



HEIGHTENED RISK IDENTIFICATION TOOL

**UNHCR Headquarters
Geneva, Switzerland**

(version: 20 June 2007)

INTRODUCTION

The Heightened Risk Identification Tool (HRIT) was developed to enhance UNHCR's effectiveness in identifying refugees at risk by linking community-based / participatory assessments and individual assessment methodologies. It has been designed for use by UNHCR staff involved in community services and / or protection activities (including resettlement) and their implementing partners to assist with the identification of individuals at risk and who require immediate intervention. UNHCR staff and NGO partners who are involved in these types of activities can use the tool and apply it in different situations. This tool serves to: (i) *implement ExCom Conclusion 105 on Women and Girls At-Risk and UNHCR's Global Strategic Objectives for 2007-09*; (ii) *strengthen needs-based planning, identification methodologies and case management systems*; and (iii) *promote age, gender, and diversity mainstreaming*.¹ The tool should be used comprehensively and not only for resettlement identification.

The HRIT is a hybrid of a similar tool developed by the University of New South Wales (NSW) to identify women-at-risk. In early 2007, UNHCR joined forces with the Victorian Foundation for Survivors of Torture and the University of NSW to further develop the methodology in order to broaden its scope to identify a diverse range of individuals at risk. This process of refinement also benefited from a series of regional workshops in 2005-2006 conducted by UNHCR's Resettlement Service in Asia, Africa and Latin America aimed at strengthening ways to identify refugees in need of resettlement. In March 2007, UNHCR piloted the tool in Bangladesh. This pilot project involved a series of community-based consultations and individual interviews with the Rohingya refugees. The project was undertaken with the support of the UNHCR Office in Bangladesh and involved a multi-functional team of NGO and UNHCR staff. The NGO team comprised staff from Amnesty International (Australia), AUSTCARE, University of NSW and the Victorian Foundation for Survivors of Torture.

Benefiting from the work undertaken in Bangladesh, the HRIT has been designed to be flexible, simple, yet comprehensive. It can be used in different ways and operational contexts, for instance: (i) prior to and as follow-up to refugee status determination; (ii) in conjunction with a participatory assessment exercise; (iii) as a stand-alone methodology involving community-based consultations and individual assessments; (iv) as a tool to sample survey the refugee population to project the level of risk within the community; (v) as an interview format or checklist for case workers ; and, (vi) as a checklist tool for roving officers to use in refugee camps or in urban settings.

What is in this packet?

This packet contains an introduction to the Heightened Risk Identification Tool (this page). The tool itself begins on the next page, and contains (in order):

- section for recording the biodata of the individual whose risk is being assessed (p. 4);
- list of preparatory measures you should consider taking prior to using this tool (pp. 4-5);
- formal introductions section (p. 6)
- list of interview-style questions (pp. 7-8);
- preliminary assessment box to record possible heightened risk categories (p. 9);
- various tick-box sections corresponding to possible heightened risk categories (pp. 10-21); and
- final assessment box to record your heightened risk assessment and referral needs (pp. 22-23).

Finally, at the end of this packet, you will find a User Guide containing detailed instructions about how to use this tool.

¹ *The concept of 'diversity mainstreaming' implies that the significant participation of refugee girls, boys, women and men of all ages and backgrounds is integral to the design, implementation, monitoring and evaluation of all UNHCR policies and operations so that these impact equitably on people of concern.*

HEIGHTENED RISK IDENTIFICATION TOOL

PHASE I: PREPARATIONS

A. BIODATA

Applicant's name:	Registration / ID no.:
Address [block / house no.]:	Date:
Country of origin:	Ethnicity:
Religion:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age:
Interviewer's name:	Interpreter's name:

B. SITUATIONAL NEEDS

1. Field-specific approach to preparations

- a. Preparatory measures will vary between field operations, and will have to be adapted to situational needs.

2. Examples. The following list includes examples of common preparatory measures but should not be construed as an exhaustive list:

- a. Identify the most appropriate methodology for use of this tool;
- b. Ensure that a proper referral system is in place and that the necessary referral services and partners are adequately prepared to receive referrals;
- c. Staff must familiarise themselves with situation-specific issues, problems, background, population, and culture. When participatory assessments and / or group consultations have already been conducted, staff should refer to any reports issued, or talk to UNHCR staff involved in the process;
- d. Staff must familiarise themselves with the layout, content, and the methodology chosen to use this tool;
- e. Update introductory remarks, open questions, risk indicators (including 'Other' tick-box), etc. to reflect local circumstances, as appropriate;
- f. Identify and notify individuals to be interviewed (for Methodology 1);
- g. Prepare a safe and comfortable interview space (for Methodology 1);
- h. Take whatever security measures are necessary to carry out identification safely under the chosen methodology. For instance, special accompaniment may be necessary when conducting camp or community visits under Methodology 3;
- i. Brief interpreters and collaborators concerning confidentiality guidelines, use of this tool, chosen methodology, relevant situational issues; local or special cultural sensitivities; ambiguous terms and choice of words, etc. When appropriate, interpreters and / or bilingual staff should be allowed to review this tool prior to actual use, in order to be prepared for potential linguistic difficulties and / or ambiguities.

PHASE I : BIODATA & PREPARATIONS

PHASE II: INTRODUCTION

A. INTRODUCTIONS

1. Introduce interviewer, interpreter, and anyone else present.

B. EXPLAINING THE PURPOSE OF THE INTERVIEW

[👏 Sample language: Methodology 1]

1. *“I [interviewer] am present to help UNHCR understand your [applicant’s] situation, and determine how to efficiently address the more pressing problems you and others in your community currently face.”*
2. *“Through consultations UNHCR held with members of your community, we have heard about many different problems affecting people. You can help us by telling me your story, and especially what you consider to be the biggest problems / dangers you face.”*

C. EXPLAINING THE INTERVIEW TIMEFRAME AND METHODOLOGY

[👏 Sample language; Methodology 1]

1. *“UNHCR is talking to people from different groups, but cannot speak with everyone. So we are meeting some old people, young people, men, and women, adolescents and children to determine the types of important problems different people face.”*
2. *“Because of the number of people that UNHCR needs to hear, I can only spend 30 minutes with you. Although you will get a chance to tell me about your situation generally, we may not be able to discuss all the things you want to talk about in depth at this time. I will ask you to tell me about the biggest / most pressing problems / dangers you think you and your family / dependants face, and to provide any information you think I need to understand them.”*
3. *“I may have to interrupt you when I think it is necessary to ask you about other things UNHCR needs to know or to move on.”*
4. Explain the confidential nature of the interview and the possibility of information-sharing with partners (both non-governmental and governmental); UNHCR’s expectation / need for interviewee’s honesty; and that the refugee is free to stop the interview and leave at any time.

D. CLARIFYING APPLICANT’S EXPECTATIONS / OUTCOME OF INTERVIEW

1. Do you have any questions?
2. Do you understand these explanations?
3. Are you willing to participate?
4. Once this interview is complete, you may be asked to go and speak to someone else. If so, you will be informed and assisted.

PHASE III: HEIGHTENED RISK IDENTIFICATION OPEN QUESTIONS

A. CURRENT CIRCUMSTANCES

1. **Can you describe the circumstances you / your family currently live in?**

- a. Do you / your family have enough access to food and water?
- b. What is your shelter like? (is it safe / secure / broken?)
- c. Who do you live with? (are you separated from close family members?)
- d. Can you briefly explain what you and your family do during the day?
- e. [Check for ration card, registration, identify any relatives in prison and unregistered family members. If it is not evident, ascertain whether the person of concern lives in a refugee camp or elsewhere.]

2. **Do you / your family currently face any security risks and / or threats?**

- a. Briefly describe the circumstances in which you / your family felt and feel most threatened. [If appropriate, elicit:
 - nature of violence;
 - number of times the risk / threat was experienced;
 - type of threat (physical / sexual assault, threats / intimidation, sexual / other exploitation)]
- b. Do you face any security risks in your neighborhood; for example while fetching water / firewood, or on your way to school?
- c. Have any of your immediate family members become separated from you, disappeared or died as a result of these threats?
- d. Are there any people, organizations or systems locally and / or within the camp / community to help address these security risks?
- e. Who do you turn to when you have other kinds of problems (e.g. with respect to health, money, family or everyday life)?

3. **Do you / your family currently face any health risks?**

- a. Do you / your family have any illnesses, conditions or disabilities?
- b. Are your daily activities affected by your physical health (e.g. disability, pain etc.) or your mental health (e.g. fear, depression, inability to concentrate, confused thinking etc)? If so, how?
- c. Who takes care of you when you are sick?
- d. Do you receive any treatment or care for these problems?

4. **Which 3 things are worrying you most at the moment and what could you, UNHCR, and / or others do to help?**

B. PRE-ARRIVAL EXPERIENCES

Note: This version of the HRIT was tabled as a draft document at the 2007 Annual Tripartite Consultations on Resettlement (Geneva, 28-29 June 2007).

1. **Why and when did you leave your home?**

- a. What were the worst experiences and greatest threats to you and your family's well-being? (There may be more than one bad experience, please talk about them all.)
- b. What were the main reasons for your flight?
- c. Can you tell me about your flight from beginning to end? [if appropriate, include:
 - the time and circumstances that have led individual to country of refuge;
 - all places of residence / stay;
 - multiple flights and countries of asylum;
 - irregular movements;
 - internal displacements; and
 - timeframe.]
- d. Were you separated from your family during your flight?

PHASE IV: HEIGHTENED RISK IDENTIFICATION TICK-BOXES

Possible Heightened Risk Categories identified (tick all applicable):

- Women and Girls At-Risk
- Unaccompanied and Separated Children / Adolescents & Other At-Risk Children
- Older Persons At-Risk
- Survivors of Violence / Torture
- Health Needs and Disability
- Legal or Physical Protection Needs / Other

PHASE IV : POSSIBLE HEIGHTENED RISK CATEGORIES IDENTIFIED

A. Women/Girls-At-Risk

Indicators: trauma, hardship, or condition	Past (✓)		Present (✓)		Self At-Risk (H/M/L)	Family At-Risk (H/M/L)
	S	F	S	F		
1. Single woman without family protection / support						
2. Pregnant woman / girl without family protection / support (see Health Needs and Disability)						
3. Widow / adolescent / single mother without family protection / support						
4. Older woman without family protection / support (see Older Persons At-Risk section)						
5. Unsafe in own home or community (e.g. incest, domestic violence, abuse by family member / other known person in community)						
6. Severe beating(s) or other severe assault that causes physical harm						
7. Physical violence while conducting daily activities (e.g. collecting firewood / water / other necessities or in neighborhood)						
8. Threats or harassment while conducting daily activities (e.g. collecting firewood / water / other necessities or in neighborhood)						
9. Threats of rape and sexual violence						
10. Rape (including marital rape) or other sexual assault						
11. Trafficked, engaging in survival sex or forced into sexual slavery / prostitution						
12. Other form(s) of gender-based violence (including state-based violence such as discriminatory laws and practices)						
13. Children conceived from rape						
14. Forced marriage (or threat(s) thereof)						
15. In a socially unacceptable marriage						
16. Unfair customary punishment and / or harmful cultural practices						
17. Experiencing rejection or victimisation by her own community						
18. Transgressing social roles						
19. In hiding (e.g. for fear of being identified or found)						
20. Detained / imprisoned in a place and denied freedom of movement (including for her own protection or to prevent her socialisation)						

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PHASE IV : WOMEN AND GIRLS AT-RISK

-RISK

21. Impairment in daily functioning due to mental illness (see definition on p. 18) (see Health Needs and Disability)						
22. Lack of access to adequate food, water and / or shelter						
23. Danger / threats due to her own / family member's / dependant's condition and / or current / past experience						
24. Danger / threats arising from exercise of social, political, or business activities of self / husband / other family member						
25. Other:						
26. Existing protective factors (if any):						

CONSOLIDATED RISK RATING (circle one): **H** **M** **L**

Comments (please indicate corresponding line / indicator number(s)): _____

B. Unaccompanied and Separated Children/Adolescents & Other At-Risk Children

Indicators: trauma, hardship, or condition	Past (✓)		Present (✓)		Self At-Risk (H/M/L)	Family At-Risk (H/M/L)
	S	F	S	F		
1. Separated child / young person (parents not in same camp / community and no close relatives in same camp / community)						
2. Separated child / young person with relatives in same camp / community						
3. Unaccompanied child (living alone in camp / community)						
4. Orphan child / young person						
5. Adolescent parent						
6. Child-headed household						
7. Unsafe living situation with family (including external family) (e.g. incest, abuse, neglect)						
8. Unsafe living arrangement with non-family member(s) (e.g. abuse or neglect)						
9. Threats or harassment while conducting daily activities or in community (e.g. collecting firewood, water, other necessities or on way to school)						
10. Physical violence while collecting firewood / water / other necessities or on way to school / in community						
11. Beating or other physical violence (non-sexual)						
12. Rape and / or sexual assault other than rape						
13. Sexual harassment						
14. Trafficked, engaging in survival sex, and / or forced into sexual slavery / prostitution						
15. Forced marriage (or threats thereof)						
16. Forced labour						
17. Other forms of exploitation						
18. Recruitment as child soldier						
19. Experiencing rejection or victimisation by his / her own community						
20. Harmful cultural practices						
21. Transgressing social roles						
22. In hiding (e.g. for fear of being identified or found)						

PHASE IV : UNACCOMPANIED AND SEPARATED CHILDREN / ADOLESCENTS & OTHER AT-RISK CHILDREN

B. Unaccompanied and Separated Children/Adolescents & Other At-Risk Children

23. Detained / imprisoned in a place and denied freedom of movement (including for his / her own protection)						
24. Of school age and not attending school						
25. Lack of access to adequate food, water and / or shelter						
26. Young people below the age of 18 who have come to the attention of the law/authorities and/or whose behaviour is drawing attention in some way to themselves						
27. Impairment in daily functioning due to mental illness (see definition on p. 18) (see Health Needs and Disability)						
28. Other:						
28. Existing protective factors (if any):						

CONSOLIDATED RISK RATING (circle one):

H

M

L

Comments (please indicate corresponding line / indicator number(s)): _____

PHASE IV : UNACCOMPANIED AND SEPARATED CHILDREN / ADOLESCENTS & OTHER AT-RISK CHILDREN

C. Older Persons At-Risk

Indicators: trauma, hardship, or condition	Past (✓)		Present (✓)		Self At-Risk (H/M/L)	Family At-Risk (H/M/L)
	S	F	S	F		
1. Unable to care for self on a daily basis (see Health Needs and Disability)						
2. Elderly person or couple with no family support, no other support within the camp and / or neglected by caregivers						
3. Grandparent-headed household						
4. Lack of access to adequate food, water and / or shelter						
5. Chronic physical health concerns (see Health Needs and Disability)						
6. Impairment in daily functioning due to mental illness (see definition on p. 18) (see Health Needs and Disability)						
7. Exposed to exploitation and psychosocial abuse						
8. Lack of access to specialized health or psychosocial support (see Health Needs and Disability)						
9. Sexual abuse / assault						
10. Non-sexual physical violence						
11. Threats of sexual violence / assault						
12. Threats of non-sexual physical violence						
13. Other threats and / or harassment in community or while conducting daily activities (e.g. collecting firewood / water / other necessities)						
14. Unsafe in own home or community (e.g. abuse by family member / other known person in community)						
15. Experiencing rejection or victimisation by his / her own community						
16. Harmful cultural practices						
17. Detained / imprisoned in a place and denied freedom of movement (including for her / his own protection or due to non abusive intent)						
18. Other:						
19. Existing protective factors (if any):						

PHASE IV: OLDER PERSONS AT-RISK

CONSOLIDATED RISK RATING (circle one):

H

M

L

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D. Survivors of Violence / Torture

Indicators: trauma, hardship, or condition	Past (✓)		Present (✓)		Self At-Risk (H/M/L)	Family At-Risk (H/M/L)
	S	F	S	F		
1. Intellectual impairment caused by torture and / or violence (e.g. head trauma acquired through beatings / torture)						
2. Impairment in daily functioning due to severe psychological trauma						
3. Impairment in daily functioning due to mental illness (see definition on p. 18) (see Health Needs and Disability)						
4. Bodily injury caused by torture and / or violence (see Health Needs and Disability)						
5. Experiencing rejection or victimisation by his / her own community						
6. Torture						
7. Severe beating or other severe assault						
8. Rape or sexual assault other than rape						
9. Repeated, systematic attacks on self or family (including while in detention)						
10. Detention / solitary confinement						
11. Victim of other severe abuse						
12. Forced to do harm to others / to do something horrific						
13. Witnessed others killed and / or physical violence to others						
14. Violent death / murder of family or close friends (including during flight)						
15. Prolonged involuntary separation from loved ones						
16. Recruitment as child soldier						
17. Combatant						
18. Forced labour						
19. Village or house raided						
20. Lack of access to adequate food, water, and / or shelter						
21. Other:						
22. Existing protective factors (if any):						

PHASE IV : SURVIVORS OF VIOLENCE / TORTURE

TORTURE

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E. Health Needs and Disability						
Indicators: trauma, hardship, or condition	Past (✓)		Present (✓)		Self At-Risk (H/M/L)	Family At-Risk (H/M/L)
	S	F	S	F		
1. Physical health problem						
2. Person with HIV / AIDS or other life-threatening disease or condition						
3. Physical disability						
4. Impairment in daily functioning due to mental illness a. Obviously confused thinking (such that responses are often incoherent); b. Disorientation in time, place or person or marked inattention (unable to identify where / who they are; unable to follow conversation / interview); c. Obvious loss of contact with reality (e.g. has highly unrealistic or bizarre beliefs); d. Clearly peculiar behavior (behaviour which is regarded as nonsensical or bizarre by the person's own community); e. Severe withdrawal, anxiety, or depression such that daily functioning is greatly affected; f. Risk of harm to self or others. (In making this assessment, it is critical that these mental illness cues also result in an impairment in daily functioning, as described by the individual or inferred by the assessing staff)						
5. Intellectual impairment from birth (e.g. Downs Syndrome, intellectual disability) or as a result of injury (e.g. acquired brain injury)						
6. Drug / alcohol abuse / addiction						
7. Lack of access to adequate / specialized health care (including psychosocial support)						
8. Unable to care for self and no caregiver available						
9. Lack of access to adequate food, water and / or shelter						
10. Experiencing rejection or victimisation by his / her own community						
11. Customary punishment and / or harmful cultural practices						
12. Detained / imprisoned in a place and denied freedom of movement (including for his / her protection)						

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F. Legal or Physical Protection Needs / Other						
Indicators: trauma, hardship, or condition	Past (✓)		Present (✓)		Self At-Risk (H/M/L)	Family At-Risk (H/M/L)
	S	F	S	F		
1. Multiple flight history						
2. Member of a minority religious, social or ethnic group						
3. Has no legal documentation						
4. In a same-sex relationship						
5. In a socially unacceptable marriage						
6. Unsafe in own home or community (incest, abuse by family member / other known person in community)						
7. In hiding (e.g. for fear of being identified or found)						
8. Experiencing rejection or victimisation by his / her own community (including due to transgression of social roles)						
9. Impairment in daily functioning due to mental illness (see definition on p. 18) (see Health Needs and Disability)						
10. Unfair customary punishment / harmful cultural practices						
11. Arbitrarily detained, imprisoned, or otherwise in captivity (including solitary confinement)						
12. Victim of abuse (including abuse / attacks by police, military, other authorities)						
13. In danger due to absence of witness protection program						
14. Physical violence / threats / harassment while conducting daily activities (e.g. collecting firewood / water / other necessities) or in community						
15. Danger / threats due to self's / family / dependents condition and / or current / past experience						
16. Other threats / dangers not otherwise identified to self / family / dependents (eg. because of current exercise of social, political, or business activities)						
17. Lack of food, water, and / or shelter						
18. Other:						
19. Existing protective factors (if any):						

PHASE IV: LEGAL OR PHYSICAL PROTECTION NEEDS / OTHER

NEEDS /

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PHASE IV: REFERRAL AND CASE MANAGEMENT

A. OVERALL RISK ASSESSMENT

1. Overall risk assessment:

H M L

B. RISK ASSESSMENT & REFERRAL

Heightened Risk Category	Consolidated risk rating	Referral type	Confirmation of receipt by referral services	Comments
<input type="checkbox"/> Women / Girls At-Risk <input type="checkbox"/> Self <input type="checkbox"/> Family	<input type="checkbox"/> H <input type="checkbox"/> M <input type="checkbox"/> L	<input type="checkbox"/> SGBV <input type="checkbox"/> BID <input type="checkbox"/> Psycho-social <input type="checkbox"/> Medical <input type="checkbox"/> Resettlement <input type="checkbox"/> Legal <input type="checkbox"/> Other: <input type="checkbox"/> No referral	<input type="checkbox"/> Weekly <input type="checkbox"/> Other	
<input type="checkbox"/> Unaccompanied and Separated Children / Adolescents & Other At-Risk Children <input type="checkbox"/> Self <input type="checkbox"/> Family	<input type="checkbox"/> H <input type="checkbox"/> M <input type="checkbox"/> L	<input type="checkbox"/> SGBV <input type="checkbox"/> BID <input type="checkbox"/> Psycho-social <input type="checkbox"/> Medical <input type="checkbox"/> Resettlement <input type="checkbox"/> Legal <input type="checkbox"/> Other: <input type="checkbox"/> No referral	<input type="checkbox"/> Weekly <input type="checkbox"/> Other	
<input type="checkbox"/> Older Persons At-Risk <input type="checkbox"/> Self <input type="checkbox"/> Family	<input type="checkbox"/> H <input type="checkbox"/> M <input type="checkbox"/> L	<input type="checkbox"/> SGBV <input type="checkbox"/> BID <input type="checkbox"/> Psycho-social <input type="checkbox"/> Medical <input type="checkbox"/> Resettlement <input type="checkbox"/> Legal <input type="checkbox"/> Other: <input type="checkbox"/> No referral	<input type="checkbox"/> Weekly <input type="checkbox"/> Other	
<input type="checkbox"/> Survivors of	<input type="checkbox"/> H	<input type="checkbox"/> SGBV <input type="checkbox"/> BID	<input type="checkbox"/> Weekly	

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<p>Violence / Torture</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Family</p>	<p><input type="checkbox"/> M</p> <p><input type="checkbox"/> L</p>	<p><input type="checkbox"/> Psycho-social</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Resettlement</p> <p><input type="checkbox"/> Legal</p> <p><input type="checkbox"/> Other:</p> <p><input type="checkbox"/> No referral</p>	<p><input type="checkbox"/> Other</p>	
<p><input type="checkbox"/> Health Needs and Disability</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Family</p>	<p><input type="checkbox"/> H</p> <p><input type="checkbox"/> M</p> <p><input type="checkbox"/> L</p>	<p><input type="checkbox"/> SGBV</p> <p><input type="checkbox"/> BID</p> <p><input type="checkbox"/> Psycho-social</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Resettlement</p> <p><input type="checkbox"/> Legal</p> <p><input type="checkbox"/> Other:</p> <p><input type="checkbox"/> No referral</p>	<p><input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> Other</p>	
<p><input type="checkbox"/> Legal or Physical Protection Needs / Other</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Family</p>	<p><input type="checkbox"/> H</p> <p><input type="checkbox"/> M</p> <p><input type="checkbox"/> L</p>	<p><input type="checkbox"/> SGBV</p> <p><input type="checkbox"/> BID</p> <p><input type="checkbox"/> Psycho-social</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Resettlement</p> <p><input type="checkbox"/> Legal</p> <p><input type="checkbox"/> Other:</p> <p><input type="checkbox"/> No referral</p>	<p><input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> Other</p>	

C. CLOSE INTERVIEW (if in interview setting under Methodology 1)

1. Note any questions refugee needs answered, or need for follow-up (not already been accounted for above)
2. Notify individual of next step(s) and or referral(s).

USER GUIDE

ACKNOWLEDGEMENTS

UNHCR would like to thank the University of New South Wales and the Victorian Foundation for Survivors of Torture for their valuable contribution to the development of this tool.

PURPOSE

The purpose of this Heightened Risk Identification Tool is to i) implement ExCom Conclusion 105 on Women and Girls At-Risk and UNHCR's Global Strategic Objectives for 2007-09; ii) strengthen needs-based planning, identification methodologies and case management systems; and iii) promote age, gender, and diversity mainstreaming.²

USES

This Heightened Risk Identification Tool serves multiple uses. It has been designed to be flexible, simple, yet comprehensive. It can be used in different ways and operational contexts, for instance: (i) prior to and as follow-up to refugee status determination; (ii) in conjunction with a participatory assessment exercise; (iii) as a stand-alone methodology involving community-based consultations and individual assessments; (iv) as a tool to sample survey the refugee population to project the levels of risk; (v) as an interview format or checklist for case workers; and, (vi) as a checklist tool for roving officers to use in refugee camps or in urban settings. The following are important considerations:

First, this tool can be used to efficiently identify and prioritise persons of concern in different operational contexts (e.g. camp, urban, IDP or returnee settings) who are most at-risk, and thus require urgent protective action by UNHCR and / or its partners (governmental or non-governmental). The identification of individuals who are at "heightened risk" should be done by considering a) their individual circumstances (e.g. exposure to trauma, hardship, threats and risks, as recorded by the tick boxes in Phase IV of the tool), as well as b) their individual coping capacities and ways to mitigate risks (as revealed by reference to existing protective factors discussed and noted in the tool, known to, or witnessed by staff). That is, identification should not be achieved on the basis of consideration of heightened risk factors alone. Rather, it should also take into account the coping capacity of the individual and the protection environment.

Second, once individuals at heightened risk have been identified, this tool aims to ensure their referral to the appropriate resources, such as SGBV, BID, and other referral services. This will require that protection services, community services, and their partners establish a formal case management system, and appropriate follow-up monitoring procedures.

Third, a proper analysis of causes and trends behind risks enables better protective strategies to prevent risks and improve the protective environment. This tool should therefore serve to inform proactive planning for durable solutions in the context of the UNHCR Country Operations Planning process, particularly with regard to resettlement. Specifically, it will assist UNHCR's operations to systematically and predictably determine the level of needs within a given refugee population warranting resettlement intervention (e.g. by using the interview methodology for a sample survey of a representative cross-section of the refugee population). In the context of resettlement, this identification tool provides for the gathering of specific information related to the individual's experience and trauma which helps plan activities and early intervention to support the reception and integration of resettled individuals. In the context of voluntary repatriation, this tool will help

² The concept of 'diversity mainstreaming' implies that the significant participation of refugee girls, boys, women and men of all ages and backgrounds is integral to the design, implementation, monitoring and evaluation of all UNHCR policies and operations so that these impact equitably on people of concern.

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ensure timely and appropriate intervention to enable safe return and follow-up. With respect to local integration, it will allow specific measures to be taken in order to address existing heightened risks.

WHO SHOULD USE IT?

This tool has been designed for use by UNHCR staff involved in community services and / or protection activities (including resettlement) and their implementing partners to assist with the identification of individuals at risk and who require immediate intervention. UNHCR staff and NGO partners who are involved in these types of activities can use the tool and apply it in different situations. The tool should be used comprehensively and not alone for resettlement identification. *Other UNHCR staff can also be trained to use it, when deemed appropriate in the context of situational or operational needs. Where external partners are using the tool, it is essential to have agreed on an appropriate referral and case management system.*

For purposes of this User Guide section, persons using this Heightened Risk Interview Tool will be referred to as “staff” or “users.”

WHEN SHOULD IT BE USED?

Although primarily subject to the timing needs and constraints of specific situations, this tool can be used at any time. For instance, it is appropriate for use both prior to and as follow-up to Refugee Status Determination. Additionally, it can also be used in the context of timed activities, such as participatory assessments, urban community or camp visits, or formal interview exercises (see ‘How Should It Be Used’ section below).

HOW SHOULD IT BE USED?

There are three possible methodologies, which field operations can apply to use this tool:

- *Methodology 1: As an interview tool (either with or without holding a prior participatory assessment);*
- *Methodology 2: As a check-list for case workers who already know their case and local circumstances well;*
- *Methodology 3: As a walk-along tool during visits of refugee camps or in urban communities.*

One or more of the three methodologies could be used in the same operation depending on the situational context. Once a field operation has selected the methodology / ies to be applied, users should refer to the corresponding explanatory sections below.

Methodology 1: As an interview tool (either with or without holding a prior participatory assessment)

The purpose of this tool is to obtain an overall understanding of the individual's circumstances, as well as the degrees and types of risk(s) s/he faces. Through a series of questions and prompts, interviewing staff can guide his / her exchange with an individual of concern so as to uncover the information needed to make a heightened risk assessment. This approach enables interviewees to describe their situation and the issue(s) they face in their own terms.

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- ❖ **Step 1: Preparations.** Turn to Phase I (at p. ____). The purpose of this preparatory phase is to encourage early planning and implementation of whatever measures are necessary for a smooth and efficient use of this tool. The measures actually taken will vary depending on situational needs, however, they will frequently include actions such as:

- Updating introductory remarks, open questions, and risk indicators in this tool.

The questions and indicators in Phases II, III and IV can and should be modified and supplemented to reflect the circumstances that are specific to each field operation. This can be achieved by modifying existing introductory remarks (in Phase II), open questions (in Phase III) and indicators (in Phase IV), and by completing the 'Other' box (located at the end of each tick-box category in Phase IV).

These modifications can be made on the basis of information collected i) through a participatory assessment or a group consultation exercise, or ii) by means of consultations with local NGOs, staff with extensive experience and knowledge of local circumstances, etc.

When situational needs and circumstances so allow, it is best to apply a participatory approach for the implementation of this tool by holding a participatory assessment exercise or group consultations. This kind of exercise enables individuals of concern to be involved in describing the problems they face and any patterns of risks, as well as identifying future challenges and possible solutions. Note that participatory assessments are held as part of the Country Operations Planning process, and may be applied to targeted or random sample populations. They are used to assess needs and protection issues / risk indicators in a systematic and reliable manner, and to complement this tool by assisting in the planning of proactive resettlement needs. Targeted group consultations may be used in addition to regular participatory assessment exercises. These may duplicate and / or supplement the effect of a participatory assessment by facilitating heightened risk identification and case management, and may be particularly useful where a participatory assessment has not yet been held (e.g. due to an emergency or situational constraints).

As circumstances do not always allow field operations to engage local communities by participatory means, field operations may consult with local NGOs or experienced staff in order to gather information to compensate for the lack of community participation. This however, does not achieve the desired benefits of participatory methods which empower refugees in the process of identifying needs and risk indicators as well as ways to address these in terms of solutions.

- Identifying and notifying individuals to be interviewed.

Once individuals have been identified for interviewing, staff must complete the biodata box with any information already available concerning each prospective interviewee. If any required information is missing from the biodata box at this stage, it can be supplemented at a later time (e.g. during or after the interview);

- Staff and interpreter familiarisation.

Users and, if applicable, interpreters should be familiar with this tool and with the issues relevant to the particular location and / or community.

- Making arrangements for an adequate interview space and security

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measures;

- Ensuring the existence and availability of referral services, and an adequate referral system.

Effective use of this tool requires the existence and availability of referral and case management services. Additionally, use of this tool will likely highlight any gaps in referral systems. Field operations that become aware of such gaps should co-ordinate with referral services, headquarters, implementing partners, as appropriate, to bridge them.

Additional preparatory measures may be necessary. Therefore, in any event, staff should always consider the needs and constraints of their field operations, and take whatever preparatory measures are appropriate under the circumstances.

- ❖ **Step 2: Introductions.** Turn to Phase II (at p. ____). During this phase, the interviewing staff should introduce all persons present, explain the purpose of the interview, its timeframe and the method used. The Phase II language provided in this tool is meant to serve as an example. Prior to its use, staff should tailor it so as to adequately reflect local circumstances, as explained in Step 1.

During this phase, staff should also obtain the individual's consent regarding information-sharing.

In an effort to minimize the duration of interviews, and thus allow a streamlined process which will benefit more refugees, this phase should ideally not exceed five minutes.

- ❖ **Step 3: Open Questions.** Turn to Phase III (at p. ____). During this phase, the interviewing staff should ask general and open questions. The objective is to allow the person of concern to explain the difficulties s/he faces in her / his own terms, without being led by the interviewing staff and her / his knowledge, understanding and expectations concerning local circumstances, needs and solutions. The use of open questions also aims to help uncover hardship, problems, and trauma that may be unique and uncommon, and thus unlikely to come up by means of closed questioning.

The proposed questions and prompts in Phase III address living conditions, health, security, daily activities and flight history. These topics encompass the areas where most problems and issues are typically identified. Nevertheless, when appropriate, staff must tailor and / or supplement open questions to more closely match situational needs and circumstances, as described under Step 1.

Here too, in an effort to minimize the length of interviews, this phase should ideally not exceed twenty minutes, and interviewing staff are not expected to take copious notes. This interview phase may be slightly extended if the interviewing officer does not intend to complete the next step in the presence of the individual of concern).

- ❖ **Step 4: Tick-boxes.** Turn to Phase IV (at p. ____). Based on staff's knowledge of local circumstances and information previously elicited (e.g. through the open questions asked in Phase III, per Step 3, above), staff must make a preliminary identification of all possible heightened risk categories applicable to the individual interviewed and / or his / her family member(s) / dependant(s) by ticking off the corresponding box(es). There are six possible categories (which reflect no particular order of priority or importance):

- Women / Girls at-Risk;

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- *Unaccompanied and Separated Children / Adolescents & Other At-Risk Children;*
- *Older Persons at-Risk;*
- *Survivors of Violence / Torture;*
- *Health Needs and Disability; and*
- *Legal or Physical Protection Needs / Other.*

It may be necessary to tick off more than one heightened risk tick-box section to record the existence of heightened risk. Note that there may be overlap between sections (e.g. an unaccompanied girl forced into prostitution may be accounted for in the Unaccompanied Child and the Women / Girl-At-Risk categories). When that is the case, interviewing staff should proceed to the tick-box section(s), which s/he has preliminarily identified as most relevant to the person of concern. As a general rule, all of the tick-box sections should be considered in each individual case to determine applicability of specific risk indicators.

The tick-boxes are thematically clustered, and list known trauma, hardship, and other conditions indicative of heightened risk. Staff filling out relevant tick-box section(s) may do so in the presence of the person of concern (by direct questionnaire-style interviewing, or by recording information whenever a relevant fact or indicator is mentioned or witnessed). Alternatively, staff may complete the tick-box section in the absence of the person of concern, based on the staff's knowledge and record of information previously collected.

'Past,' 'Present' and 'At-Risk' tick-boxes and 'High,' 'Medium' and 'Low' risk grading:

When ticking boxes, staff must indicate whether the trauma, hardship, and conditions apply to the person of concern (and / or her / his family member(s) / dependant(s)) in the past ('Past' tick-box), in the present ('Present' tick-box), and whether the person of concern (and / or her / his family member(s) / dependant(s)) is At-Risk ('At-Risk H; M; L' tick-boxes). In assessing whether the person of concern (and / or her / his family member(s)) is At-Risk, staff must indicate whether the risk is 'High' (H), 'Medium' (M) or 'Low' (L), as defined below:

- *High:* *reflects a need for immediate intervention by UNHCR or a partner agency. Staff should immediately refer the individual(s) to the appropriate referral service(s), and follow-up with them on a weekly basis until they provide confirmation that they have received the referral and that they have taken action in connection with the individual at heightened risk. This will help ensure that the individual's situation is promptly and adequately addressed, and that the referral system is functioning efficiently;*
- *Medium:* *indicates that intervention should be scheduled and occur, but that immediate intervention is not necessary. Note that cases placed in the medium risk category can move into the high risk category if intervention is not followed through. Therefore, staff should implement a structured monitoring system to ensure adequate follow-up;*
- *Low:* *denotes that the regular referral system applies. Additionally, staff should review the situation of individuals at low risk at regular, or implement another structured monitoring and follow-up mechanism to ensure that the case is handled adequately.*

The 'At-Risk' tick-box is a very important element in the ultimate determination of whether the person of concern (and / or her / his family member(s) / dependant(s)) is at heightened risk. In assessing the appropriate level of risk to tick off, staff must consider the following:

- *the existence of past and present experience, as well as the frequency and*

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intensity of these experiences;

- *the possibility that although it has not yet occurred, the risk factor is imminent. In such situations, a person might be at heightened risk, even though the indicator is not ticked off as 'Present' (e.g. an individual not presently involved in forced prostitution but at high risk of being forced into prostitution);*
- *the existence of coping mechanisms, mitigating factors, resilient personalities, etc. At the end of every tick box section, a box allows staff to indicate 'existing protective factors' to record such elements;*
- *where applicable, the chosen degree of risk should also reflect a weighing of likelihood and impact of the risk.*

Graded At-Risk tick-boxes will be instrumental in determining heightened risk, urgency and the type of intervention required, and should therefore be completed with care and using a uniform standard. In order to ensure consistency in the use of such tick-boxes, teams using this identification tool should have a consistent and uniform understanding of the levels of risk. Although possibly subject to time, needs and resource constraints, harmonisation can be achieved by various means. For instance, staff using this tool can hold regular meetings to discuss difficult or ambiguous cases, one point person can be assigned to help clarify the doubts of users within an operation, or field operations may establish guiding parameters to help achieve a degree of consistency.

'Self' and 'Family' tick-boxes:

The tick-box approach also aims to reflect the circumstances of the family members and dependant(s) of any individual whose own risk level is being assessed. Therefore, the tick-boxes also allow users to indicate whether the risk factor applies to the individual herself / himself ('Self' tick-box), or to a family member(s) of hers / his ('Family' tick-box). In this context, the concept of 'family' should be interpreted broadly, with a view to include individuals with whom there exists a relationship of dependency. Note that dependency may be financial, emotional, or social, and that it does not necessarily require a blood relationship. For instance, a neighbor's orphan child who has been taken into the individual's home would qualify as a member of the individual's family under this definition of 'family.' Additionally, the concept of dependency between family members can be mutual (e.g. where a grandfather is economically dependent on his grandson, the dependency relationship may apply both to the grandfather and to the grandson).

Sometimes, having a family member who is at risk will directly increase or compound the risk faced by a mother, carer, or older sibling, etc. As a result, each indicator can be completed for the person of concern and / or his / her family member(s). Where indicators may apply to several family members, and in an effort to keep this tool as user-friendly as possible, staff should use of the comments section to clarify any ambiguities concerning which family member(s) are at risk.

'Impairment in daily functioning due to mental illness' indicator.

Each of the six heightened risk categories contains an 'Impairment in daily functioning due to mental illness' indicator. The elements that a person has a mental illness are various and will generally be based on observations by the interviewer or by reports from the individual's family members. Most interviewing staff will likely not have a background in psychology, and should therefore look for the following indications of mental illness or condition:

- *Obviously confused thinking (e.g. such that responses are often incoherent);*
- *Disorientation in time, place or person or marked inattention (i.e. unable to identify where / who they are, unable to follow conversation / interview);*

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- Obvious loss of contact with reality (behaviour which is regarded as nonsensical or bizarre by the person's own community);
- Clearly peculiar behavior (e.g. hyperactivity, impulsivity, oppositional behavior);
- Severe withdrawal, anxiety, or depression such that daily functioning is greatly affected;
- Risk of harm to self and others.

In making this assessment, it is critical these mental illness cues also result in an impairment in daily functioning, as described by the individual or inferred by the assessing staff. Additionally, the interviewer should note any possible causes for the disturbance in the 'Comments' field at the end of each section, if they are clearly evident or known. Finally, interviewers should note that mental illness does not include intellectual or congenital disabilities (e.g. Downs Syndrome, brain damage from birth or injury, physical disabilities, etc.). Daily functioning may be impaired in these instances, but is not caused by psychological factors. Therefore, these conditions should be recorded in the Health Needs and Disability tick-box section.

'Other' box:

Each of the six heightened risk categories contains an 'Other' box in its second-to-last row. When appropriate, staff should use this box to record additional context-specific risk indicators not already accounted for. This approach is particularly useful and relevant in situations where the results of participatory assessments and group consultations are available, or where staff knows local circumstances extremely well.

'Existing protective factors' box:

The last row in each risk category is reserved for the identification of any existing protective factors. In this field, staff should record both internal and external coping mechanisms, such as a resilient attitude, UNHCR / community / family support structures in the camp and / or urban community, other mitigating factors, etc.

'Consolidated risk rating' box:

At the end of each section, staff should indicate the consolidated risk level applicable to the person of concern. In doing so, assessing staff should consider the number of boxes ticked off in each risk category, both for the person of concern and for any family members. The existence of protective factors should also be considered.

While it is clear that if an item has been ticked as high risk, immediate action is required, it is also important to identify any patterns of risk. For example, if a number of items are graded as medium risk, this may collectively place the individual (or his / her family member(s)) at high risk. As a result, there may be an urgent need for intervention even though no risk indicator has been ticked off as high. There is no mathematical formula for determining when a threshold number of tick-boxes in any given risk category has been reached. Rather, staff should use all the information collected, and grade consolidated risk consistently with other users in the same operation (see discussion on harmonisation, at p. ___).

'Comments' field:

Finally, below each of the six tick-box categories there is a field to record in more detail the item number and / or description of any indicator requiring clarification, comment, and / or follow-up. While encouraged to make use of the 'Comments' field, information about the person of concern and his / her family member(s) should primarily be recorded in the tick-boxes and consolidated risk sections, so as to avoid lengthy narratives and longer or more complicated processing.

The duration of this phase will vary depending on the number of heightened risk

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categories identified however, if the interviewing staff decides to tick the heightened risk indicator tick-boxes in the presence of the interviewee, s/he should try not to exceed ten minutes.

- ❖ **Step 5: Referral and Case Management.** Turn to Phase V (at p. ___). In this phase, staff should make an overall assessment of whether collectively, the subjects of concern (comprising the individual in question and, if applicable, any family member(s) and / or dependant(s) of concern) is at heightened risk. To record this assessment, staff must identify whether the overall risk applicable to the subjects of concern is High, Medium, or Low, and tick the corresponding box. In doing so, staff should take into account any consolidated risk ratings made at the end of each completed section.

Users should reflect overall risk rating(s) they have identified in the ProGres database in a timely manner, by using the 'Special Needs' and 'Comments' fields in ProGres. If a case file does not already exist for the individual(s) of concern, UNHCR staff responsible for registration should be notified and steps taken to register the person and establish an individual case file.

Staff should then proceed to the referral chart, and complete it as follows:

- In the first column, staff should tick off the risk categories identified for the individual of concern and / or her / his family member(s) / dependant(s) (e.g. Women and Girls At-Risk, Survivors of Violence / Torture, etc.), indicating whether the risk category applies to the individual ('Self' tick-box) or to a family member / dependant ('Family' tick-box).
- In the second column, users should tick off the risk level corresponding to each heightened risk section.
- In the third column, staff should indicate the kind(s) of referral needed.
- Then, in the fourth column, staff should indicate how frequently they need to follow up for confirmation that the referral services have received the referral ('Weekly' or 'Other'). Note that this process is only mandatory for individuals at high risk. Ideally, staff should follow-up with referral services on the status of high risk referrals every week until they receive confirmation of receipt and action. However, if such a frequent follow-up is impossible under the circumstances, staff can select the 'Other' tick-box, and note the frequency of follow-up. Staff referring individuals at medium and low risk have discretion to decide appropriate follow-up and monitoring procedures according to their job descriptions. Once referral services have provided referring staff with confirmation that they received the referral and took appropriate action, staff is no longer required to monitor follow-up action, unless required to do so according to her / his work responsibilities.
- Finally, the fifth column allows staff to make any additional comment deemed appropriate.

Staff should then close the interview by advising the person of concern as to next steps and referrals (if any) concerning him / her and / or his / her family member(s) and / or dependants. Finally, interviewing staff should ask the interviewee whether s/he has any questions or need for follow-up, and make note of them.

Ideally, this phase should not exceed five minutes.

Methodology 2: As a checklist for case workers who already know their case and local circumstances well

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Methodology 2 is designed to accommodate staff who already have very good knowledge of local circumstances and the situation of certain individuals whom they believe might be at-risk, so as to allow them to bypass Phases II (Introductions) and III (Open Questions), and proceed directly to the relevant tick-box sections in Phase IV. Note that this methodology should be incorporated as part of a broader heightened risk identification scheme, which relies on more systematic and reliable procedures linked to participatory approaches (such as Methodology 1).

❖ **Step 1: Biodata.** Turn to Phase I (at p. ____). Complete the biodata box with the required information concerning the individual of concern.

❖ **Step 2: Preparations (ensuring thoroughness, accuracy and reliability).** Remain in Phase I (at p. ____). It is essential to the integrity of UNHCR's activities and to the reliability and accuracy of results produced by this tool that users of this tool under Methodology 2 have i) an in-depth understanding of the local situation; ii) an in-depth understanding of the individual's circumstances on the basis of which they are completing the tick-boxes; and iii) sufficient assurance that the source(s) of such information are complete and trustworthy.

i) In order to gain an in-depth understanding of the local situation, staff may conduct a participatory assessment exercise or group consultation, or consult with local NGOs or experienced local staff.

When situational needs and circumstances so allow, it is best to apply a participatory approach for the implementation of this tool by holding a participatory assessment exercise or group consultations. This kind of exercise enables individuals of concern to be involved in describing the problems they face and any patterns of risks, as well as identifying challenges and possible solutions. Note that participatory assessments are held as part of the Country Operations Planning process, and may be applied to targeted or random sample populations. They are used to assess needs and protection issues / risk indicators in a systematic and reliable manner, and to complement this tool by assisting in the planning of proactive resettlement needs. Targeted group consultations may be used in addition to regular participatory assessment exercises. These may duplicate and / or supplement the effect of a participatory assessment by facilitating heightened risk identification and case management channeling, and may be particularly useful where a participatory assessment has not yet been held (e.g. due to an emergency or situational demands).

As circumstances do not always allow field operations to engage local communities by participatory methods, field operations may consult with local NGOs or experienced staff in order to gather information to compensate for the lack of community participation. This, however, does not achieve the desired benefits of participatory methods which empower refugees in the process of identifying needs and risk indicators as well as ways to address these in terms of solutions.

In either case, due to the fact that this methodology lacks a certain degree of formality, only experienced staff should use it.

ii) Additionally, staff must have an in-depth understanding of the individual's personal circumstances. As such, staff must have acquired this knowledge as a result of the individual's frequent visits to the office, or because of his / her past visits to the individual's home, or as a result of an implementing partner's referral coupled with a complete and reliable file, or due to a combination of these factors. In any event, staff should be sure that s/he has a thorough understanding of the individual's circumstances. If that is not the case, s/he should consider using a different methodology.

iii) Finally, staff must also be certain of the reliability and accuracy of the sources s/he is using (e.g. individual's statements during visits,

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completeness and consistency of file from referring organisation, etc.). If staff has any doubts concerning the reliability or accuracy of the information sources, s/he should not proceed with this methodology and consider using a more formal process.

❖ **Step 3: Preparations (other preparatory measures).** Remain in Phase I (at p. ____). The purpose of this preparatory phase is to encourage early planning and implementation of whatever measures are necessary for a smooth and efficient use of this tool. The measures actually taken will vary depending on situational needs, however, they will frequently include actions such as:

- In order to allow efficient use of this tool, assessing staff should familiarise itself with the contents and format of this tool;
- If the case worker / user has not already done so, s/he must obtain the individual's consent regarding information-sharing with UNHCR partners;
- If necessary, briefing interpreters;
- Ensuring that an adequate referral system is in place;
- If personal contact with potential at-risk individual(s) is likely, staff should also take whatever other preparatory measures are necessary under the circumstances (e.g. security measures, briefing an interpreter, etc.). See Phase I (at p. ____) for additional suggested preparatory measures.

❖ **Step 4: Preparations (updating tick-boxes).** Turn to Phases I and IV (at pp. ____). Once thoroughness, accuracy and reliability have been ascertained, and if personal contact with the individual of concern is likely to be necessary, staff should modify and supplement the risk indicators in Phase IV, as appropriate, to reflect local circumstances that are specific to each field operation. This can be achieved by modifying existing indicators and by completing the 'Other' box (located at the end of each tick-box category in Phase IV).

These modifications can be made either on the basis of information collected i) through a participatory assessment or group consultation exercise, or ii) based on consultations with local NGOs, staff with extensive experience and knowledge of local circumstances, etc., as discussed in Step 2, above.

❖ **Step 5: Tick-boxes.** Turn to Phase IV (at p. ____). Based on the user's knowledge of the individual's situation and local circumstances, s/he must make a preliminary identification of all possible heightened risk categories applicable to the individual and / or his / her family member(s) / dependant(s) by ticking off the corresponding box(es). There are six possible heightened risk categories (which reflect no particular order of priority or importance):

- Women / Girls at-Risk;
- Unaccompanied and Separated Children / Adolescents & Other At-Risk Children;
- Older Persons at-Risk;
- Survivors of Violence / Torture;
- Health Needs and Disability; and
- Legal or Physical Protection Needs / Other.

There is no specific category for men who are not elderly. If they have a significant health condition or a history of trauma their heightened risk can be identified under the relevant sections (e.g. Survivors of Violence / Torture or Health Needs and Disability). However if they don't but are at risk because they have no source of

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material support and access to food or other basic needs, it can be recorded under Health Needs and Disability as well as Legal or Physical Protection Needs / Other.

It may be necessary to tick off more than one heightened risk tick-box section to record the existence of heightened risk. Note that there may be overlap between sections (e.g. an unaccompanied girl forced into prostitution may be accounted for in the Unaccompanied Child and the Women / Girl-At-Risk categories). When that is the case, staff should only proceed to the tick-box section(s), which s/he has preliminarily identified as being most relevant to the person of concern. S/he need not complete other sections unless they also appear to be relevant to the individual, even if they contain the same indicator. Additionally, some tick-box sections may be irrelevant to the case at hand, and tick-box sections of this identification tool left out entirely as a result.

The tick-boxes are thematically clustered, and list known trauma, hardship, and other conditions indicative of heightened risk. Staff filling out relevant tick-box section(s) may do so in the absence of the person of concern based on his / her pre-existing knowledge of this individual's situation. However, if clarification is needed, staff can call in the individual for questioning (either through questionnaire-style or by means of informal questioning).

'Past,' 'Present' and 'At-Risk' tick-boxes and 'High,' 'Medium' and 'Low' risk grading:

When ticking boxes, staff must indicate whether the trauma, hardship, and conditions apply to the person of concern (and / or her / his family member(s) / dependant(s)) in the past ('Past' tick-box), in the present ('Present' tick-box), and whether the person of concern (and / or her / his family member(s) / dependant(s)) is At-Risk ('At-Risk H; M; L' tick-boxes). In assessing whether the person of concern (and / or her / his family member(s)) is At-Risk, staff must indicate whether the risk is 'High' (H), 'Medium' (M) or 'Low' (L), as defined below:

- High: reflects a need for immediate intervention by UNHCR or a partner agency. Staff should immediately refer the individual(s) to the appropriate referral service(s), and follow-up with them on a weekly basis until they provide confirmation that they have received the referral and that they have taken action in connection with the individual at heightened risk. This will help ensure that the individual's situation is promptly and adequately addressed, and that the referral system is functioning efficiently;
- Medium: indicates that intervention should be scheduled and occur, but that immediate intervention is not necessary. Note that cases placed in the medium risk category can move into the high risk category if intervention is not followed through. Therefore, staff should implement a structured monitoring system to ensure adequate follow-up;
- Low: denotes that the regular referral system applies. Additionally, staff should review the situation of individuals at low risk at regular intervals, or implement another structured monitoring and follow-up mechanism to ensure that the case is handled adequately.

The 'At-Risk' tick-box is a very important element in the ultimate determination of whether the person of concern (and / or her / his family member(s) / dependant(s)) is at heightened risk. In assessing the appropriate level of risk to tick off, staff must consider the following:

- the existence of past and present experience, as well as the frequency and intensity of these experiences;
- the possibility that although it has not yet occurred, the risk factor is imminent. In such situations, a person might be at heightened risk, even though the indicator is not ticked off as 'Present' (e.g. an individual not presently involved

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in forced prostitution but at high risk of being forced into prostitution);

- *the existence of coping mechanisms, mitigating factors, resilient personalities, etc. At the end of every tick box section, a box allows staff to indicate 'existing protective factors' to record such elements;*
- *where applicable, the chosen degree of risk should also reflect a weighing of likelihood and impact of the risk.*

Graded At-Risk tick-boxes will be instrumental in determining heightened risk, urgency and the type of intervention required, and should therefore be completed with care and using a uniform standard. In order to ensure consistency in the use of such tick-boxes, teams using this identification tool should have a consistent and uniform understanding of the levels of risk. Although possibly subject to time, needs and resource constraints, harmonisation can be achieved by various means. For instance, staff using this tool can hold regular meetings to discuss difficult or ambiguous cases, one point person can be assigned to help clarify the doubts of users within an operation, or field operations may establish guiding parameters to help achieve a degree of consistency.

'Self' and 'Family' tick-boxes:

The tick-box approach also aims to reflect the circumstances of the family members and dependant(s) of any individual whose own risk level is being assessed. Therefore, the tick-boxes also allow users to indicate whether the risk factor applies to the individual herself / himself ('Self' tick-box), or to a family member(s) of hers / his ('Family' tick-box). In this context, the concept of 'family' should be interpreted broadly, with a view to include individuals with whom there exists a relationship of dependency. Note that dependency may be financial, emotional, or social, and that it does not necessarily require a blood relationship. For instance, a neighbor's orphan child who has been taken into the individual's home would qualify as a member of the individual's family under this definition of 'family.' Additionally, the concept of dependency between family members can be mutual (e.g. where a grandfather is economically dependent on his grandson, the dependency relationship may apply both to the grandfather and to the grandson).

Sometimes, having a family member who is at risk will directly increase or compound the risk faced by a mother, carer, or older sibling, etc. As a result, each indicator can be completed for the person of concern and / or his / her family member(s). Where indicators may apply to several family members, and in an effort to keep this tool as user-friendly as possible, staff should use of the comments section to clarify any ambiguities concerning which family member(s) are at risk.

'Impairment in daily functioning due to mental illness' indicator.

Each of the six heightened risk categories contains an 'Impairment in daily functioning due to mental illness' indicator. The elements that a person has a mental illness are various and will generally be based on observations by the assessing staff or by reports from the individual's family members. Most staff will likely not have a background in psychology, and should therefore look for the following indications of mental illness or condition:

- *Obviously confused thinking (e.g. such that responses are often incoherent);*
- *Disorientation in time, place or person or marked inattention (i.e. unable to identify where / who they are, unable to follow conversation / interview);*
- *Obvious loss of contact with reality (e.g. the person has highly unrealistic or bizarre beliefs);*
- *Clearly peculiar behavior (behaviour which is regarded as nonsensical or bizarre by the person's own community);*

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- Severe withdrawal, anxiety, or depression such that daily functioning is greatly affected;
- Risk of harm to self and others.

In making this assessment, it is critical these mental illness cues also result in an impairment in daily functioning, as described by the individual or inferred by the assessing staff. Additionally, the assessing staff should note any possible causes for the disturbance in the 'Comments' field at the end of each section, if they are clearly evident or known. Finally, interviewers should note that mental illness does not include intellectual or congenital disabilities (e.g. Downs Syndrome, brain damage from birth or injury, physical disabilities, etc.). Daily functioning may be impaired in these instances, but is not caused by psychological factors. Therefore, these conditions should be recorded in the Health Needs and Disability tick-box section.

'Other' box:

Each of the six heightened risk categories contains an 'Other' box in its second-to-last row. When appropriate, staff should use this box to record additional context-specific risk indicators not already accounted for. This approach is particularly useful and relevant in situations where the results of participatory assessments and group consultations are available, or where staff knows local circumstances extremely well.

'Existing protective factors' box:

The last row in each risk category is reserved for the identification of any existing protective factors. In this field, staff should record both internal and external coping mechanisms, such as a resilient attitude, UNHCR / community / family support structures in the camp and / or urban community, other mitigating factors, etc.

'Consolidated risk rating' box:

At the end of each section, staff should indicate the consolidated risk level applicable to the person of concern. In doing so, assessing staff should consider the number of boxes ticked off in each risk category, both for the person of concern and for any family members. The existence of protective factors should also be considered.

While it is clear that if an item has been ticked as high risk, immediate action is required, it is also important to identify any patterns of risk. For example, if a number of items are graded as medium risk, this may collectively place the individual (or his / her family member(s)) at high risk. As a result, there may be an urgent need for intervention even though no risk indicator has been ticked off as high. There is no mathematical formula for determining when a threshold number of tick-boxes in any given risk category has been reached. Rather, staff should use all the information collected, and grade consolidated risk consistently with other users in the same operation (see discussion on harmonisation, at p. __).

'Comments' field:

Finally, below each of the six tick-box categories there is a field to record in more detail the item number and / or description of any indicator requiring clarification, comment, and / or follow-up. While encouraged to make use of the 'Comments' field, information about the person of concern and his / her family member(s) should primarily be recorded in the tick-boxes and consolidated risk sections, so as to avoid lengthy narratives and longer or more complicated processing.

Note that under this methodology, staff may complete this phase in the absence of the individual of concern. However, if clarification is required, the assessing staff should meet with the individual to obtain the missing information.

- ❖ **Step 6: Referral and Case Management.** Turn to Phase V (at p. __). In this phase, staff should make an overall assessment of whether collectively, the subjects of

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concern (comprising the individual in question and, if applicable, any family member(s) and / or dependant(s) of concern) is at heightened risk. To record this assessment, staff must identify whether the overall risk applicable to the subjects of concern is High, Medium, or Low, and tick the corresponding box. In doing so, staff should take into account any consolidated risk ratings made at the end of each completed section.

Users should reflect overall risk rating(s) they have identified in the ProGres database in a timely manner, by using the 'Special Needs' and 'Comments' fields in ProGres. If a case file does not already exist for the individual(s) of concern, UNHCR staff responsible for registration should be notified and steps taken to register the person and establish an individual case file.

Staff should then proceed to the referral chart, and complete it as follows:

- In the first column, staff should tick off the risk categories identified for the individual of concern and / or her / his family member(s) / dependant(s) (e.g. Women and Girls At-Risk, Survivors of Violence / Torture, etc.), indicating whether the risk category applies to the individual ('Self' tick-box) or to a family member / dependant ('Family' tick-box).
- In the second column, users should tick off the risk level corresponding to each heightened risk section.
- In the third column, staff should indicate the kind(s) of referral needed.
- Then, in the fourth column, staff should indicate how frequently they need to follow up for confirmation that the referral services have received the referral ('Weekly' or 'Other'). Note that this process is only mandatory for individuals at high risk. Ideally, staff should follow-up with referral services on the status of high risk referrals every week until they receive confirmation of receipt and action. However, if such a frequent follow-up is impossible under the circumstances, staff can select the 'Other' tick-box, and note the frequency of follow-up. Staff members referring individuals at medium and low risk have discretion to decide appropriate follow-up and monitoring procedures according to their job descriptions. Once referral services have provided referring staff with confirmation that they received the referral and took appropriate action, staff is no longer required to monitor follow-up action, unless required to do so according to her/his work responsibilities.
- Finally, the fifth column allows staff to make any additional comment deemed appropriate.

- ❖ **Step 7: Consent and notification.** Staff must imperatively obtain the individual(s)'s consent with regards to information-sharing (especially where information is likely to be shared with non-UNHCR staff such as implementing partners or government officials).

Additionally, if the individual is not present at any time while the assessing staff is filling out this tool, the staff must notify the individual of any referral made and / or next step(s). As this methodology involves a process that is less formal and structured than under Methodology 1 (the interview approach), staff must take special steps to ensure that consent and notification requirements are adequately complied with.

Methodology 3: As a walk-along tool during visits of refugee camps or in urban communities

Methodology 3 is designed to assist staff who are conducting visits of refugee camps or urban refugee communities, or encountering individuals who may be at heightened risk on an ad-hoc basis. However, this methodology should be incorporated as part of a broader Note: This version of the HRIT was tabled as a draft document at the 2007 Annual Trip Consultations on Resettlement (Geneva, 28-29 June 2007).

identification scheme, and should not be the only method used to identify refugees at heightened risk.

❖ **Step 1: Preparations (ensuring thoroughness, accuracy and reliability).** Turn to Phase I (at p. ____). It is essential to the integrity of UNHCR's activities and to the reliability and accuracy of results produced by this tool that users of this tool under Methodology 3 have i) an in-depth understanding of the local situation, and ii) sufficient assurance that the source(s) of such information are complete and trustworthy.

i) In order to gain an in-depth understanding of the local situation, staff may conduct a participatory assessment exercise or group consultation, or consult with local NGOs or experienced local staff.

When situational needs and circumstances so allow, it is best to apply a participatory approach for the implementation of this tool by holding a participatory assessment exercise or group consultations. This kind of exercise enables individuals of concern to be involved in describing the problems they face and any patterns of risks, as well as to identify challenges and possible solutions. Note that participatory assessments are held as part of the Country Operations Planning process, and may be applied to targeted or random sample populations. They are used to assess needs and protection issues / risk indicators in a systematic and reliable manner, and to complement this tool by assisting in the planning of proactive resettlement needs. Targeted group consultations may be used in addition to regular participatory assessment exercises. These may duplicate and / or supplement the effect of a participatory assessment by facilitating heightened risk identification and case management channeling, and may be particularly useful where a participatory assessment has not yet been held (e.g. due to an emergency or situational demands).

As circumstances do not always allow field operations to engage local communities by participatory methods, field operations may consult with local NGOs or experienced staff in order to gather information to compensate for the lack of community participation. This however, does not achieve the desired benefits of participatory methods which empower refugees in the process of identifying needs and risk indicators as well as ways to address these in terms of solutions.

In either case, due to the fact that this methodology lacks a certain degree of formality, only experienced staff should use it.

ii) Assessing staff must also be certain of the reliability and accuracy of the sources s/he uses to identify risk (e.g. individual's statements during visits). If the assessing staff has any doubts concerning the reliability or accuracy of the sources s/he uses, s/he should not proceed with this methodology and consider using a more formal process.

❖ **Step 2: Preparations (other preparatory measures).** Remain in Phase I (at p. ____). The purpose of this preparatory phase is to encourage early planning and implementation of whatever measures are necessary for a smooth and efficient use of this tool. The measures actually taken will vary depending on situational needs, however, they will frequently include actions such as:

- In order to allow efficient use of this tool, and because of the spontaneous nature of this methodology, it is particularly important that assessing staff using this tool be very familiar with its format and content;
- If necessary, staff should brief interpreters;
- Staff must ensure that an adequate referral system is in place;
- If personal contact with the potential at-risk individual(s) is likely, staff should also take whatever other preparatory measures are necessary under the circumstances (e.g. security measures, briefing an interpreter, etc.). See

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Phase I (at p. __) for additional suggested preparatory measures.

- ❖ **Step 3: Preparations (updating tick-boxes).** Turn to Phase IV (at p. __). Assessing staff should modify and supplement the questions and indicators in Phase IV, as appropriate, to reflect local circumstances that are specific to each field operation. This can be achieved by modifying existing indicators and by completing the 'Other' box (located at the end of each tick-box category in Phase IV).

These modifications can be made either on the basis of information collected i) through a participatory assessment or group consultation exercise, or ii) based on consultations with local NGOs, staff with extensive experience and knowledge of local circumstances, etc., as discussed in Step 1 above.

- ❖ **Step 4: Biodata.** Turn to Phase I (at p. __). Once the requirements of Steps 1-3 have been satisfied, users may utilise this tool when they encounter individuals whom they think might be at heightened risk on an ad hoc basis. Staff should record the required biodata in the box located at the beginning of Phase I before recording any additional data relating to heightened risk.

- ❖ **Step 5: Tick-boxes.** Turn to Phase IV (at p. __). When assessing staff encounters an individual of concern (e.g. during visits to refugee camps and / or urban communities), s/he should obtain his / her consent to information sharing with UNHCR partners. Once s/he has had an opportunity to listen to the individual's situation, s/he should make a preliminary assessment of the relevant box sections by ticking all corresponding 'Possible Heightened Risk Categories identified' tick-boxes. This should be done on the basis of i) the information acquired in the assessing staff's exchange with the individual, and ii) his / her pre-existing knowledge of local risks and circumstances. There are six possible categories (which reflect no particular order of priority or importance):

- Women / Girls at-Risk;
- Unaccompanied and Separated Children / Adolescents & Other At-Risk Children;
- Older Persons at-Risk;
- Survivors of Violence / Torture;
- Health Needs and Disability; and
- Legal or Physical Protection Needs / Other.

Based this preliminary assessment, staff should proceed to and complete the relevant tick-box sections in Phase IV. The information used to complete these tick-box sections may come up in various ways. For instance, individuals of concern may spontaneously volunteer information, or provide it as a result of informal open questioning by the staff (i.e. non-interview setting open questions). Staff has full discretion to determine the scope and duration of questioning in the context of this Methodology.

There is no specific category for men who are not elderly. If they have a significant health condition or a history of trauma their heightened risk can be identified under the relevant sections (e.g. Survivors of Violence / Torture or Health Needs and Disability). However if they don't but are at risk because they have no source of material support and access to food or other basic needs, it can be recorded under Health Needs and Disability as well as Legal or Physical Protection Needs / Other.

It may be necessary to tick off more than one heightened risk tick-box sections to record the existence of heightened risks. Note that there may be overlap between sections (e.g. an unaccompanied girl forced into prostitution may be accounted for in

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the Unaccompanied Child and the Women / Girl-At-Risk categories). When that is the case, staff should only proceed to the tick-box section(s), which s/he has preliminarily identified as most relevant to the person of concern. S/he need not complete other sections unless they also appear to be relevant to the individual, even if they contain the same indicator. Additionally, some tick-box sections may be irrelevant to the case at hand, and tick-box sections of this identification tool left out entirely as a result.

The tick-boxes are thematically clustered, and list known trauma, hardship, and other conditions indicative of heightened risk. Staff filling out the relevant tick-box section should do so in the presence of the person of concern, typically, by recording the information whenever a relevant fact or indicator is mentioned or witnessed. Direct questionnaire style interviewing may be used when appropriate.

'Past,' 'Present' and 'At-Risk' tick-boxes and 'High,' 'Medium' and 'Low' risk grading:

When ticking boxes, staff must indicate whether the trauma, hardship, and conditions apply to the person of concern (and / or her / his family member(s) / dependant(s)) in the past ('Past' tick-box), in the present ('Present' tick-box), and whether the person of concern (and / or her / his family member(s) / dependant(s)) is At-Risk ('At-Risk H; M; L' tick-boxes). In assessing whether the person of concern (and / or her / his family member(s)) is At-Risk, staff must indicate whether the risk is 'High' (H), 'Medium' (M) or 'Low' (L), as defined below:

- High: reflects a need for immediate intervention by UNHCR or a partner agency. Staff should immediately refer the individual(s) to the appropriate referral service(s), and follow-up with them on a weekly basis until they provide confirmation that they have received the referral and that they have taken action in connection with the individual at heightened risk. This will help ensure that the individual's situation is promptly and adequately addressed, and that the referral system is running efficiently;
- Medium: indicates that intervention should be scheduled and occur, but that immediate intervention is not necessary. Note that cases placed in the medium risk category can move into the high risk category if intervention is not followed through. Therefore, staff should implement a structured monitoring system to ensure adequate follow-up;
- Low: denotes that the regular referral system applies. Additionally, staff should review the situation of individuals at low risk at regular intervals, or implement another structured monitoring and follow-up mechanism to ensure that the case is handled adequately.

The 'At-Risk' tick-box is a very important element in the ultimate determination of whether the person of concern (and / or her / his family member(s) / dependant(s)) is at heightened risk. In assessing the appropriate level of risk to tick off, staff must consider the following:

- the existence of past and present experience, as well as the frequency and intensity of these experiences;
- the possibility that although it has not yet occurred, the risk factor is imminent. In such situations, a person might be at heightened risk, even though the indicator is not ticked off as 'Present' (e.g. an individual not presently involved in forced prostitution but at high risk of being forced into prostitution);
- the existence of coping mechanisms, mitigating factors, resilient personalities, etc. At the end of every tick box section, a box allows staff to indicate 'existing protective factors' to record such elements;
- where applicable, the chosen degree of risk should also reflect a weighing of

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likelihood and impact of the risk.

Graded At-Risk tick-boxes will be instrumental in determining heightened risk, urgency and the type of intervention required, and should therefore be completed with care and using a uniform standard. In order to ensure consistency in the use of such tick-boxes, teams using this identification tool should have a consistent and uniform understanding of the levels of risk. Although possibly subject to time, needs and resource constraints, harmonisation can be achieved by various means. For instance, staff using this tool can hold regular meetings to discuss difficult or ambiguous cases, one point person can be assigned to help clarify the doubts of users within an operation, or field operations may establish guiding parameters to help achieve a degree of consistency.

‘Self’ and ‘Family’ tick-boxes:

The tick-box approach also aims to reflect the circumstances of the family members and dependant(s) of any individual whose own risk level is being assessed. Therefore, the tick-boxes also allow users to indicate whether the risk factor applies to the individual herself / himself (‘Self’ tick-box), or to a family member(s) of hers / his (‘Family’ tick-box). In this context, the concept of ‘family’ should be interpreted broadly, with a view to include individuals with whom there exists a relationship of dependency. Note that dependency may be financial, emotional, or social, and that it does not necessarily require a blood relationship. For instance, a neighbor’s orphan child who has been taken into the individual’s home would qualify as a member of the individual’s family under this definition of ‘family.’ Additionally, the concept of dependency between family members can be mutual (e.g. where a grandfather is economically dependent on his grandson, the dependency relationship may apply both to the grandfather and to the grandson).

Sometimes, having a family member who is at risk will directly increase or compound the risk faced by a mother, carer, or older sibling, etc. As a result, each indicator can be completed for the person of concern and / or his / her family member(s). Where indicators may apply to several family members, and in an effort to keep this tool as user-friendly as possible, staff should use of the comments section to clarify any ambiguities concerning which family member(s) are at risk.

‘Impairment in daily functioning due to mental illness’ indicator.

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- Obviously confused thinking (e.g. such that responses are often incoherent);*
- Disorientation in time, place or person or marked inattention (i.e. unable to identify where / who they are, unable to follow conversation / interview);*
- Obvious loss of contact with reality (e.g. the person has highly unrealistic or bizarre beliefs);*
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The last row in each risk category is reserved for the identification of any existing protective factors. In this field, staff should record both internal and external coping mechanisms, such as a resilient attitude, UNHCR / community / family support structures in the camp and / or urban community, other mitigating factors, etc.

'Consolidated risk rating' box:

At the end of each section, staff should indicate the consolidated risk level applicable to the person of concern. In doing so, assessing staff should consider the number of boxes ticked off in each risk category, both for the person of concern and for any family members. The existence of protective factors should also be considered.

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Finally, below each of the six tick-box categories there is a field to record in more detail the item number and / or description of any indicator requiring clarification, comment, and / or follow-up. While encouraged to make use of the 'Comments' field, information about the person of concern and his / her family member(s) should primarily be recorded in the tick-boxes and consolidated risk sections, so as to avoid lengthy narratives and longer or more complicated processing.

Note that under this methodology, staff may complete this phase in the absence of the individual of concern. However, if clarification is required, the assessing staff should meet with the individual to obtain the missing information.

- ❖ **Step 6: Referral and Case Management.** Turn to Phase V (at p. __). In this phase, staff should make an overall assessment of whether collectively, the subjects of concern (comprising the individual in question and, if applicable, any family member(s) and / or dependant(s) of concern) is at heightened risk. To record this assessment, staff must identify whether the overall risk applicable to the subjects of concern is High, Medium, or Low, and tick the corresponding box. In doing so, staff

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should take into account any consolidated risk ratings made at the end of each completed section.

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Staff should then proceed to the referral chart, and complete it as follows:

- In the first column, staff should tick off the risk categories identified for the individual of concern and / or her / his family member(s) / dependant(s) (e.g. Women and Girls At-Risk, Survivors of Violence / Torture, etc.), indicating whether the risk category applies to the individual ('Self' tick-box) or to a family member / dependant ('Family' tick-box).
- In the second column, users should tick off the risk level corresponding to each heightened risk section.
- In the third column, staff should indicate the kind(s) of referral needed.
- Then, in the fourth column, staff should indicate how frequently they need to follow up for confirmation that the referral services have received the referral ('Weekly' or 'Other'). Note that this process is only mandatory for individuals at high risk. Ideally, staff should follow-up with referral services on the status of high risk referrals every week until they receive confirmation of receipt and action. However, if such a frequent follow-up is impossible under the circumstances, staff can select the 'Other' tick-box, and note the frequency of follow-up. Staff referring individuals at medium and low risk have discretion to decide appropriate follow-up and monitoring procedures according to their job descriptions. Once referral services have provided referring staff with confirmation that they received the referral and took appropriate action, staff is no longer required to monitor follow-up action, unless required to do so according to her/his work responsibilities.
- Finally, the fifth column allows staff to make any additional comment deemed appropriate.

- ❖ **Step 7: Consent and notification** Staff must also be sure to obtain the individual's consent with regards to information-sharing (especially where information is likely to be shared with non-UNHCR staff such as implementing partners or government officials).

Additionally, staff must inform the individual(s) and other relevant UNHCR staff of any subsequent referral or action. As this methodology involves a process that is less formal and structured than under Methodology 1 (the interview approach), staff must take special steps to ensure that consent and notification requirements are adequately complied with.