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Health and Human Services (HHS)

**Operation Allies Welcome (OAW) Behavioral Health Services Manual:**

**An Implementation Guide for Service Providers at CONUS Sites**

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# Introduction

We deeply thank you for your service and all of your efforts to support the Afghan population as they navigate the difficult process of resettlement and assimilation. You, as a direct service provider, will be the primary personnel to directly interface with Afghan guests (*guest* this is the official term being used at OAW sites due to these individuals not yet having refugee or SIV status) around very sensitive matters, around mental health, as well as around issues such as gender based violence, interpersonal violence, child abuse and neglect, and human trafficking, and sexual exploitation. The latter topics especially, are considered to be part of a larger protection framework (staff functioning to execute this framework are referred to as *protection staff* in this guide) that is being implemented by the U.S. Government. This guide will discuss your exact roles as you come onto the OAW CONUS Safe Havens, as well as provide you with technical assistance and guidance in the field. The guide will also discuss how you communicate and coordinate with partners from the medical staff, the protection staff, and federal staff helping to oversee your efforts.

*\*Note: This guide may also be used as a general Behavioral Health Services Standard Operating Procedure (SOP) that OAW bases can adapt locally.*

**Overview of Behavioral Health Model**

As part of Operation Allies Welcome (OAW), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of Refugee Resettlement (ORR), within the Administration for Children and Families (ACF), have developed a sustainable strategy that creates a trauma- informed, strengths-based, culturally-sensitive model of behavioral health service delivery for Afghan evacuees. The model will build upon ORR’s grantees and partner organization, including but not limited to those already engaged in providing on-site supports at Safe Havens (DOD military base and non-DOD sites). This model is consistent with best practices in emergency humanitarian settings, and one that prioritizes a do-no-harm approach that reduces over-pathologizing and re-traumatization, while ensuring care for those who are highest risk with regards to mental health and stabilization. This plan aligns with the Unified Coordinating Group (UCG) CONOP to address protection needs and psychosocial support for Afghan populations.

Components:

1. Training of all service/support staff in Psychological First Aid and cultural orientation
2. Welcome/Cultural Orientation for Afghan evacuees, complementing existing activities
3. Psychosocial needs assessment and behavioral health screening validated to be used in humanitarian emergency settings
4. Case management to coordinate care, referrals, and needs of special populations
5. Brief evidence-based, culturally appropriate therapeutic interventions with well-established utility in emergency humanitarian settings and adapted to the unique OAW context
6. Clinical treatment interventions as appropriate to provide stabilization of acute cases
7. Protection advisors on site to assist with specialized interventions for gender-based violence, human trafficking, child abuse and neglect, and suicide prevention
8. Peer support, supervision, and interventions for prevention and treatment of secondary trauma for staff on site
9. Referral and coordination with on-site medical staff

ORR, in coordination with SAMHSA, will make vigorous, good faith efforts to fully implement this strategy, to the extent practicable within the OAW context.

# Behavioral Health Staff Role Descriptions

Below is a description of responsibilities for each member of the behavioral health team. There is also a description of protection staff arriving from various agencies. *Of note the following staff will be referred to as Behavioral Health (BH) Staff in the document, which will include community health workers, case managers, therapists, psychiatrists, and psychiatric nurses.*

1. **Community health workers (CHW):** 
   * Training Level: CHWs shall be at least 21 years of age and can be non-licensed individuals with a background in peer support, community health navigation, and ideally be from the Afghan diaspora, and speak the language of Dari or Pashto. Recommend a priority on recruiting female CHWs for this role.
   * Role:
     + Design new and/or supplement existing welcome and cultural orientation activities for Afghan guests. This may involve leading group discussions on various orientation topics.
     + Design new and/or supplement existing wellness activities around recreation, safe spaces, and engaging activities.
     + Assist in approved information campaigns around mental health and related protection issues (ie, GBV, child abuse, etc). This may involve leading group discussions on various information campaigns to raise awareness and provide resources.
     + Assist with interpretation if needed
     + If the CHW is from the same cultural background as the guest, act as a cultural broker when appropriate to facilitate behavioral health and protection related services.
2. **Behavioral health case managers**
   * Training level: Case managers shall be at least 21 years of age, and ideally be licensed behavioral health providers, such as LICSWs, however this is not required. However in the case that this is not possible, case managers shall have a minimum of a Master’s degree in the behavioral sciences, human services or social services field; or a Bachelor’s degree with at least three years of progressive employment experience that demonstrates case management experience with forced migrant or immigrant populations. They shall also have a strong background and understanding of trauma informed and strengths-based case management approaches. Case management services are consistent with culturally and linguistically appropriate services standards (CLAS). Recommend a priority on recruiting female case managers for this role.
   * Role:
     + Receive referrals from on-site staff and follow up with a psychosocial needs assessment and targeted evaluation of the individual or family being referred.
     + Establish a system of referral and bidirectional communication with mental health specialists such as therapists and/or psychiatrists, that may be needed for further assessment and evaluation, as well as crisis management.
     + Notifying appropriate personnel through the chain of command around any specialized needs of guests, such as mental health conditions, medications, protection issues, appointments that may be needed.
     + Providing case management around mental health.
     + Provide case management and serve as an interim survivor advocate (in cases where there is no survivor advocate specific resources available on site) around protection related issues such as gender-based violence, human trafficking, child abuse and neglect, sexual exploitation. On these matters the case manager will coordinate with the IRC protection advisor. IRC can directly support protection cases or can provide technical support/mentorship to case managers who are working with cases that have a compounding protection issue. These case managers should also have technical expertise in protection related issues.
     + Coordination and follow-up of mental health appointments and referrals that are on or off base
     + Assisting with child-specific or peri-natal specific needs such as mental health conditions that may need acute follow up
     + Providing brief therapeutic interventions (as discussed in this guide) when appropriate to help continue to resolve distress amongst guests in a culturally sensitive and strengths-based manner. At times this may be in the form of brief individual therapy or in larger group settings (ie stress management or breathing skills, etc).
     + Assist with any paperwork needed around psychosocial needs for legal, housing, food, schooling as families prepare to move out of bases into the community.
     + Serve as a liaison to the Protection Advisor on site regarding protection case detection and follow up
3. **Therapists**
   * Training Level: Licensed behavioral health practitioners training to conduct therapy shall have at least a Master’s or PhD degree in social work, psychology, or other relevant behavioral science in which direct clinical experience is a program requirement. All clinicians shall have had some clinical experience or background in working with forced migrant or immigrant populations. All clinicians shall possess an active license to provide behavioral health treatment and be in good standing with their licensing boards. All clinicians shall have some background in trauma-informed, culturally responsive, and strengths-based care. Recommend a priority on recruiting female therapist for this role.
   * Role:
     + Receive primary referrals from CHWs and case managers on site
     + Establish a system of referral and bidirectional communication with case managers and psychiatrists
     + Triage and refer up to psychiatrists and/or NPs to aid in diagnostic evaluation, management, or crisis intervention.
     + Providing brief therapeutic interventions (as discussed in this guide) when appropriate to help continue to resolve distress amongst guests in a culturally sensitive and strengths-based manner. At times this may be in the form of brief individual therapy or in larger group settings (ie stress management or breathing skills, etc).
4. **Psychiatric nurse practitioners/Psychiatrists**
   * Training Level: Psychiatrists shall possess an M.D. or a D.O. Nurse practitioners shall possess an MSN, ARNP, or DNP. All clinicians shall have had some clinical experience or background in working with forced migrant or immigrant populations. All clinicians shall possess an active license to provide behavioral health treatment and be in good standing with their licensing boards. All clinicians shall have some background in trauma-informed, culturally responsive, and strengths-based care. Recommend a priority on recruiting female staff for this role.
   * Role:
     + Receive primary referrals from case managers, therapists or directly from medical staff on site.
     + Establish a system of referral and bidirectional communication with case managers, therapists, and medical staff
     + Be available to provide consultation to medical staff in the form of case review or direct evaluation of individuals. Psychiatrists should try to establish a half day per week where they can be available to medical staff for case review and consultation around psychotropic medications, and related behavioral health decision making.
     + Serve as the top-level clinician to manage mental health crises including stabilization of acute cases, and crisis intervention.
     + Be available to fully evaluate, manage, and treat individuals referred, including prescribing on site as needed
     + Assist with coordination, follow-up and communication of inpatient psychiatric admissions or emergency room visits
5. **IRC Protection Advisors**

Training Level: Seven years of related professional experience working in the fields of protection and social services, with at least 4 years working within humanitarian contexts in the international sector. Experience working with refugees, asylum seekers, and others who have been forcibly displaced

* + Role:
    - Map surrounding social service providers and community organizations with experience in responding to intimate partner violence, violence against children, and mental health needs, to identify options for service provision on base. Where needed, support outreach to international service providers with experience working with similar populations and providing community-based social services.
    - Support service providers to tailor and adapt their approaches for delivery on a US military base to the Afghan population. This includes thinking through how to make services safely accessible and culturally appropriate for women, adolescent girls, children and LGBTQI+ individuals.
    - Establish and facilitate regular coordination meeting for all health and social service providers, and for other stakeholders on base, for example teams running Morale, Wellbeing and Resilience activities, DHS, DOS and DOD actors, etc.
    - Facilitate the establishment of functional response and referral protocols, and ensure that all key base personnel and volunteers understand their role within the system, and how to make safe, appropriate referrals when Afghan guests disclose violence and need support.
    - Support the Guest Information and Communication Services Specialist in coordination with IRC’s Resettlement, Asylum, and Integration (RAI) Safety Education and Wellness (SEW) and Legal Services Technical Unit (TU) to standardize information systems, promote best practices and minimum standards for information provision to guests while also ensuring timely, consistent and coordinated two way communication strategies.
    - Regularly share progress, best practice and challenges with the Senior Protection Advisor, and with counterparts in the same role on other bases, to ensure ongoing learning, adaptation and agility in the face of new challenges.
    - Encourage work practices that are considerate of and promote equity in regards to: race, color, national origin, religion, gender, gender expression, sexual orientation, age, disability, marital status, and legal status.
    - Encourage all staff and volunteers to draw upon existing strengths and resiliency, practice self-care, and connect to Duty of Care.

1. **IRC Guest Information and Communication Services Specialist**
   * Training Level:
     + 2-3 years of experience working in communications, journalism or social work that is related to communications for community engagement and / or accountability to affected populations.
     + 2-3 years of experience working with refugees, asylum seekers, displaced persons, refugee hosting communities in protection or a related field.
   * Role:
   * Map information activities and modes of communication used across each base to engage with guests
   * Complete an information needs and preferences assessment with guests to better understand how to package information that will be relevant and equitable to diverse populations on base
   * In collaboration with key stakeholders, such as DHS, DOS, DOD, HHS/ORR and mental health service providers, develop or adapt/enhance a communication/information strategy for the base including feedback loops and escalation of sensitive reporting.
   * Provide recommendations for both analog and digital solutions for mass communication and feedback mechanisms, in line with industry standards and best practice.
   * Produce base-specific information products (including posters and social media posts) as finalized by interagency coordination efforts.
   * Ensure content is accurate, complete, easy to understand and engaging.
   * Work with IRC Protection Advisors and Legal Services TU and front line staff to create information products that reflect community information needs.
   * Work with interpreters on communication messaging and approaches, inclusive of information on safe and appropriate referrals for protection sensitive cases.
   * Ensure coordination between interagency stakeholders on base for a consistent and coordinated communication strategy for the base and connect guests to resources that will facilitate information provision and access to services following departure.
   * Serve as an information focal point for the base in close coordination with Protection and Legal Services Technical Advisor (TA) with any expanded efforts around other IRC-led digital platforms such as [Signpost](https://www.beporsed-ma-ra.org/hc/en-us) / [SettleIn /CORE](https://corenav.org/en/programs/cultural-orientation/) etc.
   * Help monitor guest feedback.
   * Regularly interact with counterparts across bases and within global information efforts such as Signpost / SettleIn / CORE to ensure information is accurate and up to date.
2. **HHS Behavioral Health Federal Coordinator**
   * Role:
     + Serve as a BH Consultant to the Federal Coordinator
     + Conduct assessment of behavioral health needs of existing population
     + Identify existing resources/assets to address existing behavioral health needs
     + Recommend resources and training needs for all staff to address behavioral health needs
     + Conduct train the trainer for staff on mental health first aid or equivalent
     + Provide stabilization and treatment for acute behavioral health needs
     + Engage local BH authority for assistance in addressing crisis stabilization
     + Serve as POC for additional behavioral health contractors at location

# Protection Staff

**DHS Lead Protection Officer:**

* Report directly to the Unified Coordination Group’s (UCG) Gender and Vulnerable Population Protection Advisory Group (GVPP);
* Provide interim support to vulnerable populations being housed in CONUS temporary housing waiting resettlement across U.S. communities;
* Lead strategic coordination and communication of social services to meet the immediate and long-term needs of Afghan guests; and
* Coordinate and oversee the Team to include: (1) Federal Coordinator, (2) DoD Gender Advisor, (3) DHS Cultural Competency Advisor

**DHS Federal Coordinator**

* Provide overall operational command and control of activities and
* Work collaboratively with physical security presence teams, DoD and Task Force liaisons to understand security-related issues and recommend/implement solutions.

**DOD Gender Advisor**

* Provide regular data, analysis, and recommendations about existing and emerging gender-related issues, respond to issues effectively, mitigate risks, and implement gender-informed guidance, policies, and responses;
* Identify potential secondary effects or unintended negative consequences of actions and seek to mitigate risk and potential harm to vulnerable groups;
* Support tailored strategic messaging/communications to the Safe Haven population and work with the IRC Info Specialist for a coordinated approach to communication/information provision on base.
* Deliver and host training and awareness activities; and
* Coordinate information and reporting with other CONUS Gender Advisors to provide gender-informed recommendations and solutions across locations.

**DHS Cultural Competency Advisor**

* Promote situational awareness and identify cultural concerns within the Safe Haven population;
* Work collaboratively with DoD Gender Advisors to identify unintended consequences of Protection actions and mitigate potential harm; and
* Assist IRC/NGOs with town halls and communication campaigns to inform Safe Haven populations of support activities.

# Safe Spaces for Behavioral Health Intervention:

* We understand that space is extremely limited on Safe Havens and there may not yet be a safe place for behavioral health services to take place.
* If space is an issue please report this to the IRC protection advisor as well to the HHS federal mental health liaison, so they can assist with trying to help you find a space.
* When providing psychosocial and behavioral health services, please find a safe, private space to conduct meetings or assessments with clients. Ideally this means space that is quiet and uncluttered.
* There should also be dedicated spaces for children, for women and girls, and men – these should be separate spaces and it is critical that the space for women and girls is a female exclusive space.
* Always ask if there is anything that will assist in making the individual more comfortable during the meeting. This may be a glass of water, food, or request to have family member(s) present. In most cases, it is best to meet with individuals without family members present (unless the meeting is with a child, in which case an appropriate guardian or adult of the child’s choosing should be present)
* If you have concerns about family members being present, whether it is an adult or child, let them know it is protocol to try to meet with each person individually, and offer a separate time to meet with them individually and then together with the requested family member(s).
* Keep in mind that it is difficult to interview children younger than 8 alone in this context, however if there is a safety related reason to do so, please use your clinical judgement.

# General Principles and Guidelines:

* It is a normal reaction for individuals who are impacted by relocation to experience psychological distress. Psychological distress can include many reactions, and assessments and interventions should be viewed through a culturally appropriate perspective.
* Establishing an environment to reduce psychological distress, increase protection from exposure to traumatic events, and increase resilience is essential. This can include:
* **Creating a safe environment** that promotes psychological and emotional well-being through
  + - Providing every opportunity for individuals to cope in ways most familiar to them, including the opportunity for guests to rely on their own social and cultural networks to process stress.
    - Install routines, schedules, structures, and rules that allow the individual to establish a **sense of stability and predictability** – this is particularly important for children
    - Integrating a focus on strengths and resilience into any behavioral health assessment/intervention
* When providing behavioral health support, always attempt to have gender- and language-matched staff for the guests when possible.
* **The goal of mental health support is NOT to provide in-depth treatment on site, but rather be able to identify the risk category and appropriate level of intervention and referral for each guest**
* **All efforts should also be made to use non-medication, therapeutic, interventions that are appropriate for the individual’s case and environment.** Medication is often NOT the first line of intervention for mental health concerns. Medication should be reserved for acute stabilization of mental health emergencies (the symptoms severely impact the individual’s, others’ safety and/or functioning), and crises. Referral to appropriate on-site mental health specialists and off-site tertiary centers should be made for fuller evaluation and treatment.
* **By no means should any degree of psychological debriefing regarding the guest’s past trauma or intensive prolonged psychotherapy of any kind be done on site, even by trained professionals**.
* **Staff should also be aware of maintaining appropriate emotional and psychological boundaries with the guests, i.e. do not try to be their savior, do not over-promise what you can do for them, do not try to take on the role of a parent or family member, as ultimately this can be more harmful to the family.**

# Training

1. All behavioral health service staff should be trained in psychological first aid (PFA), cultural sensitivity training, as well as protection related issues such as gender-based violence (GBV), child abuse and neglect, human trafficking, and protection from sexual exploitation and abuse and code of conduct, survivor advocacy, and obligations and responsibilities as it relates to this population. This could be done in a train the trainer fashion, so those behavioral health staff that are trained could provide further training to other support and service staff on site.
   1. Technical modules on protection related issues, such as those listed above, should be adjusted for the role of service / support staff: specialist staff facilitating direct clinical interventions will need in-depth training to handle complex cases with this population, whereas training of other frontline generalist staff should be limited to guidance on safely identifying and referring cases to appropriate service providers.
   2. Resources for training:
      1. GBV: <https://switchboardta.org/resource/fundamentals-of-gender-based-violence-for-refugee-service-providers-what-does-a-culturally-responsive-approach-mean/>
      2. Safety Planning: <https://mk0switchboardti27px.kinstacdn.com/wp-content/uploads/2020/07/Switchboard-Information-Guide-Safety-Planning.pdf>
      3. PFA: https://www.nctsn.org/sites/default/files/resources/special-resource/pfa-for-displaced-children-and-families.pdf.
2. **Staffing:** This can be done virtually through online materials such as those available above. Trained community health workers can also provide the training in groups up to 25-50 in person. An abbreviated training is still better than none.
3. **Space:** Virtually or on site in a large space to fit groups of 25-50.

# Welcome/Cultural Orientation Activities for Afghan Guests

1. Cultural orientation and psychoeducation for Afghan guests may occur in-person or virtually via videos to provide knowledge about U.S. culture, basics of assimilation, and assist Afghans in gaining a sense of control and mastery over their new environment.

BH staff should familiarize themselves with any cultural orientation activities being conducted on the base. It should be noted that on the bases cultural orientation/welcome is currently being handled mostly by USCCB. Community Health Workers should coordinate with USCCB as well as with the Information Specialist and Cultural Advisors who are often leading these activities in Town halls etc to aid in supplementing sessions and/or filling identified gaps in topics that need to be covered.

***A special note for community health workers (CHWs):*** As you get to know Afghan guests, they may confide in you and endorse behavioral health or protection related concerns. In this case CHWs should offer to connect the guest to a behavioral health case manager for further assessment, and ideally meet with the guest and BH staff together to help establish rapport and trust. Here is an example script: *“Thank you so much for sharing this with me. I understand this can be hard to talk about, but I want you to know that we care about you and your safety. I want you to know that I will keep what you tell me private and confidential. I would like to connect you with someone we call a survivor advocate – their name is NAME and they are trained to support people who have experienced violence. They can help you understand your rights and the services available to you on base and in the community you travel to after the base. Would you be ok if we go talk to NAME together?”* However, if the guest does not want to share with anyone else, please respect their privacy. Any information guests share with you should not be shared with anyone unless you believe their (or others’) safety to be at imminent risk (ie suicide, homicide, risk of serious injury, etc). Continue to check in with the guest and offer connection to behavioral health services each time but do not force them. Please see guidelines in “Specialized Interventions for Protection-Related Issues” for how to best manage these situations**, but keep in mind that assessment, intervention and management of behavioral health clinical concerns and protection-related issues is the job of a licensed behavioral health practitioner and/or survivor advocate.** CHWs should be mindful to not over function in their roles and recognize the importance of those initial connections they are making with the guests.

1. Examples of things that may help is discussion of the following topics:
   1. Enrolling children in school and orientation of the school system in the US (including age-appropriate session for school-aged minors)
   2. Overview of driving rules and transportation, including how to obtain licenses
   3. Overview of law enforcement and legal system in the US
   4. Overview of pathway to legal status
   5. Basic language and cultural differences with regards to American social norms
   6. Overview of the healthcare system
   7. Basic differences in food production, access, and culture
   8. Basic overview of U.S. currency, banking, and money management
2. **Staffing:** In addition to videos potentially being prepared by various agencies leveraging cultural brokers, community health workers on site can also serve as cultural brokers and educators if they have the appropriate background and knowledge.
3. **Space:** This activity may be done in groups or learning circle type formats so the guests have a chance to interact with each other and the education, and ideally ask questions.

# Trauma-Informed Behavioral Health Assessments

* Prior to any assessment, ensure the individual is comfortable and if they need anything, such as food, water, temperature of the room, their reading glasses, etc.
* Please allow the individual/family to set the tempo of the interview, letting them know that if at any point they feel uncomfortable, they do not have to continue. Give them the option of breaking up the session.
* If during your assessment, there are family members present, note for the family that it is standard to do assessments individually. It helps to normalize this by saying*, 'Sometimes people are worried that the things they are going to say may be distressing or painful for other family members to hear."* However, some individuals may insist on having a family member(s) present anyway. In this case offer a time to meet individually and having another meeting together with family members present. Also explain and get permission to obtain collateral information from family members with consent if/when relevant. If you sense they are uncomfortable with being alone with you, there can be many reasons for this (ie reminder of past perpetrator, body language, gender, general fear, etc). You can offer to have someone else do the assessment and/or honor their request to have the requested family member(s) present.
* If an individual does reveal trauma, be careful to not let the patient get too detailed with their description of the trauma in the initial interview
* Keep in mind any psychiatric interview can be re-traumatizing and/or therapeutic.
* Let the patient lead the conversation, remind them **they are in control** of the interview
* **Map out the interview,** including the purpose of questions, and what will occur after the interview, so there are no surprises for them
* Be aware of **body language** that may indicate the patient needs to stop the interview or is uncomfortable. In this situation, pause the interview and check in
* Let patients choose where they want to sit in the space; how to sit, etc
* Be **mindful of your own reactions** (tearing up, facial expression). Individuals with trauma may often feel they are burdening others when sharing their stories or stress. The way we conduct ourselves during the interview can worsen this feeling and may violate trust/sense of safety with us.
* Do not ask patients to describe their traumatic event and **let them refer to it how they want to** (ie “the issue”, “the problem”, “it”)
* Clearly provide information regarding confidentiality and privacy and limits to this as well (ie, letting them know you may call others to be involved if you feel that they or their family members are in acute danger).
* Explain why you are taking notes while they talk, where those notes will go and who will see them
* Explain exactly with who else the information will be shared with, for what reason, and in what manner (ie identifiable vs de-identified information).
* Focus on resilience and strengths: Ask about what they have been doing well/what’s right over what’s wrong.
* Please also reference the following guide on Trauma Informed Care: <https://mk0switchboardti27px.kinstacdn.com/wp-content/uploads/2020/01/Switchboard-Information-Guide-TIC-Movement-Towards-Practice.pdf>

# Psychosocial Needs Assessment and Behavioral Health Screening

1. ***Psychosocial needs assessment will NOT be given to every person, only to those who are identified to need it via distinct referral sources.***
2. ***It is recommended that behavioral health case managers who are licensed behavioral health providers implement the psychosocial needs assessment.***
3. ***It is recommended that for any behavioral health or protection related referrals, case managers begin their assessment with the broader psychosocial needs assessment to understand the larger context of stressors and precipitating events that may have sparked a referral, rather than direct confrontation and assessment around just the reason for the referral.*** Often this broader assessment will result in more comprehensive and sustainable ways to assist the family/individual.
4. ***Of note referrals may be sent to behavioral health for behavioral health concerns as well as protection-related concerns that intersect with behavioral health.*** The type of protection incidence that would occur that may also intersect with behavioral health includes, but is not limited to (past/current): GBV, violence/abuse/neglect/exploitation of children, suicidal ideation or attempted suicide with compounding protection concerns like violence/exploitation/family separation, grief, loss and around family separation including left behind/lost family members.
5. Both psychosocial assessment and any screening tools should be appropriate to be used in humanitarian settings. Below is the recommended guidance to use and can be found in the appendix:
   1. Technical Assistance Interview Guide for Case Managers: this is a psychosocial assessment interview guide for case managers.
   2. If a true mental health pathology is detected by the case worker, i.e., true suspicion for depression, anxiety, trauma, mood/psychotic disorder and/or substance use disorder that is significantly impacting the functioning or safety of the individual and/or family members, then they should continue on with formal mental health screening as appropriate. Please note however that the gold standard is a mental health interview by a licensed practitioner, and not any one screening tool.
   3. Mental Health Screening Tool: WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS)
      1. **The screening tool will be used in SELECT cases only, it will NOT be given to every person, only those identified to have a high suspicion of mental illness that may require acute intervention. It is NOT mandatory to use, and only serves as an additional tool for assistance with the mental health evaluation.**
      2. **The purpose of this tool is to identify persons in priority need of mental health care. So, the selected questions are meant to identify people with symptoms of severe distress and impaired functioning.**
      3. **Only licensed behavioral health practitioners should use this screening tool, in cases where they feel they need it to aid their assessment.**
      4. If this screen is positive, the individual must have a full mental health evaluation by a licensed behavioral health provider. If the case manager does feel equipped to do a full evaluation, this will require referral to a higher-level clinician on site, such as a therapist, psychiatric nurse practitioner, or psychiatrist for further evaluation. If none are available on base, the individual should be referred off site for a full evaluation.
      5. **Staffing:** The psychosocial screening should be done by case managers or social workers with a behavioral health background due to acute needs or mental distress that may arise from the assessments. In the course of the needs assessment if there is higher suspicion for mental distress, case managers should continue with a further mental health screen and involve the therapist and/or psychiatrist if assistance is needed with diagnosis and/or management.
      6. **Space:** In a private space that will allow for confidentiality and on site. Virtual options should also be available if the infrastructure exists on site.
   4. Outcomes of the psychosocial needs assessment may lead to formal case management services, referral to therapist/psychiatrist for further assessment, and/or recommendations to the UCG for structural changes to address widespread needs across bases.

# Behavioral Health Case Management

1. Case management will NOT occur for each individual, only for those identified to need it through various distinct referral sources.
2. Of note, case managers are serving as behavioral health case managers and as survivor advocates related to protection issues where these advocates are not available on site.
3. ***Referral source:*** Case managers will likely receive referrals through a type of community case detection system. It is not recommended that case managers go into the general Afghan evacuee population and start assessments randomly. Referral sources may include:
   1. DOD shelter monitors
   2. Mayor cells, patrols / base security, ex. Marines, military police, law enforcement, etc. that may witness a crisis
   3. Protection staff; please note these staff are in process of deploying and are not currently all present on bases
   4. Medical teams
   5. Morale Wellness and Recreation centers
   6. Other DOD mental health practitioners through contracts or volunteer organizations
   7. Afghan governance systems (ex. shura, barrack leaders, elders, etc.)
4. ***Upon receiving a referral:*** 
   1. Case managers should ensure they have a clear understanding of the reason for the referral.
   2. Explain to the individual/family why they were referred to you and what your role is exactly.
   3. It is recommended that case managers start with a broader general interview that examines psychosocial needs. Please see the *Psychosocial Needs Assessment and Behavioral Health Screening* section for more guidance. The appendix in this guide has a psychosocial interview guide to assist with this.
   4. Map out to the individual/family the process for the psychosocial assessment, outlining the order of and the reason for each step involved in the visit with them.
   5. In the case where mental illness may be suspected in the broader interview, case managers should go on to do a full mental health clinical interview, utilizing the mental health screen (WASSS Part A and B) only if needed as a tool in aiding those who may need immediate evaluation and treatment. Please see the *Mental Health Screening* *Tool* section above under *Psychosocial Needs Assessment and Behavioral Health Screening*. Refer the individual to a higher-level mental health clinician such as therapists, psychiatrists or psychiatric nurses on site whenever indicated. Case managers should also notify the protection advisor on site to allow for coordination and follow up if protection issues are discovered.
   6. It is expected that case managers are able to provide case management for protection related issues, as they often intersect with behavioral health. Protection related concerns include the following: Gender based violence, intimate partner violence, child abuse, neglect and exploitation, family separation, human trafficking, and suicidal ideation. For detailed technical assistance and guidance on what this case management should look like, please refer to the section below title *“Specialized interventions for gender-based violence, human trafficking, child abuse and neglect, and crisis/suicide prevention*”.
   7. Notify the appropriate personnel through the chain of command around any specialized needs of guests, such as mental health conditions, medications, protection issues, appointments that may be needed.
   8. Clearly explain any referrals that may be needed as a result of the interview and provide detailed information about the next steps for those referrals (ie who will come see them next, what will happen next).
   9. Assist with coordination of mental health appointments and referrals that are on or off base, inclusive of accompaniment, interpretation support, follow-up and organizing transport once discharged or appointment is completed.
   10. Provide ongoing brief therapeutic interventions (as discussed below) when appropriate to help continue to resolve distress amongst guests in a culturally sensitive and strengths-based manner
   11. Assist with any paperwork needed around psychosocial needs for legal, housing, food, schooling as families prepare to move out of bases into the community.
   12. Case managers should continue to follow any families/individuals that have been identified to need case management for as long as needed to help resolve the reason for referral.
5. **Staffing:** Case managers should partner with and utilize any community health workers that can serve as cultural brokers when appropriate.
6. **Space:** Case management should continue in a private area reserved for mental health assessments.
7. **Communication & Coordination:**
   1. For case supervision and technical support, case managers should talk with higher level behavioral health clinicians for mental health. For any protection related cases they should talk to the IRC Protection Advisor. Cases should be discussed in a de-identified manner unless there is a need to know identifiable information to ensure one’s safety. It is also recommended that the minimum number of staff are directly interviewing or assessing a family/individual so they are not forced to repeat their stories.

# Brief Therapeutic Interventions

1. General wellness, crisis prevention, and stress management programs/resources should be provided to broader community. These can be done in group sessions, such as townhalls, however sessions on these topics should be facilitated by a licensed provider in the case that anyone needs immediate support in the group.
2. Brief therapeutic interventions should be evidence-based or evidence-informed, culturally appropriate, with well-established utility in emergency humanitarian settings and adapted to the unique OAW context (individual and/or group settings).
3. Appropriate individual culturally sensitive and non-medication therapeutic interventions in this context include (when appropriate for group settings in addition to individual, it is noted below): **Therapy should be stabilization and crisis prevention focused only.**
   1. brief counseling
   2. brief CBT-based interventions
   3. person-centered therapy
   4. environmental strategies to increase safety – group settings appropriate
   5. problem solving- group settings appropriate
   6. management of stress and anxiety- group settings appropriate
   7. parenting support on how to best support children to cope with stress in an age-appropriate way – group settings appropriate
   8. Breathing skills – group settings appropriate
   9. Meditation/mindfulness – group settings appropriate
   10. behavioral activation
   11. teach or reinforce coping skills – group settings appropriate
   12. problem management+ - group settings appropriate https://www.who.int/publications/i/item/9789240008106

**Staffing:** Behavioral health case managers and/or therapists are appropriate to deliver the above interventions, so long as they are providing therapy that they have the appropriate training and experience for.

**Space:** Prefer guests are taken to a private area reserved for mental health interventions.

# Higher-Level Clinical Assessment, Treatment Interventions & Suicide Risk Assessment

**Psychiatric clinical interview and exam guidance for licensed clinical mental health practitioners:**

1. Maintain a present centered approach of how are their symptoms affecting them NOW
2. Assess stress reactions that may be specific to related current events and their situation on the base
3. Assess for comorbidities
4. Remember NO psychological debriefing
5. Begin with evaluation of social supports
6. Provide psychoeducation of trauma symptoms and/or other mental illness (anxiety, depression, etc)
7. Normalize what they are feeling (normal reaction to something very abnormal)

**Brief Psychiatric Interview Template (to be used for cases requiring urgent assessment and stabilization, ie, highest level of care only):** The following template is guidance for what to cover in a comprehensive psychiatric **interview for licensed clinical specialists only, namely psychiatrists and nurse practitioners. Please use the above guidance around trauma informed assessments to ask questions in a culturally sensitive and trauma informed manner.** Please also refer to the DSM V cultural formulation interview (can be accessed here: https://mhttcnetwork.org/sites/default/files/2019-12/DSMCFIfinal.pdf) to assist in re-wording traditional interview questions that are more culturally relevant and trauma-informed.

* + - 1. Primary Concern:
      2. History of Present Illness:
         1. Summary of current issues/symptoms and why they might be presenting now. Include series of events that may have precipitated symptoms
      3. Psychiatric Review of Symptoms:
         1. Should include assessment for depression, anxiety, obsessive compulsive disorders, trauma disorders, psychotic disorders (auditory hallucinations responding to internal stimuli, delusions, ideas of reference, thought broadcasting), mood disorders (history or current episode of reduced need for sleep, talking fast, grandiosity, increased activity, distractibility, indiscretions, flight of ideas), eating disorders, sleep
      4. Family History: mental illness/ developmental disorders/ substance use
      5. Social History: Lives with/ relationships/ supports
      6. Developmental and Education History: Problems with early development
      7. Past Psychiatric History: hospitalization / medications / therapies / diagnoses / treatment
      8. Past Medical History: Diagnoses / allergies / somatic medications / seizures / Traumatic Brain Injury / other Neurological conditions
      9. General Medical Review of Systems: 14 point review should include: Constitutional / Musculoskeletal / Skin / Neuro / HEENT / Cardiovascular / Respiratory / GI / GU / Endocrine / Heme / ID/Allergy / Other
      10. Substance Use: Please refer to case management interview guide for sensitive way to assess for this
      11. Mental Status Exam:
          1. General / behavior / appearance / speech / mood / affect / Thought process/ thought content / insight / judgement / impulse control / Attention/ concentration / safety (suicidal or homicidal thoughts)

**Workup and Physical Exam:**

1. Focused physical exam (only to be done my MDs or DOs or nurses); please remember to have gender matched staff to do this if possible and if not, have a chaperone. Clearly explain what the exam will entail and where they will be touched, and **always ask permission prior to the exam**.
2. Examine for signs of abuse, neglect and/or poor self-care; please see the section below entitled “*Specialized interventions for gender-based violence, human trafficking, child abuse and neglect, and crisis/suicide prevention*” for more guidance around GBV to ensure a survivor-centered approach.
3. If possible, a full basic laboratory workup, including offering an STD workup in cases of sexual trauma (with their permission)

**Suicide Risk Assessment:**

* + - 1. It is important to note the difference between suicidal ideation and suicidal intent or plan. There can be active suicidal ideation, which indicates there is a thought of actively wanting to harm oneself or passive suicidal ideation (wishing one was dead, “I wouldn’t mind not waking up tomorrow”). The latter is not accompanied usually by intent or plan to end one’s life. Many individuals may express active or passive suicidal ideation and both warrant a FULL suicide risk assessment however in the case that there is no intent or plan, it is not a crisis. It is not uncommon for suicidal thoughts, active or passive to be present and even chronic. Hospitalizing these individuals is not recommended unless there is imminent danger of suicide through expressed intent, plan, and they have the means to follow through on their plan. A more detailed evidence-based assessment for suicide that can assist but is not necessary, is the Columbia Suicide Severity Rating Scale (CSSRS) that can be adapted to this setting and is available on this website: https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english
      2. **Risk/Protective Factor Assessment and Modification**

|  |  |
| --- | --- |
| **Pertinent risk factors** | **Prominent potentially modifiable protective factors** |
| * Male gender * Timing of First episode of suicidal ideation (occurred in the last one year poses higher risk) * Worst point lifetime ideation (including precipitating factors) * Mental Health Diagnoses * Specific Stressors * Prominent Impulsivity * Active substance use disorder * Physically unbearable symptoms * Marked agitation or psychic anxiety * Psychosis * Insomnia * Suicidal ideation in the week prior to the interview * Homicidal ideation or other harm thoughts * Lifetime history of suicidal ideation, suicide attempts, non-suicidal self-injury * Abuse as a child, trauma * Prior psychiatric hospitalization * Family history of suicide * Mental status exam findings that raise concerns for inaccurate reporting | * good physical health * social supports (also engagement in activities on base and socialization) * treatment engagement * future orientation * hopefulness * no access to means (ie guns, sharps, ropes, etc) * Access to supports around faith/religion * Opportunities for socialization |

**How are acute and chronic risk factors being modified and protective factors being enhanced?**

* + - 1. Always discuss a suicide safety plan that includes ways for restricting means including guns, methods of suffocation, ingestible agents, and sharps.
      2. Discuss specific ways to modify risk such as starting treatment/ therapy, increase socialization, involve protection staff if relevant, involving family if/when appropriate, etc
      3. Discuss specific ways to enhance protective factors, such as utilizing current social networks, supports, religion/belief systems, fostering interests and activity, etc

*\*NOTE: Suicide risk level will be determined by the evaluating clinician. It is a subjective assessment based on the individual’s case, circumstance, and the above pertinent risk factors along with protective factors. Suicide risk can be lowered to the extent that the risk factors can be mitigated, and the protective factors can be enhanced. Tools such as the CSSRS may assist with this assessment.*

**Management & Risk Level:**

1. Based on all of the above evaluation components, risk categories and interventions may include:
   1. High Risk: These individuals have been determined to be at high or moderate risk of suicide, harm to others, or are unable to function due to such conditions comprising serious emotional disturbances (ie, full blown psychosis or mania, severe aggression). Referral to psychiatrist should be made immediately for further evaluation and management if not done already. The use of medications for acute stabilization is appropriate. If in crisis, these guests should be referred to tertiary medical centers for mental health evaluation and treatment immediately. See crisis prevention section below for more details on management during a crisis. If not in crisis and the individual is able to be stabilized on base, they should be followed *daily* by a psychiatrist until fully stabilized with pharmacotherapy and psychotherapy, along with case management, with simultaneous efforts to prioritize their resettlement and link them with appropriate mental health services outside the base.
   2. Moderate Risk: These guests have some significant risk factors and may meet criteria for underlying mental illness in the categories of depressive, anxiety, or trauma disorders. They may report symptoms of emotional distress such as depressed mood, anxiety, irritability, acting out (in children), trauma-related symptoms such as flashbacks, hypervigilance, trouble concentrating, and their functioning may be somewhat impaired. A licensed behavioral health provider should be consulted and involved in the care of these guests. *The provider should continue to work with this individual and obtain psychiatric consultation from a psychiatrist when necessary for symptom clarification, and assessment of appropriate level of care, and consideration of when/if medication is appropriate.* However, the BH team should continue with non-medication interventions, case management if relevant, and brief therapeutic interventions as reference above, with simultaneous efforts to link this guest to appropriate mental health services outside the base.
   3. Low Risk: These individuals may express occasional distress or trauma-related symptoms, especially in response to environmental triggers, however they are functioning well, and likely do not meet criteria for any mental illness. They may have fewer stressors or demonstration of higher resilience and effective coping skills. BH staff should continue with support around general wellbeing, encouraging peer networks, recreation/activity as often as possible, and remains available for continued assessment if/when needed.

\**Brief note on substance abuse: Aside from alcohol or benzodiazepine withdrawal, withdrawal from most other drugs is not life-threatening and should be treated symptomatically on base.*

# Crisis/Suicide Prevention

1. A behavioral health crisis consists of:
   1. A client expressing thoughts and intent and/or plan and has the means to hurt themselves or others.
   2. A client is unable to care for themselves or others due to significantly impaired functioning
   3. A client is actively manic
   4. A client is actively psychotic, agitated, or aggressive and is posing a risk to their own or another’s safety**. Note psychosis that is not posing a safety risk to others is NOT a crisis. Most people with psychotic disorders are NOT inherently more violent and should be treated with the same trauma-informed and culturally sensitive approach as all other clients.**
   5. A crisis does NOT entail just a mere expression of self-harm or harm to others (although all statements around self- harm and harm to others should be taken seriously and appropriate steps should be taken around creating a safe environment, monitoring the guest, and getting them to the appropriate treatment level, this can be common with trauma and severe stress, and can often resolve without the use of medication, hospitalization or law enforcement).
   6. In any of the above crisis situations, clients should be referred to the highest level of care for assessment.
2. Verbal de-escalation techniques, and ensuring environmental safety, should be the first response and used in all cases prior to intervention with medication.
3. Environmental safety includes making the environment safe, such as removing sharps, or objects that can be dangerous, including the minimum necessary staff only and minimizing any law enforcement officials, a quiet and private space for the guest, ensuring the guest has had basic needs met such as food, water, clothing, bathing.
4. Again, medication should only be used if the guest is ACTIVELY trying to hurt themselves or others or is in very significant emotional or physical distress where they cannot function. Even if it is believed that a guest is actively psychotic, unless they are attempting to hurt themselves or others, they do not necessarily need to be medicated on site. All of these guests in crisis should be transferred to tertiary medical care centers for fuller evaluation and treatment by specialists outside of the base.
5. If someone has expressed suicidal ideation and it is unclear, they are in crisis, please call a mental health professional for further evaluation. If a higher level clinician is not present such as a psychologist or psychiatrist, ask case management and community health workers to assist with making the environment safe and call 988 from a cell phone or Suicide Prevention Lifeline from any phone, who can assist with safety planning and evaluation. If it’s determined the patient needs hospitalization, follow the clinical crisis protocol as below.
6. Development of a clinical crisis protocol is recommended, such as:
   1. Never leave the client alone.
   2. Call mental health staff immediately for support.
   3. Transfer client to safe, private, and quiet room.
   4. Make the environment safe by ensuring no sharps, or objects that could be used as weapons are in the room.
   5. Have another staff member call law enforcement for emergency transport to a tertiary medical center.
   6. Sign out to the medical center and provide contact information for follow up. There should be a physician to physician sign out and case manager to case manager sign out.
   7. Ensure the guest has reached the center safely and connect with their providers.
   8. Make sure someone from the team is in touch with relevant family members to provide psychoeducation, updates, and let them know where their loved one is at all times, unless doing so poses further risk to the patient (ie, GBV, child abuse, etc);
   9. Prior to any referrals made, care/support arrangements need to be made for any dependents.
   10. Case manager should follow up after discharge from the center and ensure recommendations are being followed.
7. All clients who are referred to the Emergency Department, inpatient psychiatric hospitalization or are receiving ongoing care outside of the base need to have regular liaisons and follow up from the mental health staff within the base. This includes regular communication with the treating facility to ensure that all necessary recommendations are being implemented once the guests return to the bases.
8. For off-site referrals please also inquire about the institution’s language capacity and send interpreter support if needed.

# Specialized Interventions for Protection-Related Issues

*Note: Forms of interpersonal violence/abuse are defined many ways in the field, depending on the source. Violence/abuse is categorized in this protocol to align with common response and reporting actions. Refer to the Case Management Interview document for a loose guide on specific questions to pose regarding these issues.*

## **Gender Based Violence (GBV) (Adults)**

* + - * 1. **Definition:** Gender Based Violence (GBV) does not have an agreed-upon definition in the field, nationally or internationally. Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. For further guidelines and background on GBV, see (<https://interagencystandingcommittee.org/system/files/2021-03/IASC%20Guidelines%20for%20Integrating%20Gender-Based%20Violence%20Interventions%20in%20Humanitarian%20Action%2C%202015.pdf>)
        2. A guest may have experienced GBV in the past, may experience an incident while in the Safe Haven, or may be currently experiencing an ongoing relationship in which GBV exists. It is critical that targeted questions about GBV not be asked as part of the case management process. However, if a client discloses that she is a survivor of some form of GBV, the case manager should pivot to the predetermined protocols for assisting them.
        3. The primary consideration when an instance of GBV is suspected is the current safety of the guest. It is important to note that disclosure and reporting of GBV can increase risk of further violence and abuse by the perpetrator or by others in the perpetrator’s or their own family. It is essential that all personnel follow the response protocol with precision to ensure the safety of the guest.
        4. Whenever possible, contact with the BH staff should be individual and separate from family and others, ensuring this conversation is happening in a safe/private space and that the Survivor leads the discussion utilizing a survivor centered approach.
        5. **If past, recent or ongoing GBV is suspected, BH staff must do the following:**

1. If in the referral to behavioral staff there was a concern for GBV expressed**, the BH provider must not directly approach and screen for GBV with the client**. Instead they should start with doing a broader psychosocial needs assessment with guest and explain that this same assessment is being done across the base to assist with guest needs. Please see the “*Case Management Interview Guide Version 1”* to assist with appropriate questions to ask.
2. Ensure privacy and confidentiality before speaking with the guest.
3. Get permission from the guest to discuss the issue with them.
4. Avoid rushing the conversation.
5. It is important to avoid providing “advice” as part of any GBV case management process. Ensure the client is provided with the range of information relevant to her options for next steps, and available services and support to inform any choice she makes. No action should be taken without the express consent of the survivor. It is important to note that some survivors may choose actions (or no actions) that the case worker does not agree with. However, the wishes and dignity of the survivor must be respected at all steps of the case management process.
6. Avoid leading the discussion and giving “advice” or sharing opinions;
7. Offer to continue the discussion later if the interview is ended because of hesitation.
8. Explain clearly what options are available after disclosure. Examples: safety planning, physical separation from perpetrator and reporting.
   * + - 1. **If GBV is suspected but the guest does not disclose, BH staff should:**
9. Avoid pressuring the guest and offer to speak with them later if they are willing.
10. A Sample Script may include “*Many guests on base find it hard to talk about their experiences of pain and suffering and may believe that these issues are private family matter. I want to remind you that all of the staff and volunteers here care about you and your safety and that violence against anyone is something we care about and want to stop. If you decide you want to talk to someone at a different time or if you feel unsafe or overwhelmed with your experiences, you can reach out to ‘NAME’ by ‘XYZ’ for more support.”*
    * + - 1. **If GBV is disclosed through the assessment or the guest approaches personnel to disclose or be separated from their abuser,** it is essential to act with sensitivity:
11. Respond in a survivor-centered manner:
    * + 1. Validate the survivor’s emotions and experiences
        2. Listen without judgment or jumping to solutions
        3. Follow the survivor’s lead in making decisions and acting
        4. Do not force the survivor to disclose to anyone
        5. Do not engage other providers/actors without survivor’s consent
    1. Be sensitive to the emotional distress or fear the guest may be experiencing.
    2. Affirm that the guest has made an important step by talking about the violence.
    3. Listen to and acknowledge what they are saying.
    4. Validate their feelings.
    5. Reassure them that their reaction to the violence/abuse is normal (e.g. physical, emotional, behavioral reactions).
    6. Believe them. Reserve judgment. It is not the role of anyone during this process to determine the legitimacy of a claim of violence or abuse. Focus on the guest’s perspective of the incident(s) and on how to offer support and options.
    7. Avoid even subtle forms of blaming the guest. Even if some actions taken by the guest before, during or after the violence/abuse are judged by the guest as missteps, it is important to respect their wishes and perspectives and recognize that no one knows better than they do what they need, what risks they may face, or what their wishes are. Reinforce with them that the violence/abuse is not their fault, that there is no excuse for it and that the responsibility lies with the perpetrator.
    8. Convey that in surviving the violence/abuse thus far, they have shown strength and that they can channel that strength in finding additional healthy ways to cope, to recover and to actively drive decision-making regarding next steps.
    9. Specific questions a case manager or clinician can ask to gain information about the incident(s): *(Remember that you are only seeking enough information to determine questions of immediate safety for the guest and any of their children and to determine what type of reporting and possible referrals are needed.)*
       1. Do you feel safe here? When do you think you might be least safe while here?
       2. Are there situations here that you think might be violent for you or others, including your children and/or family?
       3. What actions do you recommend so that we can support you in feeling safer?
          * 1. **Responding to GBV post-disclosure**
12. Information sharing and action planning with the guest
13. Ask the guest what they need to have happen next. What information are they seeking? What resources do they need? Listen attentively and allow them to drive the agenda. They may focus on concerns about their family members, the impact on their resettlement case, financial concerns and other concerns beyond their own victimization. They may even express concerns about risking the future and wellbeing of the perpetrator. Be open to their concerns and be sure to address those concerns.
14. Provide information about local and national supportive and advocacy resources and mental health and medical services that are currently available to them (this information should only be shared with them if they are available to the survivors. No information on support or services - that is not currently available to the survivors - should be shared with them, per ethical guidance and standards)
15. Offer information about immediate shelter options (on and off-site), including temporary separation / de-escalation measures, splitting the survivor and perpetrator’s resettlement cases, and any custody questions regarding children and other dependents.
16. If more information is needed to answer their questions or address their concerns, state that you will find out the answer and will get back to them. If there is potential for immediate danger, make an effort to find out the information while the guest remains safely in the confidential space.
17. Develop a plan with the guest to address practical concerns.
18. Safety Planning
19. Anytime GBV has been disclosed, case workers are encouraged to discuss safety planning options with the client/survivor - noting that she may decline this support. If the survivor requests support with safety planning, gather enough information to assess the level of safety risk the guest may be facing. There is no need to press for every detail of the incidents(s) as this detailed recounting may be re-traumatizing and should only be done in a clinical therapeutic or, where warranted, a medical setting. See Appendix B for further information about safety planning.
20. Immediate safety concerns – If there is an immediate safety concern (i.e., the perpetrator is nearby and appears agitated and aggressive or has been threatening violence in the near future), and if the survivor has given their consent to take immediate action, communicate to them that you are going to alert law enforcement after the safety planning discussion. Be sure the survivor is clear on what actions law enforcement will likely take to support their safety so they are empowered to make an informed decision before any action is taken. Also ensure the individual understands that in some cases despite intervention from law enforcement the perpetrator may come back to the base.
21. Stay with the survivor in the confidential space until law enforcement has responded.
22. Referrals to higher level of medical and/or behavioral health care, if warranted
23. If a case manager has contact with a guest who discloses GBV and if there is a physical injury or suspected mental health issue for further assessment and potential treatment, the case manager should offer the guest referral to the appropriate mental health or primary health care provider. This referral may be made only after gaining the guest’s consent. It may also require accompanying the survivor to these services and, if desired by the survivor, ensuring they can see a gender-matched provider.
24. Reporting
25. There is no mandatory reporting the case of adult violence or abuse, except for abuse of vulnerable/incapacitated adults in some states. (Check the reporting requirements in the state in which you are licensed.) Therefore, in most cases involving adults, the choice of reporting is the guest’s. Provide information about the option of reporting but do not pressure. Staff should familiarize themselves with the reporting protocol in the Safe Haven.
26. Assist the guest in contacting law enforcement or do so yourself with the consent of the guest. You or the guest should discuss any immediate safety protection needs such as separation from the perpetrator or other relevant extended family members that may potentially retaliate.
    * + - 1. **Disclosure during a therapist or psychiatrist examination**
27. If a guest discloses GBV during a therapist or psychiatrist examination, that provider must assess safety concerns, provide information on next steps, help with safety planning, and assist the guest with the report if desired by the guest. The therapist/psychiatrist may make an immediate referral to a case manager who could assist with these functions.
28. In any case, the therapist/psychiatrist should offer to inform the case manager as soon as possible so that they can perform immediate and ongoing victim advocacy support, with the survivor’s consent. Recommend using the following script giving the survivor the option to be connected to further resources: *“Thank you so much for sharing this with me. I understand this can be hard to talk about, but I want you to know that we care about you and your safety. I want you to know that I will keep what you tell me private and confidential. I would like to connect you with someone we call a survivor advocate – their name is NAME and they are trained to support people who have experienced violence. They can help you understand your rights and the services available to you on base and in the community you travel to after the base. Would you be ok if we go talk to NAME together?”*
    * + - 1. **Communication with Safe Haven IRC Protection Advisor**
29. When a case that involves protection issues arises, the case manager, therapist or psychiatrist must communicate de-identified information to the IRC Protection Advisor in the Safe Haven immediately. The protection advisor will be providing oversight, supervision, and consultation.
    * + - 1. **Continued Case Management/Survivor Advocacy**
30. Given limited availability and access to staff, the behavioral health case managers are also serving as survivor advocates in this setting, however case managers and protection advisors should assess if survivor advocate specific services are available in the location and if they could possibly be brought in to support the recovery process. In the interim, the case manager will provide ongoing Survivor advocacy support if desired by the guest, including providing ongoing psychosocial support around the effects of interpersonal violence and abuse, information about available behavioral health and supportive services, and information about the reporting process and any investigatory/legal actions or proceedings.
31. If involved in the case, the case manager or other survivor advocate will provide continuous education and support to the survivor to navigate questions or implications for resettlement, such as splitting cases, assessing hard / soft links and family ties through to the perpetrator, and custody of children and dependents, as relevant.
32. The case managers should receive survivor advocacy training before engaging in this work with any guest.

## **Human Trafficking of Adults**

1. **Definition:** Human trafficking is the unlawful act of transporting or coercing people in order to benefit from their work or service. There are two types: sex trafficking and labor trafficking.
   1. Sex trafficking is defined by the U.S. Trafficking Victims Protection Act (TVPA) of 2000 as “the recruitment, harboring, transportation, provision, obtaining, patronizing, or **soliciting** of a person for the purpose of a commercial sex act.” It involves the use of force, fraud, or coercion to make an adult engage in commercial sex acts.
   2. The TVPA defines labor trafficking as the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery.
2. Human Trafficking can be a form of GBV but is treated separately in this protocol because it is not always a result of gender mistreatment.
3. A guest may have experienced human trafficking in the past or may be currently experiencing an ongoing relationship in which human trafficking exists.
4. The primary consideration when an instance of human trafficking is suspected is the current safety of the guest. It is essential that all personnel follow the response protocol with precision to ensure the safety of the guest.
5. Whenever possible, contact with the BH staff should be individual and separate from others, ensuring this conversation is happening in a safe/private space and that the survivor leads the discussion utilizing a survivor-centered approach.
6. **If past, recent or ongoing human trafficking is suspected, BH must do the following:**
   1. If in the referral to behavioral staff there was a concern for trafficking expressed**, the BH provider must NOT directly approach and screen for trafficking with the client**. Instead they should start with doing a broader psychosocial needs assessment with guest and explain that this same assessment is being done across the base to assist with guest needs. Please see the “*Case Management Interview Version 1”* in the appendix to assist with appropriate questions to ask.
   2. Ensure privacy and confidentiality before speaking with the guest.
   3. Get permission from the guest to discuss the issue with them.
   4. Avoid rushing the conversation.
   5. It is important to avoid providing “advice” as part of any human trafficking case management process. Ensure the guest is provided with the range of information relevant to their options for next steps, and available services and support to inform any choice they make. No action should be taken without the express consent of the survivor. It is important to note that some survivors may choose actions (or no actions) that the case worker does not agree with. However, the wishes and dignity of the survivor must be respected at all steps of the case management process.
   6. Avoid leading the discussion and giving “advice” or sharing opinions.
   7. Offer to continue the discussion later if the interview is ended because of hesitation.
   8. Explain clearly what options are available after disclosure. Examples: safety planning, physical separation from perpetrator and reporting.
7. **If human trafficking is suspected but the guest does not disclose:**
   * 1. Avoid pressuring the guest and offer to speak with them later if they are willing.
     2. A Sample Script may include “*Many guests on base find it hard to talk about their experiences of pain and suffering and may believe that these issues are private family matter. I want to remind you that all of the staff and volunteers here care about you and your safety and that violence against anyone is something we care about and want to stop. If you decide you want to talk to someone at a different time or if you feel unsafe or overwhelmed with your experiences, you can reach out to NAME by XYZ for more support.”*
8. **If human trafficking is disclosed through the assessment or the guest approaches personnel to disclose or be separated from their trafficker,** it is essential to act with sensitivity:
   * 1. Respond in a survivor-centered manner:
        1. Validate the survivor’s emotions and experiences
        2. Listen without judgment or jumping to solutions
        3. Follow the survivor’s lead in making decisions and acting
        4. Do not force the survivor to disclose to anyone
        5. Do not engage other providers/actors without survivor’s consent
     2. Be sensitive to the emotional distress or fear the guest may be experiencing.
     3. Affirm that the guest has made an important step by talking about the violence.
     4. Reassure them that their reaction to the violence/abuse is normal (e.g. physical, emotional, behavioral reactions).
     5. Believe them. Reserve judgment. It is not the role of anyone during this process to determine the legitimacy of a claim of violence or abuse. Focus on the guest’s perspective of the incident(s) and on how to offer support and options.
     6. Avoid even subtle forms of blaming the guest. Even if some actions taken by the guest before, during or after the violence/abuse are judged by the guest as missteps, it is important to respect their wishes and perspectives and recognize that no one knows better than they do what they need, what risks they may face, or what their wishes are. Reinforce with them that the violence/abuse is not their fault, that there is no excuse for it and that the responsibility lies with the perpetrator.
     7. Convey that in surviving the violence/abuse thus far, they have shown strength and that they can channel that strength in finding additional healthy ways to cope, to recover and to actively drive decision-making regarding next steps.
9. **Responding to adult human trafficking post-disclosure:**
   * 1. Information sharing and action planning with the guest
        1. Ask the guest what they need to have happen next. What information are they seeking? What resources do they need? Listen attentively and allow them to drive the agenda. They may focus on concerns about their family members, the impact on their resettlement case, financial concerns and other concerns beyond their own victimization. They may even express concerns about risking the future and wellbeing of the perpetrator. Be open to their concerns and be sure to address those concerns.
        2. Provide information about local and national supportive and advocacy resources and mental health and medical services that are currently available to them. (This information should be shared with the survivor only if they are available to them. No information on support or services - that is not currently available to the survivor - should be shared with them, per ethical guidance and standards.)
        3. Offer information about immediate shelter options (on and off-site), including temporary separation / de-escalation measures, splitting the survivor and perpetrator’s resettlement cases, and any custody questions regarding children and other dependents.
        4. If more information is needed to answer their questions or address their concerns, state that you will find out the answer and will get back to them. If there is potential for immediate danger, make an effort to find out the information while the guest remains safely in the confidential space.
        5. Develop a plan with the guest to address practical concerns.
     2. Safety Planning
        1. Anytime adult human trafficking has been disclosed, case workers are encouraged to discuss safety planning options with the survivor - noting that they may decline this support. If the survivor requests support with safety planning, gather enough information to assess the level of safety risk the guest may be facing. There is no need to press for every detail of the incidents(s) as this detailed recounting may be re-traumatizing and should only be done in a clinical therapeutic or, where warranted, a medical setting. See Appendix B for further information about safety planning.
        2. Immediate safety concerns – If there is an immediate safety concern (i.e., the perpetrator is nearby and appears agitated and aggressive or has been threatening violence in the near future), and if the survivor has given their consent to take immediate action, communicate to the survivor that you are going to alert law enforcement after the safety planning discussion. Be sure the survivor is clear on what actions law enforcement will likely take to support their safety so they are empowered to make an informed decision before any action is taken. Also ensure the individual understands that in some cases, despite intervention from law enforcement, the perpetrator may come back to the base.
        3. Stay with the guest in the confidential space until law enforcement has responded.
     3. Referrals to higher level of medical and/or behavioral health care, if warranted
        1. If a case manager has contact with a guest who discloses adult human trafficking and if there is a physical injury or suspected mental health issue for further assessment and potential treatment, the case manager should offer the guest referral to the appropriate mental health or primary health care provider. This referral may be made only after gaining the guest’s consent. It may also require accompanying the survivor to these services and ensuring, if desired by the survivor, they can see a gender-matched provider.
     4. Reporting
        1. There is no mandatory reporting the case of adult violence or abuse, except for abuse of vulnerable/incapacitated adults in some states. (Check the reporting requirements in the state in which you are licensed.) Therefore, in most cases involving adults, the choice of reporting is the guest’s. Provide information about the option of reporting but do not pressure. Staff should familiarize themselves with the reporting protocol in the Safe Haven.
        2. Only after attaining the consent of the guest, assist the guest in contacting law enforcement or do so yourself. You or the guest should discuss any immediate safety protection needs such as separation from the perpetrator. Also offer to help the guest contact the National Human Trafficking Hotline:

* Call at 1-888-373-7888, which operates 24/7;
* Text at 233733;
* Chat with staff of the National Human Trafficking Hotline at [www.humantraffickinghotline.org/chat](http://www.humantraffickinghotline.org/chat); or
* Submit an anonymous tip online at: <https://humantraffickinghotline.org/report-trafficking>

1. **Disclosure during a therapist or psychiatrist examination**
   * + 1. If a guest discloses adult human trafficking during a therapist or psychiatrist examination, that provider must assess safety concerns, provide information on next steps, help with safety planning, and assist the guest with the report if desired by the guest. The therapist/psychiatrist may make an immediate referral to a case manager who could assist with these functions.
       2. In any case, the therapist/psychiatrist should offer to inform the case manager as soon as possible so that they can perform immediate and ongoing victim advocacy support, with the survivor’s consent. Recommend using the following script giving the survivor the option to be connected to further resources: *“Thank you so much for sharing this with me. I understand this can be hard to talk about, but I want you to know that we care about you and your safety. I want you to know that I will keep what you tell me private and confidential. I would like to connect you with someone we call a survivor advocate – their name is NAME and they are trained to support people who have experienced violence. They can help you understand your rights and the services available to you on base and in the community you travel to after the base. Would you be ok if we go talk to NAME together?”*
2. **Communication with Safe Haven IRC Protection Advisor**
   1. When a case that involves protection issues arises, the case manager, therapist or psychiatrist must communicate de-identified information to the IRC Protection Advisor in the Safe Haven immediately. The protection advisor will be providing oversight, supervision, and consultation.
3. **Continued Case Management/Survivor Advocacy**
   * + 1. Given limited availability and access to staff, the behavioral health case managers are also serving as survivor advocates in this setting. However, case managers and protection advisors should assess if survivor advocate specific services are available in the location and if they could possibly be brought in to support the recovery process. In the interim, the case manager will provide ongoing survivor advocacy support if desired by the guest, including providing ongoing psychosocial support around the effects of interpersonal violence and abuse, information about available behavioral health and supportive services, and information about the reporting process and any investigatory/legal actions or proceedings.
       2. If involved in the case, the case manager or other survivor advocate will provide continuous education and support to the survivor to navigate questions or implications for resettlement, such as splitting cases, assessing hard / soft links and family ties through to the perpetrator, and custody of children and dependents, as relevant.
       3. The case managers should receive survivor advocacy training before engaging in this work with any guest.

## **Human Trafficking of Children**

1. **Definition:** See Human Trafficking of Adults section. Children: Under 18 years old.
2. The incidence of human trafficking of both children and adults in Afghanistan is high and the Afghan government has a history of both being complicit in trafficking and not doing enough to address the issue. Human trafficking of children is a particular concern when serving the guests because there have been reports of children falling victim to trafficking to ensure their passage to the United States during the chaotic exit of Afghanistan in August 2021.
3. A child guest may have experienced human trafficking in the past or may be currently experiencing an ongoing relationship in which human trafficking exists.
4. BH staff must not affirmatively ask child guests about any incidents of human trafficking. The child should be referred directly to child protective services, in accordance with mandated reporting laws, avoiding interviewing a child multiple times on the issue and potentially tainting the investigation. However, BH staff should gather any enough information to make a report, as well as ancillary information from the child, using a survivor-focused, trauma-informed and developmentally appropriate approach, necessary to ensure the immediate safety and health of the child. Examples of information that may need to be gathered from the child include identification of the perpetrator, any immediate safety concerns and a physical examination.
5. The primary consideration when an instance of human trafficking is suspected is the current safety of the child guest. It is essential that all personnel follow the response protocol with precision to ensure the safety of the child.
6. Whenever possible, contact with the BH staff should be individual and separate from family and others, unless the child is asking for their parents/caregivers/trusted individual to be present.
7. **Special considerations when interviewing children who are suspected to have been trafficked.** 
   1. Introduce yourself to the child and tell them your role using developmentally appropriate language.
   2. If possible, speak at eye level or below.
   3. Establish rapport with the child by discussing things other than the reason for their visit (e.g., school, siblings, etc.). Try to establish a neutral environment and rapport with the child before beginning the interview.
   4. Avoid making assumptions about the way the child feels about the perpetrator or the acts of violence and exploitation (i.e., that the acts were painful, that the child hates the perpetrator).
   5. Validate the child’s emotions and experiences
   6. Listen without judgment or jumping to solutions
   7. Be sensitive to the emotional distress or fear the child may be experiencing.
   8. Affirm that the child has made an important step by talking about the trafficking.
   9. Reassure them that their reaction to the trafficking is normal (e.g. physical, emotional, behavioral reactions).
   10. Believe them. Reserve judgment. It is not the role of anyone during this process to determine the legitimacy of a claim of violence or abuse. Focus on the child’s perspective of the incident(s) and on how to offer support and options.
   11. Avoid even subtle forms of blaming the child. Even if some actions taken by the child before, during or after the trafficking are judged by the child as missteps, it is important to respect their wishes and perspectives and recognize that no one knows better than they do what they need, what risks they may face, or what their wishes are. Reinforce with them that the trafficking is not their fault, that there is no excuse for it and that the responsibility lies with the perpetrator.
   12. Convey that in surviving the trafficking thus far, they have shown strength and that they can channel that strength in finding additional healthy ways to cope and to recover.
8. **Responding to human trafficking of children post-disclosure/identification**
   1. Explanation of Next Steps with Child
      1. Thank the child for being open and honest about a very difficult subject if the child disclosed to you or anyone else and trafficking was not merely identified without disclosure.
      2. Explain that part of your role is to make sure children are protected. Therefore, you will need to report the human trafficking to the authorities. If the parents are not perpetrators, explain that you will inform the parents and together, you will all make sure the child is protected and gets the support they need.
   2. Involving the non-offending parent/guardian
      1. The caseworker, therapist or psychiatrist must bring in the parent/guardian, as long as they are not complicit in the human trafficking, to inform them of the human trafficking and to inform them of the mandated reporting requirement.
   3. Referrals to higher level of medical and/or behavioral health care
      1. After obtaining consent from the non-offending parent/guardian, the case manager must refer the child guest to a medical and/or behavioral health provider if there is a physical injury or suspected mental health issue for further assessment and potential treatment.
   4. Reporting
      * 1. **Mandated reporting:** If a child has been or is at risk of being subjected human trafficking, personnel must report the incident(s) to child protective services.
        2. Practitioners are to follow their professional licensing requirements and/or mandatory reporting laws in terms of this notification.
9. **Communication with Safe Haven IRC Protection Advisor**
   1. When a case that involves protection issues arises, the case manager, therapist or psychiatrist must communicate de-identified information to the IRC Protection Advisor in the Safe Haven immediately. The protection advisor will be providing oversight, supervision, and consultation.
10. **Continued Case Management/Survivor Advocacy**
    1. Given limited availability and access to staff, the behavioral health case managers are also serving as survivor advocates in this setting. However, case managers and protection advisors should assess if survivor advocate specific services are available in the location and if they could possibly be brought in to support the recovery process. In the interim, the case manager will provide ongoing survivor advocacy support if desired by the non-offending parent/guardian, including providing ongoing psychosocial support around the effects of interpersonal violence and abuse, information about available behavioral health and supportive services, and information about the reporting process and any investigatory/legal actions or proceedings.
    2. The case managers should receive survivor advocacy training specific to serving children and their families before engaging in this work with any guest.

## **Child Abuse and Neglect**

* + - 1. **Definition:** Child abuse laws vary by state in the United States but all involve protection from physical, sexual, emotional, verbal abuse and neglect of children. Child abuse and neglect can be characterized as GBV in some instances but is treated as a separate category in this protocol because of the necessary different interactions with children and because of the separate, mandated reporting.
      2. A child guest may have experienced child abuse or neglect in the past, may experience an incident while in the Safe Haven, or may be currently experiencing an ongoing relationship in which child abuse or neglect exists.
      3. BH staff must not affirmatively ask child guests about any incidents of child abuse or neglect. The child should be referred directly to child protective services, in accordance with mandated reporting laws, avoiding interviewing a child multiple times on the issue and potentially tainting the investigation. However, BH staff should gather any enough information to make a report, as well as ancillary information from the child, using a survivor-focused, trauma-informed and developmentally appropriate approach, necessary to ensure the immediate safety and health of the child. Examples of information that may need to be gathered from the child include identification of the perpetrator, any immediate safety concerns and a physical examination.
      4. The primary consideration when an instance of child abuse or neglect is suspected is the current safety of the child guest. It is essential that all personnel follow the response protocol with precision to ensure the safety of the child.
      5. Whenever possible, contact with the BH staff should be individual and separate from family and others, unless the child is asking for their parents/caregivers/trusted individual to be present.
      6. **Special considerations when interviewing children who are suspected to have been abused or neglected.** 
         1. Introduce yourself to the child and tell them your role using developmentally appropriate language.
         2. If possible, speak at eye level or below.
         3. Establish rapport with the child by discussing things other than the reason for their visit (e.g., school, siblings, etc.). Try to establish a neutral environment and rapport with the child before beginning the interview.
         4. Avoid making assumptions about the way the child feels about the perpetrator or the acts of violence and exploitation (i.e., that the acts were painful, that the child hates the perpetrator).
         5. Validate the child’s emotions and experiences
         6. Listen without judgment or jumping to solutions
         7. Be sensitive to the emotional distress or fear the child may be experiencing.
         8. Affirm that the child has made an important step by talking about the abuse or neglect.
         9. Reassure them that their reaction to the abuse or neglect is normal (e.g. physical, emotional, behavioral reactions).
         10. Believe them. Reserve judgment. It is not the role of anyone during this process to determine the legitimacy of a claim of violence or abuse. Focus on the child’s perspective of the incident(s) and on how to offer support and options.
         11. Avoid even subtle forms of blaming the child. Even if some actions taken by the child before, during or after the abuse or neglect are judged by the child as missteps, it is important to respect their wishes and perspectives and recognize that no one knows better than they do what they need, what risks they may face, or what their wishes are. Reinforce with them that the abuse or neglect is not their fault, that there is no excuse for it and that the responsibility lies with the perpetrator.
         12. Convey that in surviving the abuse or neglect thus far, they have shown strength and that they can channel that strength in finding additional healthy ways to cope and to recover.
      7. **Responding to child abuse and neglect post-disclosure/identification**

Explanation of Next Steps with Child

Thank the child for being open and honest about a very difficult subject if the child disclosed to you or anyone else and child abuse or neglect was not merely identified without disclosure.

Explain that part of your role is to make sure children are protected. Therefore, you will need to report the child abuse or neglect to the authorities. If the parents are not perpetrators, explain that you will inform the parents and together, you will all make sure the child is protected and gets the support they need.

Involving the non-offending parent/guardian

The caseworker, therapist or psychiatrist must bring in the parent/guardian, as long as they are not complicit in the child abuse or neglect, to inform them of the child abuse or neglect and to inform them of the mandated reporting requirement.

Referrals to higher level of medical and/or behavioral health care

After obtaining consent from the non-offending parent/guardian, the case manager must refer the child guest to a medical and/or behavioral health provider if there is a physical injury or suspected mental health issue for further assessment and potential treatment.

Reporting

**Mandated reporting:** If a child has been or is at risk of being subjected child abuse or neglect, personnel must report the incident(s) to child protective services.

Practitioners are to follow their professional licensing requirements and/or mandatory reporting laws in terms of this notification.

* + - 1. **Communication with Safe Haven IRC Protection Advisor**

When a case that involves protection issues arises, the case manager, therapist or psychiatrist must communicate de-identified information to the IRC Protection Advisor in the Safe Haven immediately. The protection advisor will be providing oversight, supervision, and consultation.

* + - 1. **Continued Case Management/Survivor Advocacy**

Given limited availability and access to staff, the behavioral health case managers are also serving as survivor advocates in this setting. However, case managers and protection advisors should assess if survivor advocate specific services are available in the location and if they could possibly be brought in to support the recovery process. In the interim, the case manager will provide ongoing survivor advocacy support if desired by the non-offending parent/guardian, including providing ongoing psychosocial support around the effects of interpersonal violence and abuse, information about available behavioral health and supportive services, and information about the reporting process and any investigatory/legal actions or proceedings.

The case managers should receive survivor advocacy training specific to serving children and their families before engaging in this work with any guest.

# Referral and Coordination with Medical Staff

1. Recommend a system of integrated medical/mental health “rounds” every morning. This should include all case managers, therapists, nurses and psychiatrists. This should include medical personnel only, so community health workers should not be here.
2. Establish a POC within the medical team and from the mental health team that will be available to take referrals from medical/psychiatric. A POC should be established for medical and behavioral health case management, as well as for psychiatrist/internist levels, child pscyh/pediatrics.
3. Ensure that daily updates regarding each consultation are provided to the appropriate teams, with RECOMMENDATIONS highlighted first.
4. *Implement a collaborative consultation model with the psychiatrist or nurse practitioner on site*. Establish a half day per week to spend 20-30 minutes discussing medical cases, where psychiatric consultation can occur around psychotropic medication management, possible mental health presentations and evaluation, etc. This system can increase capacity to ensure guest mental health needs are being met, especially in cases where they may not have to see a mental health professional (ie continuing home psychotropic medications, medication adjustment, etc).
5. Case Management Coordination**:** Medical case managers and behavioral health case managers should be coordinating regularly around shared patient and family needs.

# Peer Support & Supervision

1. It is expected that supervision and peer support are built into the deployed staff’s time. Staff ratios should be cut to include protected time for these activities. Each staff should receive at least one hour of supervision per week.
2. Never force a debrief, allow people to talk if they would like to. Access to professional mental health services off-base should be prioritized in cases where staff self-identify the need and/or there is recognition of particular staff struggling to continue their assigned duties. No staff should ever be forced to stay on base if they are expressing emotional/mental distress that is putting their’s/other’s safety at risk and/or if they are unable to perform their job functions. Please see the following resources from SAMHSA on managing disaster workforce stress: https://www.samhsa.gov/dtac/disaster-response-template-toolkit/disaster-responder-stress-management
3. *Staffing:* Case Managers, therapists and psychiatrists should be equipped to provide supervision and peer support around vicarious trauma within and across disciplines. Ideally 20% of any supervisor’s time is reserved to provide peer support, supervision, and processing.
4. *Space:* This should be done in a private space away from all guests

# On Site Behavioral Health Communication and Coordination

*In addition to the hierarchical structure outlined, it should be assumed that those entities within each row should be communicating/coordinating with each other. The referral sources will refer cases up to behavioral health staff. HHS Behavioral health staff will report up to the HHS Behavioral Federal Coordinator around operational concerns and to the IRC Protection Advisor for supervision on protection related concerns. The IRC Protection Advisor will communicate and coordinate all protection related concerns with the DHS Lead Protection Officer.*

Key:

# APPENDICES

## **Appendix A**

**Behavioral Health Staffing Ratios**

**Per 5000 Afghan individuals:**

Community Health Workers: 3

Case Managers: 4

Therapists: 4

Psychiatrists: 2

Interpreters: 3

**Per BASE**

Senior Protection Subject Matter Experts: 1

US Public Health Officers: 1

## **Appendix B**

**Case Management Interview Guide Version 1**

**For Case Mangers (Please read before starting the Interview)**

The goal of this guide is to help build rapport, open lines of communication, and create a space within which an individual or family can be observed to assess for any psychosocial situations that may need urgent or emergent attention. This interview is not intended for diagnostic purposes, nor is it to be used as a screening tool. The guide may also be used to discern who might need higher level services and supports because of a suspected mental health condition or protection issue, provide psychoeducation, encourage reflective functioning about coping skills and supports, and refer to PSS and MWR supports to increase protective factors and encourage resilience. You do not need to ask each of these questions, use your judgement, this is a loose guide. Please follow the above guidance on safe spaces and trauma-informed assessments.

***A note on mental health screening (WASSS):***

* The screening tool will be used in SELECT cases only, it will NOT be given to every person, only those identified to have a high suspicion of mental illness that may require acute intervention. It is NOT mandatory to use, and only serves as an additional tool for assistance with the mental health evaluation.
* The purpose of this tool is to identify persons in priority need of mental health care. So, the selected questions are meant to identify people with symptoms of severe distress and impaired functioning.
* Only licensed behavioral health practitioners should use this screening tool, in cases where they feel they need it to aid their assessment.
* If this screen is positive, the individual must have a full mental health evaluation. Usually this will require referral to a higher-level clinician on site, such as a therapist, psychiatric nurse practitioner, or psychiatrist for further evaluation. If none are available on base, the individual should be referred off site for a full evaluation.

***Introductory remarks for the interviewer:***

Start with welcoming the guest to the United States—the greeting: “Salam” is common for both Dari and Pashto speakers. Then thank the guest for making time for you (*Tashakkur* in Dari and *Dera Manana* in Pashto) and express that you hope they will help you learn about their experience and understand their needs. You can use the following script if you wish.

*Hello, I am xxxxxxxxx. Welcome to the US! I know that you have been asked many questions already and I appreciate your patience. We would like to get to know you, talk to you about what kind of problems you are experiencing, and understand how you are coping with these experiences. Our goal is to learn from your experiences and knowledge so that we can offer resources to those who need it. Please feel free not to answer any questions for any reason if you are not comfortable. Whether you talk to me or not and your responses will not affect your immigration status or process in any way. Your answers to the questions will be kept confidential.  They will be used to better serve you, your family, and your community.*

**Interview Questions:**

State: *I understand how difficult of a situation this must be for you and your family. We are here to try to help you cope emotionally and manage your stress while you are waiting to be resettled in the U.S. I would like to ask you some questions to make sure we are doing everything possible to assist you. Would that be okay?*

**Stress and Emotional Health:**

1. We know the journey to come here to America has been very difficult. There have been many steps in your process, and some steps are taking much longer than anyone anticipated. How have you been doing?
2. What are your primary stressors? What are your health and emotional needs at this time? Are they being met now? What would be helpful? (*Attempt to rank needs/stressors*)
3. We also know that it is challenging to face any new situation. Major life changes and uncertainties can affect people in different ways - in our sleep, our thoughts, our mood. I would like to ask you some questions about how you are feeling emotionally. What are your difficult emotional experiences at this time? Can you please describe them?
4. I understand that American culture may be very different than your country’s culture and moving suddenly to a new culture can be very stressful/challenging. Has there been particular stress on you or your family around this sudden cultural shift? Can you explain?
5. How do you currently deal with hardships and difficulties? What do you do? What helps you feel better? Is there anyone who helps you?
6. How has the way you deal with hardships now changed from how you dealt with them back home? How did you deal with hardships back home? What would you do? How did people in your society deal with emotional problems/psychological difficulties back home?
7. Is your stress here so bad that you feel you cannot go on with everyday functions to care for yourself or others? (*If the above questions are indicative of underlying mental health condition(s) that seems to be severe and persistent, you may use the WASSS mental health screen to assist in detecting priority need for further mental health assessment and intervention. See note on screening above*)

**Safety**

*Refer to the OAW Behavioral Health General Protocol for general guidance when addressing gender- based violence, human trafficking and child abuse and neglect with adult and child guests.*

1. How safe do you feel in your new environment emotionally and physically? Can you explain?
2. Are you very worried about one or more of your family member’s health or safety? If yes, can you please explain? (*If GBV, human trafficking or child abuse and neglect is suspected or someone comes to you about these issues, refer to the OAW Behavioral Health General Protocol for separate guidance on addressing these issues with adults versus children and by issue.)*

**Activity**

1. How do you spend your day here? Do you feel you are able to engage in any of the activities set up here to fill some of your time? Why/Why not?

**Family Separation**

1. Were you separated from your family and other relatives as a result of the recent evacuation? From whom have you been separated*? (Our intention is find out about anyone who may no longer be in Afghanistan but may be in other US domestic bases, abroad or third country bases. Make sure to offer and facilitate communication with these family members. Do not over-promise on reunification however you may state you will notify the appropriate authorities to help locate family members that may currently be on U.S. domestic bases, U.S. bases abroad or third country bases only.*)

**Basic Needs**

1. Do you feel you have access to your basic needs, such as food, shelter and clothing, and sanitation? *(Unmet needs should be communicated up to the HHS Federal Coordinator on site.)*

**Behavioral health medications**

1. In the past, have you taken medications on a regular basis to help with your levels of emotional stress? If yes, what are the names of those medications? Did you bring them with you? When did you last take them and do you need to see a doctor here to continue them?

**Other**

1. Is there anything else you would like to discuss with me today?

Tip: *This question may result in a referral or a simple response with information requested by the guest. If it’s a simple request for information, you might have the answer or say you will find out/connect the guest to someone who knows. If it’s something specific the guest needs, please do NOT over promise or instill false hope. Rather recap by thanking the guest and saying that you will notify the appropriate person.*

## **Appendix C**

**Culturally Adapted WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings** (**WASSS)**

The purpose of this tool is to identify persons in priority need of mental health care. So, the selected questions are meant to identify people with symptoms of severe distress and impaired functioning. Those individuals that screen positive should be referred up to the highest clinical level for assessment and intervention. This tool is designed to be used with interviewees 18 years or older. It is also designed to be used at least two weeks after the onset of a crisis.

Script for Interviewer:

*Hi, my name is [ ]. How are you? I am a [ title] and want to learn about how you are feeling and any problems you are experiencing. I know that you have been through a lot and have probably been asked many questions by many different people, so I appreciate your patience. If you are uncomfortable answering any of the questions, please let me know and I will skip to the next question. I want you to know that just because I am asking you a question does not mean that I am assuming that any of these apply to you directly. This will only take about five minutes of your time.*

For the Interviewer: [*In case respondents need clarification on answer choices, use the following: All of the time = 7 days a week for the past two weeks; Most of the time = 4-6 days a week for the last two weeks; Some of the time = 2-3 days a week for the last two weeks; A little of the time = 1 day a week for the past two weeks. Sometimes these likert scales can be difficult for people to understand. It may be useful to do a two-step process of asking yes/no and then follow up with the scale.]*

PART A

A1. You may have experienced one or more events that have been intensely upsetting to you, such as the recent evacuation and changes in Afghanistan. During the last two weeks, about how often did you feel so severely upset about these events or other events in your life that you tried to isolate yourself or avoid places, people, conversations or activities that reminded you of such an event? (IF NECESSARY: all of the time, most of the time, some of the time, a little of the time, or none of the time?)

* All of the time
* Most of the time
* Some of the time
* A little of the time
* None of the time
* Don’t know
* Refused

A2. The next questions are about how you have been feeling during the last two weeks. About how often during the last two weeks did you **feel so afraid that nothing could calm you down** — would you say all of the time, most of the time, some of the time, a little of the time, or none of the time?

* All of the time
* Most of the time
* Some of the time
* A little of the time
* None of the time

A3. About how often during the last two weeks did you feel that you **completely lost control** of your feelings - meaning you were crying a lot when you didn’t want to be or feeling very angry when you didn’t want to be? Would you say all of the time, most of the time, some of the time, a little of the time, or none of the time?

* All of the time
* Most of the time
* Some of the time
* A little of the time
* None of the time

A4. During the last two weeks, about how often did you feel so uninterested in things that you did not want to do **anything at all**? (IF NECESSARY: all of the time, most of the time, some of the time, a little of the time, or none of the time?)

* All of the time
* Most of the time
* Some of the time
* A little of the time
* None of the time

A5. During the last two weeks, about how often did you feel so hopeless or sad (*jigar khon)* that you did not want to carry on living? (IF NEC: all of the time, most of the time, some of the time, a little of the time, or none of the time?)

* All of the time
* Most of the time
* Some of the time
* A little of the time
* None of the time

A6. The next question is about how these feelings of fear, anger, fatigue, disinterest, hopelessness or upset may have affected you during the last two weeks. During the last two weeks, about how often were you unable to carry out essential activities for daily living (ie, eating, hygiene, caring for your children) because of these feelings? (IF NECESSARY: all of the time, most of the time, some of the time, a little of the time, or none of the time?)

* All of the time
* Most of the time
* Some of the time
* A little of the time
* None of the time

*Exit Script:*

*Thank you for taking the time to answer these questions. Is there anything related to any of the questions I just asked of you that you think I should know?*

***Next Steps for Interviewer****:*

The interviewer should also provide brief psychoeducation at this point and anticipatory guidance around next steps. Be empathic and reserve judgement. Normalize their symptoms in the current context. State this if screen is positive: *Based on what you shared, I would like to connect you with someone who could assist further with your needs and help you with your stress. Would it be okay if we talked with that person together? Their name is xx.*

If the screen was negative, let them know you will continue to be available if they do develop any concerns or want to talk further about the questions asked in this assessment.

**\*\*\*Special Note\*\*\*: Any positive response to A5 requires a suicide risk assessment.**

**SCORING:** Responses of ‘some of the time,’ ‘most of the time,’ and ‘all of the time’ should be grouped into a positive category (1) and other responses as a negative category (0).

Triage and Referral: Any positive score on any of the above questions warrants further mental health assessment by the interviewer, or if needed by higher level mental health clinicians. If there is any concern that this individual is in crisis, they should immediately be referred to the highest level of care for assessment.

## **Appendix D**

**Gender Based Violence**

WHAT IS GENDER-BASED VIOLENCE?

“Gender-based violence” is defined as violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.

Gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, “honor” killings, and female genital mutilation/cutting. Women and girls are the most at risk and most affected by gender-based violence.

Consequently, the terms “violence against women” and “gender-based violence” are often used interchangeably. However, boys and men can also experience gender-based violence, as can sexual and gender minorities. Regardless of the target, gender-based violence is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control.

- Definition adapted from Gender-based Violence and HIV: A Program Guide for Integrating Gender-based Violence Prevention and Response in PEPFAR Programs

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## **Appendix E**

**Safety Planning with Guests Experiencing GBV and Human Trafficking of Adults**

Gather enough information to assess the level of safety risk the guest may be facing. There is no need to press for every detail of incidents as this detailed recounting may be re-traumatizing and should only be done in a clinical therapeutic or, where warranted, a medical setting. In the case that the guest is a parent or guardian, the safety of the children should also be assessed.

**Ask about immediate safety, including whether the guest would be safe if they returned back to their family/living unit in the Safe Haven.** If the guest needs some assistance deciding if there are safety concerns, either immediate or potential, examples of questions you could ask are:

* Has the physical (or sexual) violence happened more often or gotten worse over the past 6 months or do you believe it is likely to happen again?
* Have they [the perpetrator] ever used a weapon or threatened you with a weapon?
* Have they ever threatened or harmed anyone close to you (children, family, friends, etc.)?
* Do you believe they could kill you?
* Have they ever beaten you while pregnant? (If applicable)
* Are they violently or consistently jealous or possessive of you?

**If there is an immediate safety concern (i.e., the perpetrator is nearby and appears agitated and aggressive or has been threatening violence in the near future), offer to take immediate action by alerting law enforcement (for adults, IF the guest has provided informed consent for this; in the case of a child being threatened informed consent is not necessary and reporting to child services and law enforcement is mandatory) after the safety planning discussion. Stay with the guest in the confidential space until law enforcement has responded and be sure to explain next steps and expected outcomes of this action.**

Even if there is no apparent immediate safety concern, it is imperative to offer to develop a safety plan for any future incidents.

**Safety Planning Elements in the Safe Havens:**

* Safe place to go/reporting resources -- Where could you go/whose help could you seek in the Safe Haven if needed? Include staff, DOD, MWR centers, etc.
* Planning for children – How could you support the safety of your children? Are there trusted family members or friends here that could ensure their safety if you need to separate from them as you seek help?
* Needed items -- What would you need to keep with you at all times? Do you have essential documents/possessions that you will need to keep in case an incident erupts or there is need to flee and seek assistance? Could you keep items with others just in case?
* Support of someone close by – Is there anyone who you could tell about the violence/abuse that could watch out for any escalating tensions and violence and who could help you seek any assistance needed? Is there anyone you can talk to for support?

If you provide the guest with any informational or resource materials, discuss a plan for them keep the materials away from the perpetrator to avoid escalation of tension and/or violence. Consider providing the information verbally if the risk of possessing the material would be too great.

Begin discussing future safety planning after re-settlement. To the discussion points listed above, add a discussion of financial resources, employment, community support, etc. in the new community. Encourage the guest to seek advocacy resources upon arrival in the new area.