PGI staff, you should still always follow-up with the receiving agency on the case follow-up and closure (by simply checking if the person is accessing those services or has exited the care of that agency).

What to do in case of case closure?

- Document when the case is closed and the specific reasons for doing so.
- Safely store the closed case file. Move the file to a "closed case" cabinet if your program has one. Do not include the consent form in the closed file for confidentiality purposes.
- Where possible administer a client feedback survey.

Case closure should be incremental and the case worker should work with the client/survivor to determine a timeline assuming no new incidents or life events come up.

It is possible that the client/survivor may experience difficult feelings around loss and change once the case closure process is mentioned, and may initially be reluctant or unsure. It is important to recognise that these feelings are normal and they should be discussed and validated. The case worker should provide an opportunity to reflect with the client/survivor on how far they have come, the positive changes they have seen and the goals that they have met.