HIAS

HIAS Mental Health and Psychosocial Support Curriculum

Promoting Newcomer Mental Health and Wellness through Support Groups

May 2021

Introduction

How to Use the Training and Resource Annex

This Training and Resource Annex provides supplementary materials, resources, and tools to use in the implementation of MHPSS Support Groups. This Training and Resource Annex should be used alongside the HIAS Mental Health and Psychosocial Support Group Curriculum during the planning stages. The target readers for this Training Annex are program or project managers, supervisors, leaders, or individuals who will play the role of managing the support group.

The Annex contains materials aimed to enhance a support group facilitator's knowledge and skills to deliver a non-clinical support group. It contains:

1. Definitions of mental health and psychosocial support interventions and approaches
2. Recommendations on how to:
    a. Select skilled group facilitators, as well as a Sample Job Description for facilitators
    b. Conduct early-stage listening sessions with your community
    c. Conduct service mapping of mental health resources in your community and city and establish referral pathways for specialty and non-specialty providers
    d. Establish or improve safety protocol and safety response for situations of client crisis, escalation, and other safety risks
3. Information to use when training facilitators, including:
    a. Resources on cultural competency and examining personal biases
    b. Tips for working alongside interpreters
    c. A tip-sheet for facilitators to use before, during, and after each Support Group Session
    d. Self-Care tips and practices for facilitators

Each organization or provider should modify and localize their training and planning depending on the resources, capacities, and target demographics. We encourage the use of this Training and Resource Annex in the following ways:

1) **Use it as a starting point for training group facilitators;** In this document, providers can review critical topics related to MHPSS, facilitation, group dynamics, and other subjects. Providers can identify subjects that are strengths for your community facilitators and topics that require further training.
2) **Use it with other trainings;** Complement this Training and Resource Annex with other trainings or curricula. This Annex is not comprehensive. We encourage the use of other trainings or trainers available to your organization.
3) **Help with your planning;** Use this document in tandem with the HIAS **Curriculum Implementation Guidelines** available for download from the HIAS website. These two documents should be used together to review considerations that should be integrated before groups begin, in your planning phase.
4) **Create or improve critical protocol;** Read through HIAS' guidance below to create, improve, or identify gaps in your organization's protocol and practices related to: responding to clients in crisis or safety risks; conducting inclusive listening sessions; conducting landscape assessments and establishing referral pathways with other MHPSS providers, and other organizational practices.
5) **Develop learning and feedback processes;** Reference the facilitator tools and weekly feedback forms included below to integrate important learning, debrief, and feedback practices into your program planning and implementation.

HIAS' Approach to Training

During HIAS' implementation, HIAS conducted three online trainings for program management staff and facilitators, averaging 1.5 hours each:

1. **Training 1** focused on MHPSS foundations, including: MHPSS-based group interventions, concepts, and foundational knowledge; participant outreach, recruitment, and retention; and group dynamics and cultural considerations for MHPSS groups for newcomers.
2. **Training 2** detailed the HIAS curriculum and sessions, including: the content and activities in the 9-week curriculum, the structure of the curriculum, and dynamic facilitation strategies.
3. **Training 3** elaborated upon program management and evaluation, including: the importance of evaluation, the use of participant surveys and weekly de-briefs, and other program evaluation components.

In addition to these three online training, HIAS partners provided additional, localized trainings for support group facilitators. HIAS program management staff further created a peer mentorship model, to provide ongoing support to supervisors and facilitators alike on the curriculum's implementation. Keep in mind that different organizations can provide training to facilitators based on the facilitator's natural and learned strengths. Organizations are encouraged to localize their training models. Depending on skills and knowledge, facilitators can receive training on topics related but not limited to the following:

- Respecting confidentiality, promoting safety and trust, and establishing ground rules,
- Respecting and celebrating differences, cultural awareness, and practices to enhance cultural humility,
- Basic MHPSS principles, including but not limited to introductions to Mental Health First Aid, Psychological First Aid, Motivational Interviewing, trauma-informed care, self-care and wellbeing, and other elements of MHPSS,
- Group facilitation and adult education skills, such as: role-playing, active and emphatic listening, summarizing and re-phrasing, bridging and connecting ideas, careful use of self-disclosure, and other group facilitation skills,
- Identifying scenarios of safety, risk and referral.

Disclaimer

These training materials are not exhaustive. The material in this Annex is not a certified training program and does not subscribe to a specific training agenda or objectives. The use of this Training and Resource Annex should not take the place of other skill development resources on topics such as: Psychological First Aid, Mental Health First Aid, strength-based services, trauma-informed care, cross-cultural training, and other readily available trainings available to your organization. We strongly believe that facilitators leading MHPSS support groups can draw on their perspectives and experiences and that this Annex should complement but not replace valuable community skills, knowledge, and wisdom.

Definition of MHPSS Group Interventions

Overview: Group Interventions

When training facilitators, it is helpful to distinguish between different types of group interventions. Mental health and psychosocial support groups can be facilitated in both clinical and non-clinical settings. Overall, group work is a highly effective intervention strategy in supporting individuals experiencing mental health challenges towards recovery, healing, and resilience. HIAS's curriculum follows a model of non-clinical, community-based groups.

Clinical vs. Non-Clinical Group Support

Clinical group services are usually offered in a clinical setting, such as a mental health agency or hospital. These groups may require additional considerations, as group participants are most often enrolled in mental health services that involve insurance billing. Clinical groups need to be linked to the group participant's (client's) treatment plan and clinical mental health needs. Clinical group facilitators may also have access to the participant's mental health records with detailed information related to their bio-psychosocial history. Mental health agencies may provide both individual and group counseling options; they may recommend involvement in groups depending on the individual's needs and treatment plan goals. These groups can have different purposes, models, and structures, usually informed by the needs of the members and the setting the group is taking place. In the United States, clinical groups often adhere to state-required credentialing.

In contrast, **community-based groups** tend to be facilitated by trusted community leaders, lay persons, or paraprofessionals. Non-clinical groups may focus more on support, education, cultural identity preservation, and resource sharing, including linkage to other community supports. Non-clinical group facilitators may not necessarily have background information related to group members, or be knowledgeable of specific psychological approaches, or Western orientations related to mental health service provision. They may be knowledgeable of culturally-appropriate ways to nurture help, healing and wellbeing. Non-clinical groups aim to facilitate families and communities in supporting others in ways that restore and strengthen collective structures.

Benefits of Non-Clinical Groupwork

Group community-based interventions have many notable benefits when compared to providing specialized services. Community members are often the best to provide healing support to others, which can facilitate collective healing.[i] As noted in the curriculum, many mental health disparities exist for refugees and newcomers, who are often less likely to access and to utilize traditional outpatient mental health services. Other approaches, such as peer and community models, can have a positive impact on reducing stigma. Group community-based interventions can empower the community at-hand to address mental health issues from within the social structure of the community itself.

Community-based group approaches often center the experience of newly arrived refugees. Such support groups are an important vehicle to offering awareness-raising about the impact of the refugee experience and migration upon physical and emotional well-being. Typically, these support groups can impart information on how to access much needed social services, community resources, and strategies for navigating different health and human services systems, in addition to psychoeducation, stress management and overall wellness promotion.[ii] This is often in tandem with creating space to process common challenges due to resettlement, adjustment, or the asylum process.

Landscape Analysis Tool

Instructions: This tool comprises 10 questions to assess the current state of mental health and psychosocial services within your community within the United States. This tool can be completed by staff, individuals, or providers that are implementing an MHPSS Support Group.

This tool should be completed during the planning of MHPSS Support Groups, before implementation, to capture existing service provision. This tool will help providers:

(1) Understand referral pathways and resources
(2) Document the local mental health landscape
(3) Avoid duplication of community-based mental health support group efforts

After completing this questionnaire with your staff or team, HIAS encourages that you begin mapping new service providers and resources and maintain an up-to-date contact list. This should include clinical services, non-clinical services, sexual assault response, emergency care, and other service providers relevant to your target community. This referral list should be updated regularly and at least every six months. Support groups may be a first step to providing psychosocial care, but they are not the only approach.

1. **Do you know the Medicaid-supported mental health providers in your community, that provide culturally competent services to refugees and immigrants in your area? This can mean, but is not limited to: Medicaid-supported mental health providers that provide language interpretation, or that have a range of staff who share identities (racial, ethnic, religious, etc.) with individuals from refugee and immigrant communities, or that have demonstrated experience serving diverse communities, and/or are have received cross-cultural mental health training.**

   - Yes, I know most of the providers:
   - I know some of these providers, but not all.
   - I do not know of any Medicaid-supported culturally competent mental health providers.
     - If you are unaware of any such providers, consider connecting with other refugee or immigrant agencies in your area to identify additional resources. Investigate Medicaid-supported mental health providers that are accepting referrals.

2. **For the Medicaid-support mental health providers that you do know, do you know the eligibility criteria that a client must meet in order to qualify for services? A provider's eligibility criteria for new clients can include: a client's specific city/county of residence, age, gender, sexual orientation, mental health symptoms, etc.**
   - Yes, I know most of the eligibility criteria.
   - I am aware of some provider's eligibility criteria.
   - I do not know any of the provider's eligibility criteria.

3. **Is there an Office of Refugee Resettlement (ORR) funded program for Services for Survivors of Torture (SOT) in your area? Please list the program or agency name below.**

4. **Is there a community-based anti-violence or sexual assault response center in your area that provides care to refugees and immigrants? Does your community have a designated sexual violence treatment? Please list the name of the program or treatment center below.**

5. **Are there any Mutual Assistance Associations (MAAs)[1], Ethnic Community-Based Organizations[2] (ECBOs), or other Community-Based Organizations (CBOs)[3] in your community that offer therapy or mental health services to refugees and immigrants? Please list the ones that you know below.**

6. **Are there any faith-based groups in your community that offer therapy or mental health services to refugees and immigrants? Please list the faith-based groups or leaders that you know below.**

7. **Do you have any Federally Qualified Health Clinics (FQHC) in your community that support refugees and immigrants, and if so, do they offer culturally competent mental health care?**

8. **Do you have anyone on your staff that is dedicated to addressing mental health or adjustment issues? Please describe their role, if yes:**

9. **Does your agency have confidentiality/HIPAA procedures in place to ensure the safety of confidential medical information? Please briefly describe the confidentiality/HIPAA procedures in place:**

10. **Do you regularly coordinate with other agencies serving refugees in your community in the areas of physical health and mental health care coordination? Please list any relevant work groups.**

[1] Mutual Assistance Associations (MAAs) refer to refugee- and immigrant-serving community organizations that help newcomers navigate new systems that are part of everyday life. MAAs are often called "Mutual Assistance Association of _____ State/Community."

[2] Ethnic Based Community Organizations (ECBOs) have different definitions depending on the location and state; broadly, it is a non-profit community organization whose staff is mainly composed of refugees or immigrants that provides services for other newcomers.

[3] Community Based Organizations (CBOs) also have different definitions depending on the state and locale; broadly, they are non-profit community organizations that work at the local level within your community.

Strategies for Selecting Effective Facilitators

Identifying group facilitators is not an easy task. Below are some considerations for you to explore as you look to engage, train, support, and build community capacity for MHPSS support groups.

Characteristics of an Effective Facilitator

An effective facilitator for supportive group services can apply life experiences and knowledge and connect this to group participants' experience in a way that is inclusive, safe, and dynamic. Skilled facilitators can apply concepts of psychosocial healing, follow a curriculum—and make modifications as needed—while also raising the awareness of community assets, practices, beliefs, and traditions. This person can learn to recognize when extra support or referral of a group member may be necessary. A skilled facilitator can receive positive feedback from peers or supervisors, works to maintain group cohesion, and remains flexible to the participant's needs and desires that arise throughout the support group.

Keep in mind that some community members may feel comfortable with the selected facilitator, but others may not—be open to exploring this over time. Facilitators can learn to recognize how their own social positionality (e.g., race, ethnicity, socio-economic class, gender identity, sexual orientation, etc.) shapes their perspectives and reactions.[iii] Be aware of the effect this may have on group dynamics.

How to Identify Leaders from within the Community

- Through community needs assessments, such as a listening sessions or focused discussions, during which a natural leader may arise
- Through referral or recommendation by other service providers, or word-of-mouth
- Through advertising with a job description
- Through past or current clients with demonstrated strengths

Important Considerations

1. Has the facilitator received any training related to the following areas?
   a. Cultural orientation approaches, group facilitation, Mental Health First Aid or Psychological First Aid, responding to trauma, and knowing how to recognize and make referrals for specialty mental health care
   b. If they are an interpreter, any training related to sensitive topics such as mental health, or other health or family related issues that may be stigmatizing (e.g. a person living with a disability, someone living with HIV/AIDS, or families experiencing violence in the home)
2. Have they, a loved one, or a community member they know received group support or clinical mental health services? If so, what are their beliefs and perceptions around supporting someone that is experiencing mental health challenges?
3. What is their belief around supporting the mental health and well-being of community members in general?
4. What have they found to be helpful to support natural healing? What have they found to be helpful for adjusting to life in the United States?
5. What are their beliefs around confidentiality? How do they describe this concept and how does it relate to them personally and within the context of group programming?
6. Are they familiar with boundaries and if so, what are some common practices they use to ensure professional boundaries? How do they manage being in a "dual role"? Can they maintain careful use of personal disclosure?
7. What do they consider to be important skills and abilities for group facilitation?
8. How familiar are they with principles of adult education?
9. What techniques do they like to use when facilitating (lecture, sharing stories, dialogue, etc.)?
10. Do they have experience role-playing, modeling, rehearsing or coaching others in an education context?

Sample Job Description for MHPSS Support Group Facilitators

During internal implementation, some HIAS partners used a Job Description to recruit and hire facilitators. HIAS partners provided a paid stipend to all community facilitators. HIAS strongly recommends that any community facilitator is monetarily compensated for their role in the MHPSS Support Group.

Sample Program Description

[Organization] is launching a new program aimed at providing members of the refugee and immigrant community with tools, skills, and knowledge in the topic of Mental Health and Psychosocial Support (MHPSS) *[during/after]* COVID-19. The program will convene a *[virtual/in- person]* support group for a 9-week period, bringing together members of the refugee and newcomer community within the *[region, city, state].* The support groups will follow an MHPSS curriculum covering topics including psycho- and trauma education, community healing, family and community-resilience building, and culturally appropriate coping strategies for refugees and immigrants. *[Organization's]* goal is to create an improvement in mental wellness and psychosocial wellbeing of program participants and equip them with skills to identify, refer and access mental health resources. This *[virtual/in-person]* mental health support group will be facilitated and delivered by community members, in a community-based group model. One of the best ways to promote mental health and wellbeing is to strengthen existing relationships, networks, and practices that communities use to cope and heal, thereby improving community resilience.

Sample Job Description

[Organization] seeks a *[part-time/hourly/stipend/etc.]* Community Facilitator to lead a virtual Mental Health and Psychosocial Support group. The support group will serve refugees and newcomers in *[region, city, state].* The Community Facilitator will be responsible for co-delivering a curriculum in mental health and wellness for a 9-week week period, beginning in *[date].* Community Facilitators will work alongside a member of *[organization's]* staff to deliver prepared content related to: common reactions to a global pandemic, principles of Psychological First Aid, cultural adjustment, and family resilience. The Community Facilitator will facilitate the group curriculum on a weekly basis *[in-person/virtually/over Zoom],* outreach to group members, identify group participants that need more support or referral, help respond to the needs of newcomers during the COVID-19 pandemic, and support the program's overall delivery. *[Organization]* will provide ongoing training and support to the Community Co-Facilitator on the curriculum, principles of mental health and wellness, as well as group facilitation, as needed.

This position is ideally suited to a *[language-speaking]* community member with some knowledge of concepts of mental health and some past experience working with members of the target community or facilitating a support group. No clinical background or licensing is required. The Community Facilitator should be willing and able to apply life experiences and connect this to group participants' experience in a way that is inclusive, safe, and dynamic. This person can learn to recognize when referral of a group member to specialized mental health care may be necessary. A skilled facilitator can receive positive feedback from peers or supervisors, work to maintain group cohesion, and navigate group dynamics.

Sample Required Qualifications

- Candidates must possess good communication with ability to speak at a level of ease of English *[and participant language*] fluency. Reading and writing at a level of English fluency *[is not/is]* required.
- Candidates must be willing to commit to *[hours]* per week beginning in *[start date]* until *[end date]*
- Candidates must be comfortable interacting with refugee and immigrant communities with a high degree of sensitivity to new arrivals and refugee groups who may lack family or community tie,s and may experience multiple barriers to accessing key services.

Sample Preferred Qualifications

- Candidates have preferably received training related to group facilitation, Mental Health First Aid, responding to trauma, and/or knowing how to refer for specialty mental health care.
- Candidates have preferably received, or known a loved one or community member, to receive mental health support, clinical or non-clinical. Candidates should have open and receptive beliefs around supporting individuals who are experiencing mental health challenges.
- Candidates should have strong beliefs around client or group member confidentiality, be familiar with professional boundaries, or be willing to learn and apply concepts of confidentiality.
- Candidates should preferably have experience with group facilitation, adult education, popular education, *[and/or virtual learning techniques].*
- Candidates should be comfortable communicating with group participants through a variety of platforms, such as WhatsApp, Text, Google Voice, and Zoom.

Sample Contact and Anticipated Timeline:

Interested candidates should contact *[name, contact information]* with an *[email, phone call, etc.]* of interest. The position is set to begin by *[date].*

Group Dynamics: Key Topics to Review

We recommend that program management staff, supervisors, or leaders review these key topics with facilitators related to group dynamics and group facilitation, in advance of support group implementation. Facilitating an MHPSS group can be very different than working with an individual one-on-one.

Key Definitions

Group Dynamics refers to the forces that result from interactions of group members. This can be understood in terms of individual interactions between members of a group, or the "group as a whole." These dynamics can have an impact on how a group functions or reaches its desired goals. For example, if trust and safety is not fostered within a group, members may be reserved and guarded; this can reduce the effectiveness of a support group's goals. Group dynamics deal with the attitudes and behavioral patterns of a group.[iv] They are influenced by how groups are formed, their structure, and the processes that are followed in their maintenance. Group dynamics may also be influenced by the identity of the facilitator as well the group's composition.[v] Sometimes a community support group may take a life of its own; this is often due to the interplay of the different personalities, behaviors and cultural interactions that evolve in the group process. This may result in harmony, or occasionally lead to conflict or different inter-personal group dynamics.

Do No Harm is an important principle that requires providers to strive to minimize the harm they may inadvertently cause through providing assistance and aid.[vi] As mental health support groups can discuss highly sensitive topics, they have the potential to cause harm. Facilitators should aim to adhere to ethical standards of participant engagement and avoid harm to participants. Potential harm to group members can be reduced by meeting group members "where they're at", [vii] developing cultural sensitivity and competence, committing to evaluation, critical thinking and reflective approaches, and consistently reflecting on power relations in-between newcomers and organizations—as well as in-between group participants and group facilitators.

Know Your Limits as a Facilitator

When training facilitators, it is helpful to emphasize the roles, responsibilities, and limitations of being a facilitator. This can help the support group run more smoothly and effectively, and also sets up important boundaries that promote self-care and prevent burn-out. Group work is complex and requires a great deal of skill, attention, and thoughtfulness—as a facilitator, there are ethical responsibilities and limitations to the support that can be provided to participants. Remember that:

- Facilitators are not being asked to be mental health experts or therapists. It is important to recognize when an issue that arises in group may be better handled by a mental health professional and that requires referral. Facilitator can refer a group member to other needed supports, if case management, basic needs, or mental health concerns arise. See **Prepare for Client Referral** in the accompanying **HIAS Curriculum Implementation Guidelines,** available for download from the HIAS website. Follow-up and referral can be an effective way of setting appropriate boundaries.
- Facilitators can redirect an individual or group if the content is feeling uncomfortable or outside of the facilitator's job responsibilities. Facilitators can politely interrupt group members who are taking too much time during Check-Ins or discussions and redirect and remind participants of the purpose of the group.
- Facilitators should not be implementing support groups in a vacuum. It is important for facilitators to seek supervision as needed, reflect on their own limitations and seek supervision, and be provided with ongoing organizational support.

Cultural Competency within Groups

Throughout the support groups, facilitators are encouraged to remember that culture is not static or universal —it changes over time. It can be important for facilitators to receive training on cultural competence and humility.

As referenced in the **HIAS Curriculum Key Concepts,** culture is very nuanced. It does not only include one's country of origin, language, and religion. Culture includes how one develops their identity while living through life-changing circumstances.[viii] Culture can often dictate group behaviors and can therefore influence an individual's role in society—as well as in a support group.[ix] There is more variability within a single culture than not; it is important to not assume that everyone has been through the same experiences. Review the following recommendations:

Reflect on their own personal identities and cultural background. How a person interprets and makes sense of their lives is crucial, and this may differ amongst individuals, even when sharing the same cultural group membership as a group participant. For example, in many cultures, age and gender may influence an individual's power, status, or expected role and authority in society.[x] Cultural factors, including attitudes, beliefs, can determine the type of support an individual can get from their family, community, and society when it comes to mental health. Facilitators can complete the *Iceberg Identity Exercise* below, which invites you to reflect on different aspects of your identity that inform how you experience and are seen in the world.

Support the practice of self-awareness. Self-awareness, like cultural reflection, allows the opportunity to explore areas of one's identity in relation to different dimensions of their lived experience (for example, their race, gender, sexuality, nationality). A *Diversity Wheel* is often used in cultural competency training as it allows persons to better see areas of similarity and difference. Consider using the Diversity Wheel below to allow facilitators to reflect on themselves in terms of their role, status, or privilege that may be in direct relationship or difference to another group member.

Avoid generalizations about specific cultures. Although facilitators may already have exposure to diverse refugee communities, a facilitator should make efforts to understand varying participant mindsets and ways in which participants may view the world differently. One important note is that although culture can be a group characteristic, even within the same cultures, individuals can have different social positions, ages, incomes, health statuses, class positions, and migration journeys.[xi]

Adopt a learning approach based in cultural humility. This approach is continuous and never fixed in time; it entails being open to learning about a client's cultural explanations of the causes and consequences of their experiences, including their psychosocial health and wellbeing.[xii] When we use a culturally humble approach, we embrace differences with respect and equanimity toward others. This may entail challenging one's own cultural biases and socially engrained identities, as well as one's power and privilege.

Remember that marginalized members of a cultural group may have different experiences. For refugees and other persons that have been forced to migrate, many do not identify with their dominant cultural group. This may be due to an experience of persecution or oppression on the basis of their identity. Or, participants may have fled their home country a long time ago – they may not identify with the culture of their home country, and there can be sensitivity around that. Knowledge of variance within the same cultural and national group can ensure that participants are not alienated, or do not feel generalized.

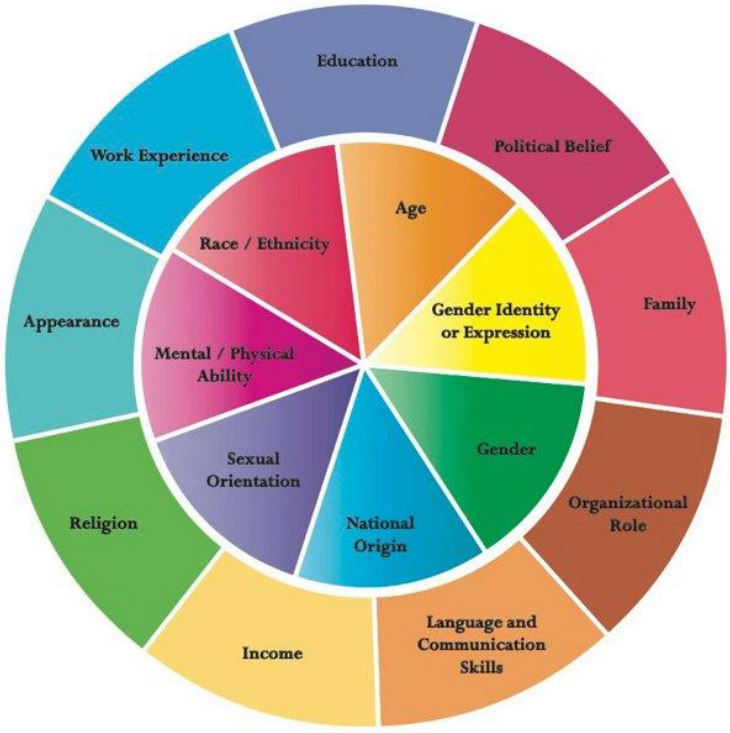

Figure 1: Johns Hopkins University Diversity Wheel[xiii]

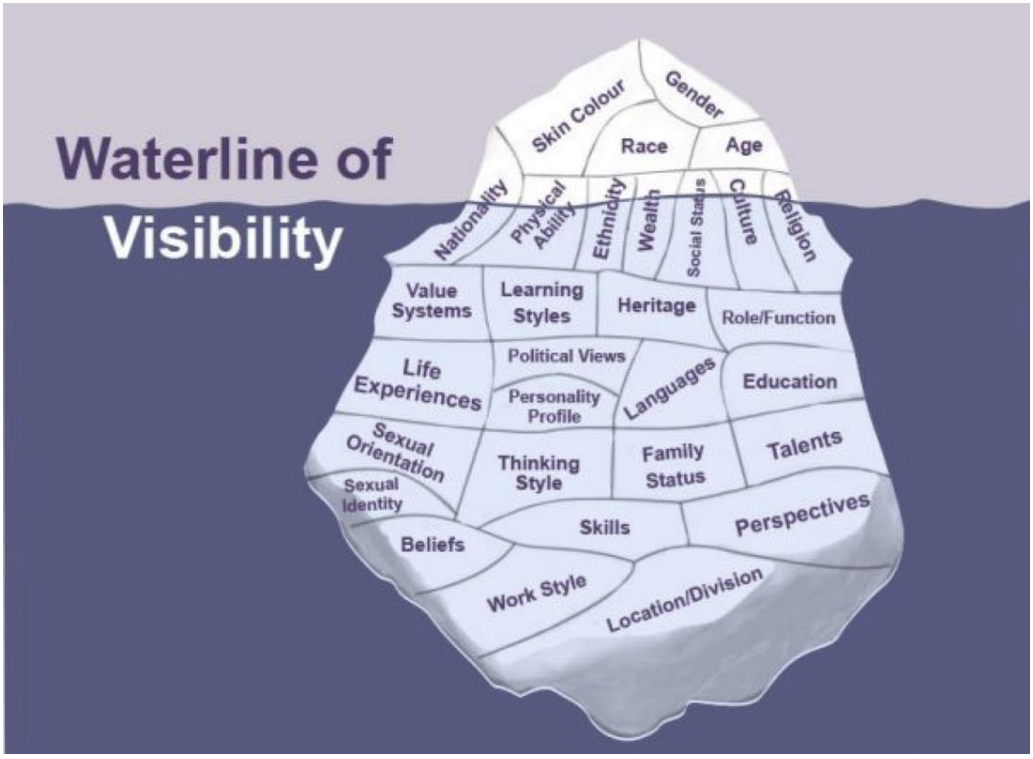

Figure 2: Iceberg Identity Exercise[xiv]

Key Definitions: Biases in a Group Context

When training facilitators, define different types of biases and the impact this may have upon individuals.

Bias can be defined as a personal attitude or perspective that is not impartial and tends to prefer one viewpoint or one social group to another. Bias is often unconscious. Whether conscious or unconscious, it may lead to prejudice and acts of discrimination against an individual or group, and these behaviors may manifest in group-related work. Sometimes these biases are obvious to recognize and sometimes these are implicit.

Explicit bias occurs when there is awareness of prejudices and attitudes directed toward certain groups or individuals. In contrast, **implicit bias** is used to describe when attitudes towards people, stereotypes, or beliefs occur without our direct conscious knowledge. Thoughts and feelings are "implicit" if we are unaware of them. We have a bias when—rather than being neutral—we prefer or develop a judgment or aversion toward a person or group of people. The term "implicit bias" is used to describe when we have attitudes towards people or associate stereotypes with them, without our conscious knowledge of our attitudes.[xv] In addition to completing one's own, Diversity Wheel above, HIAS recommends facilitators complete their own implicit bias test through an online tool available at: www.projectimplicit.com.

In-group and out-group membership is another helpful term to review with facilitators. People often view and consider groups in society in one of two ways: they appear to belong to our own social group (in-group), or they do not (out-group). We knowingly or unknowingly regard "in-group" membership in more positive ways, perceiving them as safer or more accepting. From infancy, we perceive people in terms of such groups based on social categories such as race, education, native language, and so on. We tend to be biased for the people we see that are "like us" and may develop aversion towards those we feel are different from us—but we are not usually conscious of these biases. By exposing ourselves to other perceptions and values, we can learn to train our mind to accept these differences in an inclusive fashion.

Considerations for Interpreters vs. Co-Facilitators

We highly encourage that support groups are led in the target language of the support group members. However, some situations may arise when groups might be led or co-led by someone who does not have the required fluency in the target language and would need support with interpretation. Many community-based organizations working with newcomers might be familiar with models of interpretation. In these support groups, HIAS recommends a model of **co-facilitation** instead of **direct interpretation.** Co-facilitators in community-based support groups play an active role in the delivery of content and management of the group. We offer some distinctions between a traditional interpreter and a co-facilitator in the chart below.

	Interpretation	**Co-facilitation**
Prior Training	Interpreters and providers should have received training on different techniques, such as a professional course or certification. Facilitators and interpreters might speak before each session to ensure understanding of sensitive words and themes, such as mental health. However, interpreters would not receive robust training in the curriculum content.	Co-facilitators will ideally have training in interpretation skills, procedures, and practices – see the tool "C.I.F.E." for reference.[xvi] However, co-facilitators also should be trained on curriculum content, engaged in planning and preparation, and the topics in the Training and Resource Annex. Co-facilitators should be poised to lead or co-lead weekly sessions.
Confidentiality	Interpreters should be trained in confidentiality.	Co-facilitators should be trained in confidentiality.
Role	Interpreter's role is on the sidelines, interpreting verbatim the words of the participant and facilitator. An interpreter does not add or subtract any spoken content from either party. Interpreters are not asked for personal opinions; they are only the voice of the provider.	Interpreter's role is as part of the facilitation team. They can lead content, manage the group dynamic, serve as a facilitator of the curriculum and interacts directly with participants. Co-facilitators can be valuable sources of explanation and frame concepts in culturally- appropriate ways. Interpreters can elaborate on concepts to enhance group comprehension.
Timing	Standard interpretation may double or triple the time length of each of weekly session.	Co-facilitation may slightly increase time length of sessions, but not by a significant factor.
Consistency	Interpreters may change from session to session, with no continuity or long-term relationship-building.	Co-facilitators should be a fixture of the entire group, build relationships, and attend consistently.

(continued)

	Interpretation	**Cofacilitation**
Comprehension	The facilitator understands all content delivered and received, via the interpreter.	The primary facilitator may not understand all content; throughout the session, the co-facilitator may speak directly with the participants for long stretches of time, only pausing to update the facilitator, request support, or seek advice during these periods.
Dynamic	Interpreters may not be involved in planning before and after each session to share feedback and learnings.	Facilitators and co-facilitators should engage in robust planning to determine their roles and responsibilities. Co-facilitator cultivates their leadership and facilitation skills; facilitator and co-facilitator both lead and guide each other.
De-Brief	Interpreters may not be involved in weekly de-brief.[xvii]	Co-facilitators may come from similar lived experiences as the persons for whom they are providing language assistance. They may be deeply affected by the content they hear during interpretation and could suffer from vicarious or secondary trauma. Debriefing should occur or a support system should be available for interpreters, just as for facilitators.[xviii]
Outreach	Interpreters are involved only during the weekly sessions; they are not contacted by group participants in-between sessions.	Co-facilitators may be contacted outside of the group setting to request additional support or guidance.

Strategies for Outreach and Retention

Sample Participant Outreach Script

The following outreach and engagement script can be used with participants:

> "*Through participation in the support group, we aim to increase your resilience during/in the aftermath of the COVID-19 pandemic. As we support each other in the community, each one of us can provide each other with caring and encouragement to do things that help us cope with stress and gain a sense of control over our lives. Even though it is hard to be connected to our usual support networks while remaining at home, we can find creative ways to stay connected (like through this group)!"*
>
> *"In our group, we will learn about practices and habits that reduce our stress level and allow us to feel calmer. By knowing more about common stress reactions and utilizing these principles, we hope that you will be able to enhance resilience in yourself, your family, and in your community. This is a practical approach that we can take in supporting each other today; it does not take the place of seeking additional support for mental health needs."*

Tactics for Promoting the Group in Your Community

As referenced in the curriculum, "framing" the group is an important tool in recruitment. Other tactics include:

- Using flyers, social media, or e-mail list-serves in your community that serve refugees and immigrants,
- Outreaching to trusted community-based organizations and that work with refugees and immigrants; connecting with community leaders, or refugee resettlement agencies in your area,
- Outreaching to existing clients, if your organization already serves refugees,
- Using de-stigmatizing titles to describe the group, such as "Adjustment Group" or "Support Group," which may be more inviting than "Emotional Health Group" or "Mental Health Group." Due to the presence of mental health stigma in many cultures around the world, be mindful of the language being used to promote or describe a group.

Strategies for Encouraging Participant Engagement

As mentioned in the curriculum, engaging participants *throughout* the group is an important tool for encouraging group members to return every week.

- Facilitators may choose to follow up with group members through social media platforms, such as WhatsApp, a secure Facebook group, or through regular phone-check ins to ensure ongoing participation and engagement. For some group participants, this may be a helpful way to ask clarifying questions or gather more information about the sessions topics or other areas that may be of concern for the community member. This helps to build cohesion and a sense of ongoing connection which is especially important during a time of disconnection, due to living in a pandemic.
- Depending on resources available, facilitators may choose to provide gift cards, food and drink, or raffle gifts or items for participants each week. Participants with limited time may be more likely to participate in a weekly program if financial incentives can be provided, although this may not be the case for all participants.

De-Escalation in the Context of Group Support

De-Escalation in the Context of Support Groups

When training facilitators, it is advantageous to offer guidance on how to de-escalate in times of crises. Newcomers that participate in a group may have experienced trauma or distress in the past or are currently coping with stressors, the trauma of resettlement or other adversity. During the MHPSS Support Groups, there may be situations in which clients become overwhelmed. Some group members may have emotional reactions to the curriculum content or to the content shared by a fellow community member. As group dynamics take a shape of their own, there may also be instances of individual or group triggering, a group member dominating the conversation, or other conflicts.

If a group member is experiencing distress or is in an active crisis response, facilitators have an important task of using de-escalation tactics. Facilitators have an opportunity to redirect the group as needed, reinforce cohesion, support healthy communication, and model de-escalation.

Key Definitions

A **crisis** is a time of intense difficulty, trouble, or danger that overwhelms an individual's ability to cope and that involves some risk to the person or others. Crisis may be associated with any area of a person's life, including finances, relationships, physical and mental health, employment, safety, and more. A crisis can be a safety risk – such as risk of suicide, gender-based violence, or other abuse that requires emergency response. However, a crisis can also occur for participants during a group session, if a participant becomes emotionally escalated and cannot function.

Escalation is a term used to describe situations where a person's thoughts, feelings, and emotions overwhelm them and make it harder to cope, listen, or act effectively. When someone is escalated, it may or may not be a crisis.

In contrast, **de-escalation** is a term used to describe what happens when a person moves from an escalated or a heightened state back to a more balanced state. It is here where their ability to cope, listen, or act effectively returns. De-escalation is sometimes referred to as "returning to calm, or the "here and now."

The "**fight/flight/freeze**" response can be awakened among group members during an MHPSS support group. This may naturally arise in a community group setting, as members hear from others about similar lived experiences or relate to the content in significant ways. Trauma response may become active when experiencing things like stress, uncertainty, and frustration, that source from the personal stressors in the lives of participants, outside of the group context. This may cause people to exhibit behaviors in the group that could be concerning or disruptive to the group.

How Can I Plan Ahead to Address Escalation and Crisis?

Keep in mind that specific stress events, such as: loss of a job, domestic violence, living in a pandemic, or losing housing can cause stress that may lead to escalation or a trauma response. Even if you are unaware of the stress events taking place in the lives of specific group members, it's best to be prepared for how to handle de-escalation in a group setting.

Active, in-group prevention is the best way to manage crisis situations. The facilitator should consider the following during each session:

- **Self-reflect:** What are you, as the facilitator, thinking, feeling, and doing? Are you paying attention to the group members body language? Are you experiencing strong and normal emotions yourself, such as fear, grief, anxiety, or doubt?
- **Stay aware of Group Member(s):** Ask yourself, what is this person thinking, feeling and how are they doing? Do they feel threatened, frightened, helpless, powerless? Is their body language showing increased signs of agitation or overwhelm?
- **Examine the Environment:** Is the virtual setting to chaotic, noisy, or overwhelming for them in some way? What other factors could be contributing to how the person is doing? [1]

How Do I Recognize Escalation?

Many escalated situations begin gradually and with some common signs that things are getting worse – these are called **warning signs**. Warning signs can help us decide what kind of response is needed: creative space in the group to process moments of escalation together or providing one-on-one support.

For example, a group member may:

- Withdraw their participation
- Raise their voice or display a lot of frustration, anxiety, overwhelm, or grief
- Become noticeably agitated or squirm in their chair
- Have a red face
- Become unusually quiet
- Start trembling
- Appear suddenly unfocused or detached from the conversation
- Cry or demonstrate other forms of upset

These emotional responses alone to do necessarily mean someone is escalated. Note that there are numerous ways in which individuals communicate thoughts, feelings, and emotions, depending on cultural norms. However, if it impacts their overall functioning and they do not report to you or appear to be getting better, *further action is needed*. If someone is upset or appears escalated during the group, there are several strategies included below that may help de-escalate the situation. These tactics benefit both the individual affected and the group members.

How Do I Respond to an Escalated Situation?

In-Group Tactics for Group Members in Escalation[1]

1. **If you feel your own emotions rising, work to remain calm.** *Breathe deeply. Actively work to allow group members to stay calm by demonstrating this yourself. If you feel yourself getting upset or if you feel unable to remain calm, request support from a supervisor or colleague.*

2. **Use neutral, non-threatening body language.** *Nonverbal communication is important, even with a virtual platform. Convey a posture that communicates you care and that you are listening. Be present, and use facial expressions, eye contact, and body language to convey to the participant that you are listening, to the extent possible over a virtual platform.*

3. **Actively listen without judgement and respond with empathy.** *It is extremely important that as a facilitator, you validate the client's emotions and listen without judgement. This can be done non-verbally (for example, by nodding your head) or verbally, (for example, by saying something like: "That does sound overwhelming" or "that does sound scary"). You can reflect, repeat back, or paraphrase what the participant says to be sure you understand but minimize your own opinions or observations. Empathize with the participant, show compassion, and let them know they are not alone.*

4. **Do not engage with provocative statements or rhetorical questions.** *Engaging with these can further escalate the situation and does little to honor where the client is at. Try to validate the client's underlying sentiments. For example, a client might say, "I am so overwhelmed, I have too much frustration" and you could respond, "I can see you are frustrated or may be having some reaction to what we are discussing today."*

5. **Keep responses simple, focusing on the present moment. Keep questions to a minimum.**
    a. *When people are overwhelmed, it can be difficult to concentrate, take in a lot of information and make concrete choices. Respond to what the client is saying and wanting in the active moment, as simply and clearly as you can. For example: "I can see that this may be overwhelming to talk about."*
    b. *In an escalated situation, you may choose to offer a grounding exercise to encourage the individual to come back to the present moment. You will need to decide if is best to offer this as a one-on-one support or during the group, depending on the severity and safety of what the group member is experiencing. Be aware and sensitive to how other group members may react.*

If a group member is escalated, follow your organization's protocol or the steps below to support that group member. Adjust tactics according to your organization's guidance and the scenario at hand.

How Do I Respond to Crisis?

Assess Warning Signs and Identify the Situation

Identify if it is an acute crisis or an escalation situation. If a community member is experiencing acute crisis, follow your organization's safety protocol. You can also reference HIAS' **Safety Guidelines** below, for additional information about how to create these protocols in advance.

Provide Crisis Response Tactics

If a group member is in crisis, follow your organization's protocol or the steps below to support that group member. Adjust tactics according to your organization's guidance and the scenario at hand.

In-Group Tactics for Group Members in Crisis[1]

Step 1: Preserve Safety: Consider using a safety statement or alternative way to ask how others are doing.

Step 2: Consider a Group Exercise: Grounding exercises help participants return to calm or the present state and can help to de-escalate a potential crisis. Offer a simple grounding exercise to all group members.

Step 3: Dismiss the Group: For the person in crisis, offer a gentle opportunity for them to leave the session. If they are unable to do so or choose not to proceed, use your judgement to end the group session if necessary to preserve the safety of the group cohesion and the individual.

Step 4: Implement Safety Protocol or Call Emergency Number or Crisis Line: If you feel that you are not able to safely handle a crisis, please follow your safety protocol, or call the emergency number and allow trained professionals to offer a risk and wellness check.

Step 5: Self-Care: Once the crisis has been resolved, you may find that you are feeling overwhelmed, exhausted, or triggered. Take time to practice your own self-care.

Step 6: Reflect and Learn: De-brief with your team and the group members in a follow up meeting or session.

What are the Next Steps after an Escalation Experience?

Any time a crisis or situation is de-escalated in a group setting, it is a good idea to revisit and reflect. We strongly encourage reflecting with group members as well as staff who participated in that session.

- **Follow up with the individual:** Depending on the situation, you may choose to follow up privately with the person(s) who was escalated and offer further support, remembering to actively listen. Once they are completely de-escalated from the moment, assess if they may need additional mental health resources, case management resources or referral.
- **Follow up with group members:** If escalation occurred in the presence of other group members, take a moment to reflect on any moments of community support: did group members support a fellow community member? Did they provide any assistance in returning to a more balanced state? Remind the group members of the purpose of the group and redirect the group as needed to reinforce cohesion and healing.
- **Follow up with colleagues:** Among your colleagues and co-facilitators, examine what should be done again if a similar situation arises. Share how your facilitator(s) helped support a group member in the moment or if there are areas of learning. It can sometimes be emotionally difficult to witness a member of our community undergo escalation or crisis. It is important to share with your colleagues if you need any additional support from witnessing escalation, to carve out space to de-compress as a group or individually and receive the necessary emotional support before entering next week's session.

It is important to continuously add to your own "De-Escalation and Crisis Toolbox." We strongly encourage you to practice tactics in a safe place (e.g., with colleagues, in a training, in the mirror). Make the techniques your own so you'll be comfortable using them when they're needed.

Group Dynamics: Safety and Risk Considerations

The following considerations are for your organization to reference and are not intended to replace any organizational, local, or state risk and/or safety protocols already in place. This guidance document is primarily written for supervisory staff as they prepare for MHPSS Group implementation with facilitators.

Safety Planning in the Context of Support Groups

It is helpful for facilitators to have a working knowledge of risk and or safety related issues and develop ways to respond to them. Group facilitators may be the first person to respond to the psychosocial needs of group participants. This may be in addition to the role as a community facilitator or mental health worker. Developing familiarity with signs to look for, and how to support community members who may not be functioning well, is important.

Facilitators can listen deeply for any safety related issues, like violence in the home, abuse toward children, or intentions of self-harm or suicidality. In these situations, it is critical to always function within your role and be alerted to any specific safety issues by following your organization's specific client safety protocols or policies.

If you are a facilitator that is not affiliated with a community-based organization and there is no existing safety protocol in place, it is strongly advised that you develop a community collaboration or partnership with a community-based mental health agency or a primary care clinic in which you can refer clients should they be experiencing acute issues. Having on hand a county or clinic crisis line is also a good practice.

When training facilitators, it is critical to offer training on how to respond to safety and risk related issues and risk-related concerns that may arise amongst participants of a support group. Safety and risk- related concerns include but are not limited to: sexual and gender based violence, abuse and neglect of children, seniors, and dependent adults, and intentions of harm to self or others, or suicidal thoughts. Sometimes, client safety needs overlap and may be equally important. Some safety needs must be addressed immediately, some within a short timeframe, and others are long-term processes. As a result, this guidance document offers strategies for developing specific protocols for responding to varying levels of risk.

Why Do We Need Safety and Risk Protocols?

Refugees, immigrants, and other newcomer groups may face unique risk factors before, during, and/or after migration that can place some clients at higher safety risks, in particular during COVID-19.[i] Sometimes, a group facilitator may be a newcomer's only trusted support during a time of crisis or stress. Due to regular contact, group facilitators may also pick up on critical warning signs. As a result, a facilitator may be the first person to respond to the psychosocial needs of someone in crisis. Although certain safety risks can be difficult to predict, knowing how to respond with action steps can help clients at risk remain safe.

Safety plans can be used in many different situations. Some examples of times when a safety plan would be appropriate include situations of intimate partner violence, during situations in which a client expresses thoughts or articulates a plan of ending one's life, or in situations in which a client identifies difficulty in one area of life that is causing significant emotional distress, and situations in which a client lives in a dangerous neighborhood.[xix]

Areas to explore in safety and risk assessment include: understanding risk, danger and urgency level, client needs and wants, as well as identifying resources, strengths, protective factors and other supports.

Key Definitions

A **safety protocol** is a procedure or system implemented by an agency or organization to respond to safety concerns. Safety protocols could vary from program-to-program but should be formally established prior to the start of the program. It is important that supervisors ensure that relevant staff are aware of the safety protocol to follow.

A **safety plan** is a personalized, practical plan developed during a time of relative stability (i.e., not during an active emergency) that can help a community member avoid dangerous situations and take steps to remain safe when in danger.[ii] Safety plans can be used in many different situations. A safety plan is a summary of coping strategies and sources of support a client may use during or preceding a crisis situation. A safety plan should be realistic, easy to remember, and tailored to an individual's unique situation. Safety plans could be appropriate in a variety of settings, including in situations of Intimate Partner Violence (IPV), suicidality, significant emotional distress, or in a range of situations or environments when an individual fears for their physical safety or wellbeing.[iii]

A **crisis** is a time of intense difficulty, trouble, or danger that overwhelms an individual's ability to cope and that involves some risk to the person or others. Crisis may be associated with any area of a person's life, including finances, relationships, physical and mental health, employment, safety, and more.[iv]

Best Practices for Developing Safety Protocol

Below are six themes that should be considered in the establishment and execution of safety protocols.

1. Review and Update Existing Protocol

Address new risks Check to determine if your organization already has a safety protocol in place. Consider any adaptations, additions, or considerations that might be relevant to the MHPSS Groups. If your organization is undertaking new programs or work activities that are linked to new risk areas, protocol should be updated accordingly. Organizations that are prepared for new risks can ensure that staff have sufficient resources and training in advance of a crisis.

Address COVID-19 modifications Protocol should be reviewed and updated to prevent and reduce transmission of COVID-19 and maintain healthy work practices during crisis response.

2. Tailor Protocol to Local Context

Conduct service mapping – Safety protocols should be clear, concise, and suited to the local context. In the context of the MHPSS Support Groups, it is strongly recommended that agencies complete service mapping. This will allow you to chart relevant mental health providers in your area, including emergency and crisis response contacts and other resources that can complement safety planning for clients experiencing acute issues. This vital step will ensure that you have a list of resources on-hand if someone needs an immediate or any referral.

Integrate your organizational strengths – For refugee organizations working within a resettlement context, there are distinct advantages that can be brought into safety protocols. Organizations can integrate safety and mental health prevention into Resettlement and Placement, cultural orientation, and other programs. Your organization may wish to enhance conversations during early resettlement to normalize mental health, challenges during adjustment, and encourage early coping strategies. Early prevention can also be a part of safety planning. Resettlement agencies can provide opportunities to integrate risk prevention at multiple points of a client's resettlement experience. Different organizations will have different strengths – integrate your service provision as much as possible.

Identify expert areas – Although all relevant staff should be trained in identification of risk, some risk scenarios will naturally fall outside the expertise of any organization. Service Mapping allows you to identify other groups in your community that can provide more effective safety planning for your client and refer appropriately.

3. Outline a Chain of Command

Establish clear responsibilities – Protocol should include a defined chain of command and roles, which takes the guesswork out of a stressful scenario. Guidelines should identify a supervisor and the staff member who is responsible for conducting any safety assessment – this can depend on training, existing reporting structures, and the relationship with the client. For your support groups, decide if and when facilitators will play a role in crisis response.

Outline different scenarios – Consider if a modified chain-of-command is needed in some situations. What is the chain of command during and after typical work hours? In cases of gender-based violence, you may decide that a different staff member will implement safety planning due to gender fit. In cases of suicide risk, individuals at risk should not be left alone; this may require "back-up" staff to be specifically written into your protocol. Consider whether certain scenarios require a different chain-of-command and outline it in advance.

Embed systems of discussion – Protocols should normalize obtaining peer and/or supervisor feedback. Supervision and assistance should be provided on an ongoing basis. Crisis situations can come in many shapes and forms and do not always have routine signs, so it is important to create spaces for discussing unique developments. This can look like: de-briefs that provide opportunities for the sharing of lessons learned and challenges encountered; case conferencing; written reporting or feedback, or through routine training.

4. Engage Clients Collaboratively

Recognize client strengths – When writing new protocol or conducting trainings, agencies should consider how to engage the client in a participatory process that identifies their strengths and needs. Protocols should collaboratively recognize that clients are experts in their own life and have strengths within or around them, as well as build a sense of autonomy in the client. Implementing protocol is a two-way street: just as the trained staff-member has knowledge about safe behaviors or environments, the client has valuable knowledge about their own needs. Engaging clients involves highlighting client assets; providing transparent and clear information, assistance, and referrals; following up and reinforcing the use of their own strengths. Even urgent safety risks can provide opportunities for client autonomy.

Plan for changes – Safety protocols can include assessment templates or other written documents that help staff assess client needs. While a written template is helpful to address a set of safety questions, it is important to remain in dynamic conversation with the client as safety risks can constantly change. Remember that risk situations are not static and can change at any time.

Discuss follow-up – Safety protocols can involve long-term planning. It is important to discuss with the client that the case manager will follow up, such as on referrals, check-ins, resources, or other planning. Clarify what areas you will follow-up on, what areas the client will follow-up on, and create the expectation of collaborative follow-up. For the MHPSS Support Groups, relevant staff should be prepared to follow up on crisis scenarios disclosed by participants individually or in group settings.

5. Ensure Training of Staff

Schedule Safety Trainings – Emergency situations are not the expected norm in MHPSS Support Groups. However, these situations can happen, and agencies should prepare and train staff in implementing emergency

protocols. Clear written guidelines must be complemented by appropriate training. It is important to train relevant staff in both the written protocol and the "soft skills" of relationship-building, client engagement, and strength-based approaches needed to identify and address client safety needs. Such skills are key to working with vulnerable clients and building their self-sufficiency towards safety for themselves and their families. This may involve engaging an external partner to provide a safety training, reaching out to HIAS for resources, or independently providing trainings. [xx]

Be Inclusive – The training and skills required for safety decision-making processes may fall outside the scope of an MHPSS Facilitator or a case manager. Despite this, relevant staff can be trained to serve as the initial contact for a client and assess needs. Existing safety planning protocols may be primarily designed for trained health care workers or licensed social workers. Remember that MHPSS support groups rely on the important work of community workers or un-licensed case managers, and these staff should be included in training on assessments, screenings, and identifying risk factors.

6. Establish Clear Definitions

Define emergencies – Protocol should outline succinct guidelines on how to determine when a situation evolves into a life-threatening emergency and requires crisis response. The point at which staff members should involve external crisis responders should be clarified. Considerations include: if collaborative long-term safety planning can proceed or immediate crisis response is needed; what scenarios and warning signs must be immediately notified to a supervisor; what scenarios and warning signs result in a staff member calling 911 or taking a client to an Emergency Room; if clients can be left alone or not; how to preserve staff safety at all times; how response will take place during COVID-19.

Support staff mental health – Safety response can include stressful elements, such as calling 911, as well as hospitalization or involuntary psychiatric holds of clients. Staff should be prepared for these realities in advance. Agencies and supervisors must provide opportunities for self-care following stressful crisis situations.

The "How, Who, Where, and What" of Safety Protocols

Before starting an MHPSS Support Group, discuss these safety protocols with your co-facilitators to ensure consistency in your organization's response for all participants. Consider the following areas of support:

→ **How** to respond to concerns regarding client safety or risks. For example, if a group member describes distressing thoughts or situations during the group, plan to offer one-on-one connection with them to explore risks. It is best to do this separate from the group to avoid causing undue harm or discomfort for the individual and maintain privacy. Follow your organization's safety assessment protocol and seek out guidance and support from peers and supervisors as needed to determine appropriate referrals. Obtain the consent of the client to share information with other providers who may be able to help.

→ **Who** can provide a comprehensive safety assessment? Safety Protocols should identify if implementing staff, an assigned case manager (if available), clinical mental health provider, or other type of health worker will be conducting safety assessments. Be sure to obtain the client's consent to involve a new provider. Further, if teaming with an agency, determine who is their assigned case manager, clinical provider, or health worker that with their permission can be notified. When possible, a trained and culturally competent mental health professional is the best individual to conduct suicide assessment.

→ **Where** to connect the community member to such as specialty behavioral health providers, crisis lines, or other referral sources to contact. This may entail informing the client about relevant services and referring

appropriately. If a referral to external services is required, explain clearly what the next steps will be and liaise with appropriate staff for warm handoff.

→ **What** warning signs or behaviors may be worrisome? Are there cultural expressions or ways to discuss extreme distress or emotions that are considered acceptable or would warrant further support that you can become more familiar with?

Facilitator Debrief Tools

Sample Weekly Preparation Checklist

Consider using this quick tip sheet before each Support Group session.

The Week Before Each Session: Participant Readiness Questions

- Are all participants able to access the virtual platform? Or, all the participants able to transport to and attend the in-person venue?
- What additional support may participants need during this upcoming session?
- Are there competing priorities, such as caring for children, employment, and other commitments with the time scheduled for this particular session?
- Did participants request any particular information, resources, or referrals from the previous session that should be followed up on?
- Were any participants emotionally activated, upset, triggered, or require any follow-up support or referrals?
- Did any participants stop attending and why?

The Week Before Each Session: Facilitator Readiness Questions

- Are facilitators familiar with the session content before the session begins? Have we scheduled enough time to meet together, including with the interpreter if any, to discuss curriculum adjustments, group dynamics, and divide tasks?
- Do facilitators have all the materials needed implement this session? If remote, is my Zoom and audio functioning; do I have all the exercises and activities prepared; do I have any additional materials ready? If in-person, is the venue booked and accessible?
- If there is more than one facilitator for the same support group and you are *co-facilitating*: have we co-facilitated a group together before and do we understand each other's dynamics? Who will be the lead, co-lead, or provide technical support? Who will present which part of the session?
- Am I emotionally prepared to facilitate this session? Do I anticipate any triggering or activating content? Have I set out an individual, team, or community self-care plan and am I following it? See below for **Self Care Definitions and Strategies.**

During each Session: Re-Directing and De-Briefing Considerations

- It is almost guaranteed that group members will bring up issues that are off-topic from the current group session. As a facilitator, it is your job to decide which issues are relevant to the group and are helpful to the group process, or may be off-topic and require re-directing. Is the "off-topic" topic more helpful or distracting to the message of the current group session? Is the "off-topic" topic more helpful or distracting to the other group member?
- Is this topic likely to trigger a trauma response in any of the group members? Try to stay on topic of the current session as much as possible. If something off-topic arises, such as a case management need, it may not need to be addressed immediately and with the whole group. Facilitators can politely let the participant know that you can meet after the group, follow up, and provide referrals as needed.
- Remember to use de-escalation tactics if a group member is sharing an experience, story, or information that triggers themselves, other group members, or yourself. Follow the **De-Escalation Guidelines** suggested above or your organization's protocol for de-escalation.

After each session: Facilitator De-brief Questions

- Have we created enough time to de-brief every week? Have we discussed what was challenging and what was successful? What co-facilitation styles and processes worked that week?
- Do we need to reach out to peers, colleagues, or supervisors to seek additional support?
- How are the group dynamics forming and how are group participants responding to each other and to the curriculum content?
- What are my feelings and emotions after this session? Rely on your Self-Care plan as needed.

Sample Weekly Discussion Check-List for Facilitators

Consider using or modifying the below Weekly Checklist to reflect on challenges and best practices.

Sample Checklist: Session One			
Session or Activity of the Curriculum	**I completed this component.**	**If you did not, reflect on why or what you did differently:**	**Notes & Reflections**
Example: Session 1, Activity 1	**Y/N**		
Example: Session 1, Discussion 1	**Y/N**		
Example: Session 1, Activity 2	**Y/N**		
Did you make any significant modifications from the curriculum?			

Self-Care Definitions & Strategies Sample

Bearing witness to another person's traumatic history can lead to vicarious trauma in any individual. For facilitators or community interpreters working with clients who have similar backgrounds and life histories as oneself, participant's histories can bring up emotions, fears, and preoccupations from the past.[xxi]

Review the definitions below with facilitators. Depending on your organization and capacity, review information on self-care and stress management with facilitators during the planning stages *and throughout implementation.* Self-care strategies should be reviewed and affirmed on an ongoing basis to be effective. Facilitators, community interpreters and other staff should be supported in practicing self-care suited to their needs, cultural practices, and individual preferences.

Individual self-care is an intentional practice that reduces stress levels and allows one to maintain and restore a sense of balance in all aspects of one's life (both professionally and personally). Self-care begins with awareness, entails sustaining wellness practices through action planning and reassessing overall wellbeing.

Organizational resilience is an intentional response to managing stress. It may entail work related components such as normalizing staff resilience in the organizational culture by promoting wellness practices.[xxii] Organizations can

encourage individual practices including psychoeducation about stress and trauma; stress management training; de-briefing and communication skills; relaxation and mindfulness; coping strategies; social support; counseling; and resiliency training.

Vicarious trauma (VT) is used to describe a profound shift in world view that occurs in professionals when they work with persons experiencing trauma.[xxiii] It is most often a process of cognitive change that results from ongoing empathic engagement with trauma survivors. Vicarious traumatization often represents shifts in thinking and one's beliefs; it may entail altered views of one's worldview or view of oneself. Vicarious trauma can result in changes to one's sense of safety, trust, and control, as well as changes in spiritual beliefs.[xxiv]

Secondary Traumatic Stress (STS) is experienced when a helper begins to display trauma responses similar behaviors to those of persons directly exposed to trauma.[xxv] When someone experiences secondary stress, they may develop behaviors and emotions resulting from knowing about a traumatizing event experienced by someone they have assisted, and experience stress resulting from helping or wanting to help that person. STS results from engaging in an empathic relationship with an individual suffering from a traumatic experience and bearing witness to the intense or horrific experiences of that person's trauma. Secondary traumatic stress symptoms are very similar to those of PTSD, such as hypervigilance and intrusive thoughts, except that the exposure to trauma is secondary rather than primary.[xxvi] The signs of STS may include traumatic memories or nightmares associated with client trauma, insomnia, irritability or angry outbursts, fatigue, difficulty concentrating, avoidance of clients and client situations, and startle reactions toward stimuli or reminders of the person experiencing trauma.[xxvii]

Burnout is a term that is used to describe physical and emotional exhaustion that people can experience when they have low job satisfaction and feel powerless and overwhelmed at work. Burnout does not necessarily mean that one's view of the world has been altered or entail loss of the ability to feel compassion for others. Most importantly, burnout can often be easily resolved: i.e. changing jobs, and other lifestyle changes.

Compassion Fatigue (CF) refers to the profound emotional and physical erosion that takes place when helpers are unable to refuel and regenerate. Most often this includes emotional, physical, and spiritual distress when those providing care to another. Compassion fatigue often consists of a combination of symptoms of secondary traumatic stress and burnout. CF usually combines a chronic use of empathy, combined with the day-to-day bureaucratic hurdles that exist for many workers, such as: agency stress, billing difficulties, and balancing clinical work with administrative work.

Stress refers to physical, mental, or emotional strain or tension which may build up over time. It can also be the result of chronic stress that is not been resolved. The causes of stress, or stressors, may be internal or external, and our own response to them may result in the natural stress response. Although stress is a natural part of life, and can be challenging to manage at times, there is much we can do to prevent stress from causing us harm. When stress becomes too great it can lead to other behavioral, emotional, or physical challenges. Some of these include depleted energy, anxiety, reduced joy or motivation, fatigue, problems concentrating, problems with relationships, increased alcohol and drug use, irritability, pessimism, and feeling trapped. Organizations and supervisors must provide opportunities for self-care through training, teaching, coaching, teamwork, and supportive supervision.[xxviii]

Self-Care Strategies for Organizations

Create a self-care plan in advance Before support groups begin, set aside time to map out specific self-care strategies for facilitators and involved staff. Self-care strategies can be personal, physical, social, or shared with other staff. Consider building in the review of self-care strategies into work schedules, such as on a quarterly basis. Facilitators can complete their own self-care assessment using this sample worksheet. Determine if it is best for facilitators to build their self-care plans individually or as a team.

Outline roles and limitations Before and during support groups, clearly outline roles, limitations, and professional boundaries in advance of the support groups. Outline over-involvement; acknowledge and address any dual roles that providers or staff may face when serving their own communities. Culturally expected behaviors for same-culture providers can often blur professional boundaries; reinforce that individual providers must practice wellness to best serve clients and communities.

Affirm supervision opportunities Normalizing seeking peer-to-peer advice and supportive supervision for stressful situations or instances in which Secondary Traumatic Stress, Compassion Fatigue, or Vicarious Trauma may occur. Provide advice and supervision after any escalated or crisis scenarios, in addition to routine de-briefs.

Review organizational approaches Staff resilience can be nurtured by organizational re-structures, such as schedule changes, caseloads alterations, job rotation, management support, the use of supportive supervision, collegial and multi-disciplinary support, team building and the use of external providers to offer employee counseling or group support.

Honor the "here and now" Consider using Check-Ins at the beginning of team meetings, during which staff and facilitator share how they're feeling or stressors in their lives that are pulling at their attention. Just like Check-Ins in support groups, this is a way to acknowledge facilitator emotions and honor the "here and now"

Set a model for staff Supervisors and organizational leaders should aim to normalize self-care through communications, language, and setting a model for staff. It is important to make workers feel like self-care is not selfish or abnormal, and counter any norms in the non-profit sector that associate guilt with self-care; this can be achieved through regularly using language that de-stigmatizes self-care during individual check-ins, team meetings, and other communications. In addition, whether consciously or not, individuals often take the lead from those higher up in organizations. It is critical that supervisors and leaders set an example that models boundaries and breaks; supervisors should reflect on how their actions influence perceptions of collective care.[xxix]

Endnotes

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