Group psychological first aid for humanitarian workers and volunteers

About this report

This report forms part of Wellcome s 2020 Workplace Mental Health Commission. The aim of the commission was to understand the existing evidence behind a sample of approaches for supporting anxiety and depression in the workplace, with a focus on younger workers.

You can read a summary of all the ndings from Wellcome s 2020 Workplace Mental Health Commission on our website: https://wellcome.org/reports/understanding-what-works-workplace-mental-health

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A Rapid Realist Review of Group Psychological First Aid for Humanitarian Workers and Volunteers, aged 14-24

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Executive summary

Similar to other high-risk professional groups (e.g. military, emergency first responders) humanitarian workers are at an elevated risk of occupational trauma exposure and its associated psychological

consequences. Humanitarian workers experience increased levels of anxiety, depression, and post-traumatic stress disorder (PTSD) compared to the general population. Moreover, younger humanitarian aid workers and volunteers are at an increased risk of experiencing burnout than their older counterparts. The consequences of a negatively affected health workforce are not only determinantal to humanitarian efforts and humanitarian organisations themselves, but also pose a risk to the efficacy and quality of humanitarian interventions.

Psychological first aid (PFA) involves providing humane, supportive, and practical help to individuals who are suffering and in need of support. It is typically provided in the immediate aftermath or in the days or weeks following a traumatic event or crisis, or within programmes where humanitarian workers are exposed to prolonged and chronic stressors (i.e. within a protracted crisis), and aims to prevent acute distress reactions from developing into longer-term distress. **Group PFA** (GPFA), a more recent adaptation of PFA, involves delivery of PFA in a group or team setting. As exposure to trauma can be extremely isolating provision of psychoeducation and PFA in a group setting can help normalise reactions and responses to trauma and strengthen group cohesion.

However, little is known about how GPFA works for the humanitarian workforce, and specifically on its applicability to younger populations. As such, this research sought to understand '*What works, for whom, in what context, and why for Group-Psychological First Aid for Humanitarian Workers, including volunteers, aged 14-24?"*

We used a Rapid Realist Review to answer our research question. This involved generating initial theories to answer the question, and refining them based on documents (n=15) identified through a systematic search of databases and grey literature, and the inputs from leading experts in GPFA in the form of core experts (n=3) as part of the research team and two external experts. Our findings generated seven (7) programme theories that work to explain the research question, and provide considerations for implementation of GPFA for the humanitarian workforce across contexts and age groups, including youth age 14-24. The seven identified theories, and their associated recommendations include:

Programme Theory	Key Recommendations
GPFAs influence on natural reactions and adaptative coping strategies	• GPFA should be provided as soon as possible and as is appropriate following a trauma. • Following an acute traumatic event, 2-3 sessions of GPFA may be appropriate. When the event is chronic or ongoing, GPFA should be provided more regularly, and support informal communication networks of support between participants.
GPFAs ability to meet basic needs of participants, providing stability and reduced stressors	• GPFA should be implemented within wider system of support – to both physical and mental health resources. • Clear expectations as to what can and cannot be provided during GPFA should be set prior to the session. • Facilitators should be well-equipped with information on services available in order to link participants to further support where needed.
GPFAs focus on matching response to individual needs, including referral to additional services	• Facilitators should be trained to be able to identify participants requiring additional support. • Links should be provided to other services or support appropriate for each individual.
GPFA participants shared experiences fosters support and social cohesion, increasing sense of belonging and security	• GPFA should be implemented with an understanding of the group history and dynamics. It should be tailored appropriately to each group of participants, based on the demographics and whether or not they already know each other, for example. • Additional sessions may be necessary to build group cohesion. For youth, activity-focused sessions are recommended. • Following GPFA, informal communication channels among participants can foster ongoing peer support.
GPFA group composition influences participation and cohesion	• Group composition is context-specific, considerations should be made appropriately in regards to members age, gender, experience, exposure, etc. • Youth are not a homogenous group and considerations for group make-up should based on age and/or life experiences and dependent on context
GPFAs linkages with other services improve access and sustainability	• Youth may require an activity-based introduction to GPFA approach and members to reduce stigma of care seeking and facilitate necessary group bonding prior to more intensive sessions. • GPFA should link to complementary services. • During chronic events, more GPFA sessions, and/or informal communication platforms should be supported for participants.

	• Informal communication networks among groups following GPFA may be an additional supportive tool
GPFA having well trained, supervised and contextually appropriate facilitators improves effectiveness	• To meet the demands of facilitation and looking for participants needing further support, GPFA likely requires 2 facilitators. • Consideration should be made to the gender and positions of the facilitators and how that will affect power dynamics, depending on context and group • Facilitators must undergo appropriate and comprehensive training and have supportive supervision structures in place.

Introduction and background

The problem

Similar to other high-risk professional groups (e.g. military, emergency first responders) humanitarian workers are at an elevated risk of occupational trauma exposure and its associated psychological consequences. The significant risks to the health of humanitarian aid workers are well documented by a range of studies spanning the last two decades. Reviewing the evidence for trauma exposure and trauma-related mental illness among humanitarian aid workers for example, Connorton et al. (1) found that humanitarian workers experience increased levels of anxiety, depression, and post-traumatic stress disorder (PTSD) compared to the general population. Similarly, anxiety and depression symptoms have also been reported among aid workers when controlling for the presence of such disorders prior to deployment, providing evidence for the experiential nature of the missions as a mediating factor in mental health outcomes (2).

Further differentiating between expatriate and national staff, Lopes Cardozo et al. (2) found that national staff (i.e. hired within the country of mission) reported more exposure to traumatic events as well as greater anxiety, depression, and PTSD symptoms, compared to expatriate staff (i.e. those hired outside of the country of mission). Despite an arguably greater need for psychological support among national staff however, extant studies on traumatic exposure and mental health among humanitarian aid workers have overwhelmingly focused on expatriate or international staff (3, 4). There has been considerably less focus given to national staff and volunteers, the latter of which represent a significant proportion of the humanitarian workforce, and many of whom are at an early stage of their career (under 25 years). One report for example, suggests a ratio of 1:180 staff to volunteers within humanitarian organisations in low and middle-income countries (5). Volunteers and national staff are thus likely to face elevated risks of depression and anxiety, while also receiving limited organisational support (2). Moreover, younger humanitarian aid workers and volunteers are at an increased risk of experiencing burnout than their older counterparts, even when controlling for years working within a humanitarian agency (6).

The consequences of a negatively affected health workforce are not only determinantal to humanitarian efforts and humanitarian organisations themselves, but also pose a risk to the efficacy and quality of humanitarian interventions. Humanitarian organisations that respond to the needs of volunteers, through supportive practices and skill-building approaches for example, have been found to enhance motivation and well-being among volunteers (7). These psychological states are documented as important determinants of workforce retention and performance (8). Consequently, an increasing number of humanitarian organisations are providing resources and efforts into improving the care and well-being of their workforce, including volunteers. The International Federation of Red Cross and Red Crescent Societies (IFRC) for example, recently published their *Caring for Volunteers* psychosocial support tool kit, as a way to equip volunteers with the skills they need to ensure that they are caring for their own mental health and well-being, in addition to those of programme beneficiaries.

Psychological First Aid

Psychological first aid (PFA) evolved as an alternative to critical incident stress debriefing (CISD) (9) and involves providing humane, supportive, and practical help to individuals who are suffering and in need of support (10). It is typically provided in the immediate aftermath or in the days or weeks following a traumatic event or crisis, or within programmes where humanitarian workers are exposed to prolonged and chronic stressors (i.e. within a protracted crisis), and aims to prevent acute distress reactions from developing into longer-term distress (11). This is done by having a peer or lay facilitators, trained on the PFA approach, in a one-to-one with an individual who experienced the event. The main ethos of providing PFA entails caring for an individual in distress by supporting their safety and providing comfort, engaging in active listening, and providing practical assistance or referrals for further support (if needed). PFA can be provided wherever it is safe to do so. Often it is provided in places where individuals in distress are being served, such as shelters, distribution centres, health centres, etc (10). Largely grounded in the principles of Hobfall (12), the main purpose of PFA is to instil feelings of safety, calmness, self- and community efficacy, connectedness and hope. PFA thus first ensures that basic physical needs are met, and then works to meet psychological needs through providing comfort and support, psychoeducation[1], and facilitating service connections to continued mental health resources (13). The three main principles of PFA are to **look** (for safety, for who needs help), **listen** (to the person in distress) and **link** (to further support) (10, 14).

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[1] Is a process of equipping individuals with knowledge and information to better understand their reactions and distress

Group Psychological First Aid

Group PFA (GPFA) delivered in a group or a team setting is a more recent adaptation of PFA that is supported by several major agencies, including the IFRC, as an effective way to care for staff and volunteers in crisis (11). GPFA works similar to PFA, in that peer or lay counsellors work with a group of individuals at the same time following the **look, listen** and **link** principles. As exposure to trauma can be extremely isolating (15), provision of psychoeducation and PFA in a group setting can help normalise reactions and responses to trauma and strengthen group cohesion (13). According to Eriksson et al. (6), organisational support and positive relationships with co-workers may also increase resilience among staff.

GPFA in Practice

In 2019, shortly after Cyclone Idai hit Mozambique, IFRC ran GPFA for their volunteers and staff who were responding to the crisis. Through these facilitated meetings, workers were able to share their stories and experience of the hurricane.

In 2013, Typhoon Haiyan struck the Philippines. Soon after, local government employees from the affected areas were brought to a safe location to receive GPFA. Groups of 5-7 participants were composed based on their post-traumatic stress symptoms. Through group discussions and psychoeducation, feelings of self-efficacy and positive coping among participants increased.

Despite a dearth of studies examining the effectiveness of PFA (16), PFA is widely used within the humanitarian sector, including during disease outbreaks and pandemics. While ascertaining the effectiveness of PFA remains particularly challenging, PFA is recognised as being evidence-informed (17), and has been shown to improve knowledge and understanding of psychological response and skills in providing support to those exposed to acute adversity (18). Like PFA, the provision of GPFA is not limited only to professional counsellors but can be provided by trained workers, volunteers, and peers (10, 14). GPFA therefore offers humanitarian organisations the opportunity to provide an important resource to staff and volunteers, as a lower-cost, scalable, and potentially highly-effective mental health and psychosocial support initiative, which can be delivered by managers to humanitarian workers before, during and after responding to crises. In addition, GPFA also has the potential to build peer support networks within a team (13, 14). Given the increasing recognition of the importance of supporting staff and volunteer mental health within crisis settings (19), including within key guidelines and existing policies, it is likely that GPFA will continue to gain increased attention in the coming years.

Research team

Our research team includes academics from University College Dublin (UCD) and Trinity College Dublin (TCD) with research experience in mental health and the humanitarian work psychology, and practitioners and experts on psychosocial and mental health from International Humanitarian Organisations, including the British Red Cross. Based on our team's experience, we identified a need to further understand how the emerging approach of Group Psychological First Aid (G-PFA) works, and specifically to understand how this approach works for a large, yet often underrepresented population of humanitarian workers and volunteers, including youth. By bridging academic and practitioner experience on the topic, our team aimed to provide stakeholders with context specific and evidence-based recommendations to support the implementation of PFA and G-PFA to reduce anxiety and depression for millions of humanitarian workers and volunteers worldwide.

Research aim and question

The aim of this rapid realist review is to outline the likely or proven impact of Group Psychological First Aid to preventing or addressing anxiety and/or depression[2] in the workplace, with a focus on those under

[2] We define anxiety and depression disorders in line with the WHO'S classification of disease (ICD-10/ICD-11)., and the APA's diagnostic and statistical manual (DSM-IIIR, DSM-IV, DSM-IV).

25, based on inferences drawn from the available evidence or theoretical frameworks. Specifically, we ask, "What works, for whom, in what context, and why for Group-Psychological First Aid for Humanitarian Workers, including volunteers, aged 14-24?". Additionally, we explore how these findings are relevant to the humanitarian volunteer workforce currently responding to Covid-19 globally.

Methodology

The methodology chosen to answer the research question was a rapid realist review (RRR). Realist methodology aims to understand what works, for whom, under what circumstances, and why, through examining how interactions between contextual factors (C) and underlying mechanisms (M) affect the outcomes (O) of interventions (20). To do so, it elicits and refines programme theories by exploring generative causation (that is, Contexts trigger Mechanisms, and together this combination generates Outcomes). It is these CMO Configurations (CMOCs) that provide the support to both generate, and then refine, programme theories that answer our research question.

Whereas traditional realist reviews require both considerable time and investment, a RRR maintains the same core principles and approach while streamlining the review process through engaging experts in the field of study. The literature included in RRRs is not intended to be exhaustive, but rather represent the most relevant and informative resources. Therefore, RRRs are particularly useful to policy-makers and stakeholders facing time-sensitive decisions (21). This methodology also allows the application of existing theories and evidence to make inferences as to how programmes are expected to work, which can be useful for topics with limited evidence bases.

Expert Groups

Another key distinguishing factor of RRRs is the involvement of a Reference Panel (21). For this review, we established a *Core Expert Group* which guided the development of our research question, protocol and provided feedback on the theory development throughout the study. The panel consisted of an academic with expertise in mental health service delivery, and two programme implementers with extensive experience in designing and implementing workplace mental health interventions within NGOs, including PFA and GPFA.

We also consulted two *External Experts*, one of which works for a large NGO, and the other for a UN organisation, both designing, training and implementing GPFA across a wide variety of contexts. These experts were consulted at the end of the review for validation of findings and insights into recommendations.

Methods and Tools

This RRR had numerous iterative steps to identify and refine the programme theories. Appendix 1 describes the key steps, and the associated methodological processes and methods used to conduct the steps.

Systematic Searching

The systematic searching for relevant literature consisted of database searching, grey literature searching and snowballing. Searching of three academic databases (PubMed, Scopus and Taylor and Francis Online), seven websites of relevant organisations, emailing to MHPSS listserv requesting documents, and snowballing of included studies references were all completed.

Appendix 1 details the specific search terms, dates of searching and returns for each source. Inclusion and Exclusion criteria are outlined in Appendix 1. While inclusion criteria were quite broad in terms of context, study type, or literature type, included resources must have been able to contribute to our theory refinement in order to be included. Once results were returned, a minimum of two investigators screened each resource for relevance. Any disagreements were settled by a third review and/or group consultation.

Iterative Approach to Understanding Youth Application

No identified resources addressed GPFA specifically for young populations (14-24 years). To address this issue, we completed the RRR with the included studies for a more general understanding of 'how, why and

for whom GPFA works for humanitarian workers and volunteers'. After which, we reviewed youth/adolescent specific literature to make inferences about how the findings are relevant to this population.

Results

As highlighted in Appendix 1, findings from this review resulted from the analysis of numerous data sources and the following research activities:

- 15 documents were included after the systematic search of databases, websites and grey literature
- 2 Core Expert virtual group meetings[3] were held where theories were presented and feedback provided
- 2 solicited feedback reports from the Core Experts on how input was incorporated, consisting of providing updated findings (programme theories) for their review
- Review of literature specific to youth/adolescents participating in group interventions and/or youth/adolescents mental health considerations for interventions
- 2 virtual meetings with External Experts[4], where the refined programme theories (PTs) and findings from youth lens supplemental work were disseminated. Inputs and recommendations were sought, and changes made to produce Finalised Programme Theories

Group Psychological First Aid

Throughout the included documents there was variety in the type of programme conducted (i.e. PFA or GPFA) and differences across the specific components of the programme. To this end, and to ensure our findings result from, and support, high-quality, ethical and evidence-based GPFA, it is important to define what exactly this review classifies as GPFA. Box 1 offers an overview of what is considered best practice for GPFA by our team's experts.

Box 1: Best Practice Group Psychological First Aid

GPFA is a focused, non-specialised support provided to a group of individuals that have collectively experienced an acute stressor (e.g. natural disaster, violent attack, accident) or who are currently experiencing a period of protracted stress (e.g. an ongoing conflict persistent threat of violence), ideally as soon as possible and where appropriate. GPFA should serve as an entry point for access to a wider system of supports and other resources, whenever they are available. Like PFA, the three main principles of GPFA remain to **look** (for safety, for who needs help), **listen** (to the person in distress) and **link** (to further support). In doing so, GPFA aims to instil feelings of safety, calmness, self- and community efficacy, connectedness and hope, by providing individuals with coping strategies and skills, and facilitating relationship building among group members. GPFA should ideally be led by two facilitators and conducted more regularly in cases of prolonged or more chronic stress. Facilitators do not need to be mental health professionals, however they must be properly trained in group facilitation skills, in order to effectively provide PFA in a group format. Careful consideration must also be given to group composition (i.e. in terms of sex, age, education level, and other forms of social hierarchies), in line with prevailing social norms withing different cultural contexts.

Anxiety and Depression

As indicated in the research aim, we sought to understand how GPFA can address or prevent anxiety and/or depression in the humanitarian workforce. None of the included studies however explicitly measured the approaches' (either PFA or GPFA) effect on levels of anxiety and/or depression. However, numerous studies did report that the approaches were effective in promoting feelings of support and belongingness and positive coping strategies, which are noted as protective factors and help prevent anxiety and depression

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[3] These meetings comprised of 6 individuals: PI, Co-PI and Research Assistant, along with the Core Experts consisting of Mental Health Academic and two programme experts

[4] One working for large-scale NGOs and one for Bilateral Organisation within the UN. Both with experience in developing GPFA interventions, implementing and training on GPFA and supporting research and evaluation activities on GPFA

(22). Therefore, while a specific relationship between GPFA and anxiety and/or depression cannot be made from this study, findings do indicate its strong positive potential to address and prevent anxiety and/or depression within the humanitarian workforce.

Theory Refinement

Theories related to this research question went through four phases of refinement as a result of literature searches and data extraction, and feedback from both Core Experts and External Experts. Appendix 1 demonstrates the progression of the finalised programme theories throughout the review process.

Finalised Theories

As noted in Appendix 1, this review found seven (7) PTs which address the research question. The full programme theories and the sources which fed into their development and provide support can be found in Appendix 4, with Appendix 3 containing the Initial Programme Theories.

Table 1 below provides an overview of these seven PTs, including specific contextual conditions that may require consideration, the theories application to youth age 14-24 years old, and key recommendations for practice.

Table 1: Finalised Programme Theories, Contextual Conditions and Recommendations

Programme Theory 1: Natural Reactions and Adaptive Coping Strategies			
Following an acute crisis or period of prolonged distress, if GPFA is delivered early and appropriately, it provides a space to discuss natural reactions, normalise relationships, and address expectations. If this occurs, participants will be better equipped to process experiences early, feel their reactions are natural, and to continue supporting their mental health. This can lead to improved healthy coping strategies, self-awareness, and the management or prevention of distress escalation or re-escalation. (23-32)			
Summary	Caveats/Notes	Youth Application	Recommendations
Programme theory one focuses on participants' natural reactions to abnormal events, and the importance of learning adaptive coping strategies to cope with the trauma.	The nature of humanitarian work often results in workers and volunteers prioritising others' well-being before their own. The group format of GPFA may encourage this workforce to attend to support their peers, and through this they may also receive benefits. GPFA provision can help facilitate the recognition of stress reactions as natural and reduce hesitancy toward care-seeking among the workforce. Provision of these practical tools, dedicated time and space may be especially important in settings with limited or disrupted services.	Skill building is a critical component for youth (33), many of whom are still learning and developing their own coping strategies. Equipping youth with the tools and positive strategies to cope can develop healthy coping strategies.	• GPFA should be provided as soon as possible and as is appropriate following a trauma. • Acute event vs. Chronic event may require different approach. Following an acute traumatic event, 2-3 sessions of GPFA may be appropriate. When the event is chronic or ongoing, GPFA should be provided more regularly, and support informal communication networks of support between participants.
Programme Theory 2: Meeting Basic Needs			
Acute crises and periods of prolonged distress affect individuals differently depending on exposure levels or previous life experiences. Basic resource needs may be disrupted, requiring different levels of physical and psychological support. If GPFA is provided in a comfortable location, using a layered system of complementary supports[5], this can help meet an individual's basic physical[6] and/or psychological needs, which can increase their sense of stability, safety, and control. If this occurs, individuals are able to be more emotionally expressive, self-efficacious, and recognise their reactions as natural. This helps to prevent distress escalation through emotional stabilisation, reduced secondary stressors, and helping individuals cope on their own. (23-25, 29, 32, 34, 35)			
Summary	Caveats/Notes	Youth Applications	Recommendations

[5] Complementary supports include information, psychoeducation, social, emotional, physical, and psychological support. This can also include psychological triage and service connections for more acute needs.

[6] Physical needs may include food, water, shelter, basic personal protective equipment, etc. Needs often vary based on context.

Summary	Caveats/Notes	Youth Applications	Recommendations
Programme theory two is about meeting basic physical and psychological needs of participants.	In an ideal situation, basic needs (for example food, shelter, clothing, financial support, etc) would be met during GPFA. However, practical challenges may arise, particularly in meeting physical needs, based contextual factors. This is especially true in low-resource settings. Setting clear expectations prior to the GPFA meeting is important to the well-being of both beneficiaries and facilitators.	Emotional stabilisation and reduced secondary stressors may help establish a sense of control, facilitating recovery among youth (36).	• GPFA should be implemented within wider system of support – to both physical and mental health resources. This includes having clear links with more formal mental health services and other supports for referrals. • Clear expectations as to what can and cannot be expected during GPFA should set prior to the session. • Facilitators should be well-equipped with information on resources available in order to link participants to further support where necessary.
Programme Theory 3: Response Matched to Individual Needs			
Acute crises and periods of prolonged distress affect individuals differently depending on exposure levels or previous life experiences. When there is an existing social support/resource system, if GPFA is linked with this system (like connections to other forms of humanitarian assistance or forms of healthcare) and facilitators can gauge individual reactions and needs, this can enable an open space for members to share reactions, coping strategies, and resources. This can also support individuals to be referred for additional support[7] appropriate for them. Supporting service connections in group formats can reduce stigma associated with care-seeking and increase access to needs-matched services, reducing secondary stressors and strengthening an individual's ability to cope on their own. (23-25, 27, 30-32, 34, 37)			
Summary	Caveats/Notes	Youth Applications	Recommendations
Programme theory three highlights the importance recognising individual needs within the group, and providing those members with needs-matched services.	Additional support and resources can be either formal service connections, or informal one-on-one meetings with a facilitator.	GPFA may facilitate youth recovery through reduced stigma of care-seeking. The group format provides an opportunity for members to listen, without pressure to share or participate in a discussion (38). Reducing this stigma and pressure to share can facilitate recovery among youth (36, 38).	• Facilitators should be trained to be able to identify participants needing additional support, including mental and/or physical health, and support for other basic needs to be met. • Links should be made to other services or support appropriate for each individual
Programme Theory 4: Fostering Support and Social Cohesion			

4.1: *When GPFA is provided to a small group of individuals who already know each other and share similar experiences and stress levels, it provides an opportunity to discuss reactions and emotions. This helps individuals feel more supported by peers, strengthens group cohesion, validates reactions, and opens communication about mental health. The outcome is the fostering of relationships, reduced isolation, increased sense of safety and belonging, and improved coping (23-25, 27-29, 31, 32, 34, 39).* **4.2:** *When GPFA is provided to a small group, who may not know each other but share similar experiences and stress levels, this can develop or strengthen sense of belonging to communities, fostering relationships, communication, and helping group members feel less isolated (23-25, 27-29, 31, 32, 34, 39).*			
Summary	Caveats/Notes	Youth Applications	Recommendations
Programme theory four focuses on fostering support and social cohesion among group members in situations when they already know each other, and when they do not already know each other.	GPFA can be provided to members who do not know each other beforehand. However, an icebreaker and/or group activity aligned with the culture should take place prior. This approach may be useful in circumstances where individuals are disconnected or separated from their families or communities. The group nature of GPFA may be particularly important in collectivist cultures that naturally feel comfortable in group settings. Additional informal or social group spaces beyond GPFA may support ongoing dialogue and support among members. Online platforms such as WhatsApp or Facebook groups can also be useful in events interrupting social gatherings (like epidemics).	For youth, the provision of GPFA among peers supports their natural tendencies to share with peers and request support in groups (40) Given that social relationships are important to the development of youth (36, 38, 41), group interventions are well suited to this age group (38, 41), and have been shown to be effective across a broad range of mental disorders (42). Providing an activity before and/or during GPFA with youth may also increase participation and build connections with peers (41). These connections facilitate recovery (36). Online platforms such as WhatsApp or Facebook groups may be especially relevant to reaching youth, who frequently use and are often comfortable with these medias (36).	• Context specific design of GPFA required – GPFA should be tailored appropriately to each group of participants, based on the demographics and history of the group. • Additional sessions or focused team building may be necessary for groups that do not have a prior history together. • For youth, additional activity-focused team building prior to GPFA sessions is recommended to build group cohesion
Programme Theory 5: Group Composition			
When people experience a similar acute crisis or prolonged stress, and GPFA is provided with members and facilitators working at similar levels (or if different, neither holding direct authority), power imbalances can be reduced, supporting open and honest sharing. This can also develop a sense of comradery and group cohesion, increasing communication, participation, and attendance. (24, 25, 27-29, 31, 32, 35, 39)			
Summary	Caveats/Notes	Youth Applications	Recommendations
Programme theory addresses the group	Balancing power dynamics is heavily context specific. Considerations are especially important in cultures with strong social, gender, and/or age hierarchies, where	Both age groups (43) as well life stages, which may differ between cultures and contexts, should be	• Group composition is context-specific – considerations should be made appropriately

composition of both members and facilitators.	heterogeneity may influence individuals' participation in the group session. This may also be particularly relevant in humanitarian workforces with national and local staff both coming from diverse backgrounds and cultures, though again is highly context specific.	considered when composing groups. Youth often process trauma differently than their older counterparts. If grouped together, understanding natural reactions may be especially difficult or confusing (44).	in regards to members genders, positions, ages, experiences, exposure, etc. • Depending on context, facilitator may need to be peer or person in more authoritative role • Youth likely require two or more groups for ages 14-24. Depending on context may be by divided by their age (i.e. 14-17, 18-24), or experiences (i.e. married or non-married)
Programme Theory 6: Sustainability and Accessibility			
Following an acute crisis or period of prolonged distress, when GPFA is linked into complementary supports safely and with cultural competence, it can improve support and access to these support services through increasing visibility and reducing stigma of care-seeking. The outcome may be more individuals access ongoing support, reduced secondary stressors, decreased isolation, and support becomes sustainable. (23-25, 34, 35, 39)			
Summary	Caveats/Notes	Youth Applications	Recommendations
Programme theory six addresses how GPFA can be accessible and sustainable for members.	These linkages may be especially important in contexts where individuals may be displaced or have lost access to prior services. In a few cases, tools learned from previous GPFA sessions have supported early management of reactions among previous participants experiencing new or re-occurring traumas. Individuals in this instance may be more likely to seek out support or additional GPFA for themselves or others.	Reducing stigma of care-seeking can facilitate recovery among youth (36, 38)	• Youth may require initial 'activity-based' introduction to GPFA, to reduce stigma around care seeking. • GPFA should link to complementary support services, and informal communication platforms for continued group engagement/support encouraged . • In chronic events, more GPFA sessions and/or informal communication platforms such as WhatsApp, group bonding activities, etc. should be supported for participants.
Programme Theory 7: The Facilitators			

Acute crises and periods of prolonged distress affect individuals differently depending on exposure levels or previous life experiences. When GPFA is provided by appropriately trained facilitators[8] (ideally two) able to gauge individual reactions and needs, groups can be composed based on similar distress levels or needs. A second facilitator supports severely distressed members by taking them aside and providing or linking to more specialised care. This protects individuals' dignity, reduces exposure of members to secondary trauma, and ensures needs-matched care.(23, 25, 27, 30, 32, 34, 37, 39)			
Summary	Caveats/Notes	Youth Applications	Recommendations
Programme theory seven focuses on the facilitators and their training.	Facilitators should be accessible for continuation of care through further informal, interpersonal discussions (particularly in low-resource settings) and/or linking to ongoing support where available. It is also important that the facilitator is relatable to the members, particularly for youth, though again is context specific. Facilitators themselves need supportive supervision and linkages to additional services, and/or GPFA, to support their own well-being.	It is also important that the facilitator is relatable to the members, particularly for youth, though is heavily context specific.	• GPFA should be led by a minimum of two facilitators per group • Context-specific considerations should be made as to who facilitators should be; gender balance, peer vs. non-peer, age, etc. • Supportive supervision must be built into GPFA design to support the facilitators • Training of facilitators needs to be robust and comprehensive. • Strong interpersonal skills, empathy, and ability to gauge reactions are needed as a facilitator • For youth, facilitator should be relatable in age (i.e. late youth/early adult).

[8] Facilitators must be trained not only to provide GPFA, but in how to work with the demographics of the groups. Training should be as comprehensive as possible, and should involve practice or role playing.

Application to COVID-19

Humanitarian workers across the globe are responding to COVID-19 either directly, or are continuing their regular responsibilities (often with new adaptations) under the new threat of COVID-19. The findings of our review are likely very applicable to the COVID-19 response for these populations. Some specific findings may however be particularly relevant given their elicitation from similar contexts (i.e. Ebola response).

Notably, given COVID-19's transmission pathways means social boundaries and bonds may be changing, and increased stigma and fear emerging. If GPFA can be offered in a safe fashion, it can be an important tool to support the re-building of such social bonds for humanitarian workers. This may also require innovative methods to implementing GPFA through more distanced or remote procedures, something which has yet to be explored. This however may have implications for the approach across settings (i.e. more remoted with connection issues and/or for certain populations), management and facilitation of groups especially identifying those in-need of additional supports, and how remote GPFA may influence the social bonding and peer support that is essential to this approach. The Inter-Agency Standing Committee has produced Operational considerations for PFA during COVID-19 pandemic (available here).

While COVID-19 is an ongoing event, it might be important to have more structured or frequent sessions to enhance feelings of social support and reduce perceived isolation. For example, monthly or bi-monthly as opposed to 2 sessions occurring in the more immediate aftermath of an acute event. Or, it may facilitate the use of external networking and connection building, such as integrating communication platforms (WhatsApp groups, phone trees etc) for continued peer support.

Discussion

Effectiveness and contextual influences of GPFA

GPFA and PFA evolved as an alternative to critical incident stress debriefing (CISD) (45), which involves group members sharing details of their traumatic experiences and emotions (46). Multiple studies have shown that CISD does not improve recovery from psychological trauma (46), and in some cases, may actually negatively impact mental health outcomes (47, 48). GPFA and PFA do not involve discussions about the recent trauma, but rather focus on assessing needs and providing the support and tools to help individuals to cope on their own. Because GPFA provision is informed by the culture and context, it is considered a practical and highly adaptable approach to providing psychosocial care and support to staff members working in humanitarian contexts (45). A systematic review by Jones et. al found that psychoeducational interventions may help to prevent and/or manage depression in adolescents (49). Additionally, findings from a cross-sectional study in Iran by Reza Roohafza et. al show that perceived social support and positive coping strategies can serve as protective factors for anxiety and depression (22). Given that PFA and GPFA aim to provide psychoeducation, support positive coping strategies, and increase psychosocial support and access to further resources, it is possible that these interventions may help reduce anxiety and depression. While it was beyond the scope of this review to identify evidence demonstrating the effectiveness (or ineffectiveness) of PFA, the consensus among experts is overwhelmingly strong in favour of PFA and GPFA (50).

While our review did not specifically address effectiveness or scenarios on how effectiveness may be optimised, our findings do give important insights into contextual conditions that can affect how, why and for whom, GPFA works for humanitarian workers/volunteers. As detailed in Table 1, these include the implementation conditions in which GPFA is established, the supports and relevant linkages participants have available to them, the connectivity of the group and their ability for peer-support, the group make-up including sharing of past experiences, and in some contexts how these groups are divided across age, gender and other social characteristics, and the facilitators' make-up, skill-level and supports.

Young people and GPFA

This review did not find any literature regarding provision of GPFA for youth. Instead, the reviewers had to infer how GPFA could work with youth through examining literature about other group-based interventions with this age group. Evidence suggests that youth would be receptive and benefit from the group format of GPFA, given that group interventions and discussions are common practices within youth services (38, 40-42), and that peer-based learning and group techniques strongly support the developmental stages of this age group (36, 38, 41). Receiving psychosocial care alongside peers can reduce feelings of stigma associated with individual counselling (51). The relationship building and sense of belonging that is fostered in group settings facilitates recovery among youth through developing interpersonal skills, working toward shared goals, and decreasing isolation (36, 51).

Based on these findings, the reviewers have provided recommendations for 'youth friendly' GPFA among humanitarian workers and volunteers, which can be found in Table 3. These largely revolve around the need to ensure strong group connectivity so that participants can benefit from peer learning, and also work to increase normalisation and decrease stigma around GPFA. Whereas typically, GPFA is offered in 1 or 2 sessions (however, we recommend that a minimum 2 sessions for GPFA is ideal), for GPFA with young persons it is likely necessary to increase the number of sessions to allow for more connectivity building. In addition, exploring informal methods to maintain relationships (i.e. WhatsApp groups) could be an important tool moving forward for GPFA for youth. Group make-up needs to be carefully considered within youth populations, especially given the vulnerability to peer influence within these populations.

Scalability, Applicability and Contextual conditions

The group format of GPFA increases the capacity of psychosocial support provision through providing PFA to several individuals at the same time, while also fostering support and relationship building between group members (23). Additionally, because individuals do not need to be mental health specialists in order to become facilitators, GPFA is a practical approach for providing psychosocial support to populations affected by a crisis, particularly in low-resource settings, so long as sufficient training of facilitators occurs (24, 52). However, GPFA is still an intensive approach that needs comprehensive consideration prior to implementation.

GPFA is a complex approach that is embedded within wider support systems (Box 1), as such linkages and well-structured supports are required. GPFA should only be implemented when organisations can either link to or provide additional resources to participants, specifically basic needs support and further services (i.e. more advance mental health support). Appropriate staff make-up and competencies is also essential, including supervisors, trainers and facilitators. Resources for facilitators should also be available. As such, organisations need to carefully plan and consider whether their institution can support GPFA or its scale-up.

GPFA is very applicable to a wide variety of contexts, especially less resourced contexts where it is often implemented. However, best practice still needs to be applied to ensure the ethical and proper support of participants. Our findings highlight many different contextual nuances to the implementation of GPFA, highlighted in Table 3. Of main importance from these findings is that each context in which GPFA is implemented is different, and the specifics of GPFA is not one-size-fits-all. Any consideration of design or implementation should be preceded by a thorough contextual analysis which aims to identify: 1) existing support services available for linkages and referral; 2) basic needs requirements and ability for the organisation to support or provide these; 3) group history and experiences, for example if they are pre-existing group or to be newly formed; 4) socio-cultural conditions for the composition of group, including any gender, age, or cultural considerations; and 5) composition of facilitator(s) and how they will be trained, supervised and supported.

Limitations

There were no resources that explicitly implemented GPFA to young people. While experts were very encouraging of its application to this population, to date no research has validated or tested this approach within this population. Our unique methodological approach, using a rapid realist review, and then applying youth specific literature to our theories allowed us to infer from a wide variety of literature to overcome this obstacle. There is also an overall paucity of research on GPFA for humanitarian workers. While implemented,

a large proportion of our included documents were implementation guidance as opposed to research studies. As such we included articles that more broadly applied to GPFA, such as those for PFA, GPFA outside of humanitarian workers, for other group-based events for humanitarian workers. Additionally, how GPFA was implemented varied across included resources. Given the nature of the review question, and also the type of methodology we utilised, we did not seek to identify effectiveness of GPFA. Lastly, no youth representation was included within the expert groups or research team. While experts had experience in working with youth, their input would have further strengthened this work and is an important limitation.

Recommendations

This review has provided insights into a number of contextual conditions that affect how, why and for whom, GPFA works for humanitarian workers and volunteers. Based on the evidence, (as presented in Table 1 and Appendix 4) the researchers have developed the following recommendations:

- GPFA should be embedded within a **broader system of support**, in order to adequately meet resource needs and facilitate service connections to further mental health support and/or resources for physical needs among group members.
  - In resource limited contexts, broader support may be scarce. Under these circumstances, it is especially important for GPFA to provide further informal support. This can be done through conversations/meetings with facilitators following sessions, and/or through developing platforms for communication among participants (i.e. WhatsApp, Facebook)
- Approaches to implementing GPFA vary depending on **contexts** including:
  - **Group make up** – considerations to gender, exposure to trauma, age groups, etc. Depending on the context, it may or may not be appropriate to separate individuals by gender. Groups should also be organised based on similar exposure levels and/or reactions to the trauma, in order to prevent secondary trauma among participants. **Age groups for youth** are heavily context dependent. It is important to understand the contextual differences before composing groups. For example, in some contexts youth groups may be separated by 14-17 year olds and 18-24 year olds. However, cultural norms such as marital status, for example, should also be taken into consideration.
  - The **history of group members** – If group members do not already know each other, group bonding activities/icebreakers are imperative prior to beginning the GPFA session.
  - **Relationship to facilitators** – Facilitators as peers, group leaders, managers, elders, etc. may be appropriate depending on the culture/context. For example, in some cultures/context peers working at the same or similar levels may be best suited to lead GPFA, while in some cultures a respected elder or leader may be most effective.
- Facilitators must have **strong training**, including how to create a safe and inclusive environment, active listening, conflict resolution, managing group dynamics and consensus building. They must be properly supervised through supportive supervision which is, "an approach to supervision that emphasises joint problem-solving, mentoring and two-way communication between the supervisor and those being supervised" (Marquez & Kean, 2002, p. 3) (i.e. not fault-finding, inspection, and control as means of pushing individuals to perform their duties)
- A **minimum of two GPFA sessions** should be provided following an acute traumatic event to foster group connectivity and provide psychosocial support. **For youth, the minimum is three.** Youth may require an additional 'bonding' session during the first meeting, consisting of a 'fun activity' in an informal setting in order to develop group cohesion.
- **Chronic event contexts** may benefit from a structured, regular meeting schedule as well as informal supports for members to stay connected, for example via WhatsApp groups, weekly activities/informal meet-ups (i.e. lunch/dinner group), etc.
- GPFA should encourage **linking members** via social media or other ways to connect (for example a phone tree, WhatsApp, Facebook, etc.) for all ages, and especially for youth.

It is also recommended that further research on this topic be explored, specifically around:

- Remote opportunities and challenges for GPFA, especially in the context of COVID-19.
- How informal communication networks can support GPFA members and integration considerations

- Testing of the finalised programmes theories through real-world implementation, specifically in relation to GPFA for young adults.

Conclusion

The humanitarian workforce faces many challenges and experience increased levels of anxiety, depression, and post-traumatic stress disorder. Group Psychological First Aid is implemented and widely recommended to provide humane, supportive and practical help in a group setting after an acute or during an ongoing event. However, there is a dearth of evidence on how, why and for whom GPFA works to address the needs of this cadre, and moreover the literature on GPFA for youth is extremely sparse. Findings from this review however have developed programme theories to understand 'how, why, for whom and in what contexts' GPFA works. By applying these theories to existing evidence on youth we have provided key contextual and programmatic insights into GPFA. Largely centering around the benefits of having appropriately implemented peer-support, GPFA enables individuals to understand their natural reactions and develop adaptive coping strategies, while also building social connections that promote a sense of belonging and security. The integrated design of GPFA ensures individuals are linked to additional supports and have their basic needs addressed. While the evidence-based is sparce on this approach, its applicability to youth and its ability to provide support to humanitarian workers is likely very strong.

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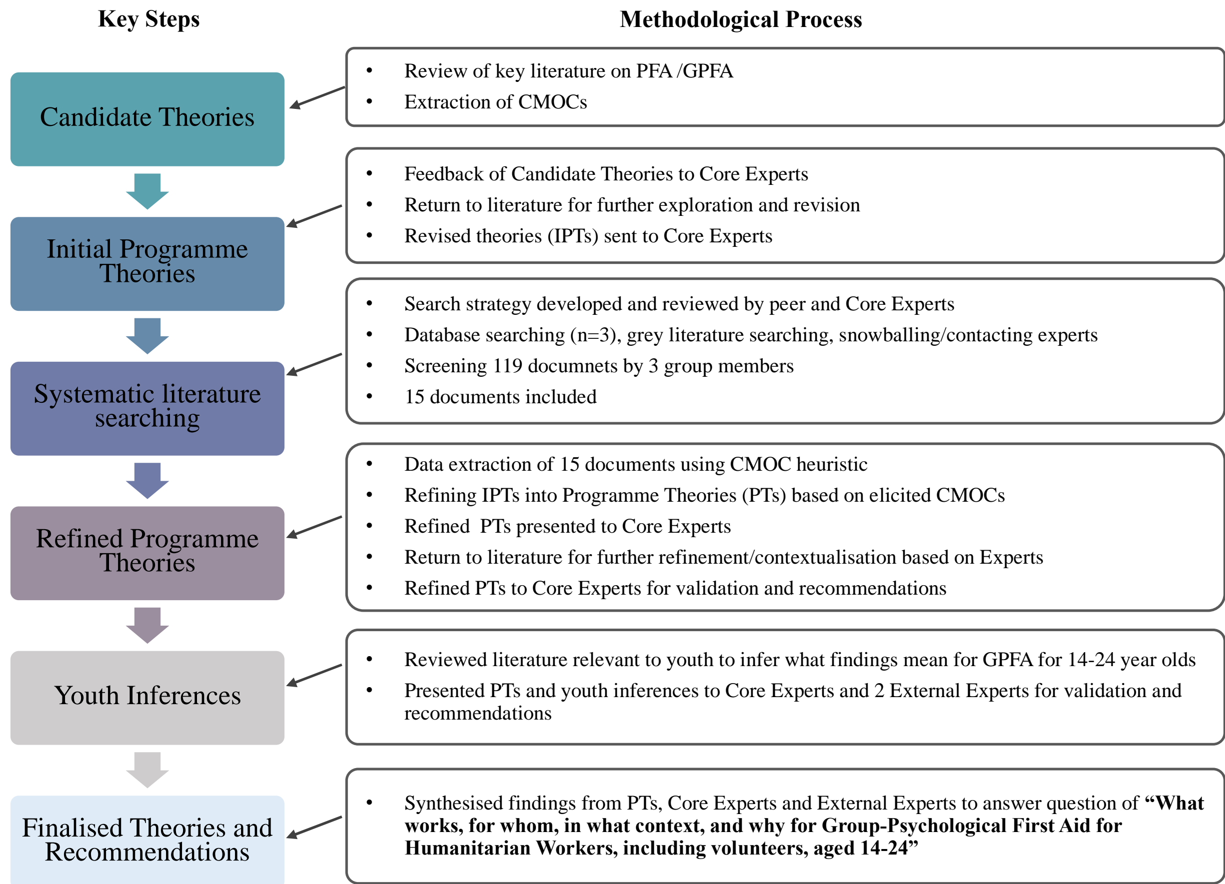
Appendix 1: Key Research Steps and Methods Overview



Process of refinement

<table>
<tr><th rowspan="10">Preliminary literature review</th><th rowspan="10">Candidate theories</th><th rowspan="10">Core expert meeting 1</th><th>Theory refinement</th><th>Literature search & appraisal</th><th>Data extraction</th><th>Theory refinement</th><th>Core expert meeting 2</th><th>Second review of literature and youth lens</th><th>Core experts and External expert meetings</th><th>Resulting Programme Theories</th></tr>
<tr><td colspan="3">IPT 1</td><td colspan="2">PT 1.1</td><td colspan="2">PT 1.2</td><td>PT 1.3</td></tr>
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Appendix 2: Detailed Search Strategy, Returns, and Inclusion/Exclusion criteria

Search terms for databases:

Population 1 (OR)	Population 2 (OR)	Exposure (OR)	Intervention (OR)
Humanitarian workers Humanitarian volunteers Emergency workers Emergency volunteers Crisis workers Crisis volunteers Relief workers Relief aid workers NGO staff NGO volunteer	Youth Young persons Young adults Adolescent	Trauma Traumatic event Critical incident Emergency Crisis Humanitarian crisis Acute crisis Disaster Terrorism Depression Anxiety	Psychological first aid PFA Group psychological first aid G-PFA Team PFA Stress first aid SFA Mental health first aid Psychoeducation

Search string used:
Population 1 AND Population 2 AND Exposure AND Intervention

Database search:

Database	Date	Results
PubMed	7/9/2020	37
T&F Online	7/9/2020	22
SCOPUS	7/9/2020	20

Grey literature search*:

Website	Date	Reviewed	Included
WHO	31/8/2020	7	0
	1/9/2020	2	0
United Nations	1/9/2020	1	0
MHPSS Network	2/9/2020	6	3
ReliefWeb	2/9/2020	8	7
Elrha	3/9/2020	5	0
ICRC	4/9/2020	6	0
IFRC	4/9/2020	5	0

Search terms used for grey literature searching included:
Group psychological first aid, Group PFA, psychological first aid, "group psychological first aid", "psychological first aid", "psychological first aid" group, and "group PFA"

Inclusion/exclusion criteria

Inclusion criteria:	Exclusion Criteria:
Main subject, or important area of the wider topic discussed, must be: • Group psychological first aid, OR • Applicable to GPFA (i.e. PFA) The resource must describe or be relevant to at least one of the following: • Contextual details about GPFA • Mechanisms through which GPFA is provided • Strategies and processes through which GPFA is implemented • GPFA models or theories • GPFA as a new approach to mental health care Study design/literature type: • Open Published date: • 2010 - present Language: • Any	Main subject of literature is: • Not applicable to GPFA • Focused on long-term care/support • Critical incident stress debriefing • Critical incident stress management Participants/target populations: • Explicitly described as being 25 years or older

Appendix 3: Initial Programme Theories

IPT 1: Normalization and adaptive coping

Following a traumatic event (C), G-PFA is held within an appropriate time frame (R1) to support members to use their natural comping mechanisms, normalise relationships and learn additional adaptive coping strategies (R2). The outcome can be the prevention of distress escalation (O).

IPT2: Meeting basic needs

After a traumatic event people are often affected differently and require different levels of support (C). G-PFA using a layered system of complementary supports, including information, psychoeducation, social, emotional, physical and psychological support through group methods (R1) can increase an individuals' sense of safety and emotional expression (R2), ensuring basic physical and psychological needs are met (O).

IPT3: Response matched to individual needs

After a traumatic event people are often affected differently and require different levels of support (C). G-PFA uses a layered system of complementary supports, including information, psychoeducation, social, emotional, physical and psychological support and also psychological triage and service connection for more acute needs (R1). This means individuals can be referred to and access additional services and access a level of care that is right for them and their current needs (O).

IPT4: Fostering support and connection/cohesion

When people experience a similar traumatic event (C), and G-PFA is provided to a small group (around 10 people) who already know each other and have they shared experienced or exposure (R1) this can strengthen group cohesion and a sense of connectivity (R2) having group members feeling less isolated, the fostering of relationships and communications pathways (O).

IPT5: Group composition and stigma

When people experience a similar traumatic event (C) and G-PFA is provided to a heterogenous group, which can be made up of different ages, gender, or life experiences usually working at the same or similar levels (R), the group setting can mean members learn from each other, and can feel comfortable sharing (R2) which may influence stigma associated with care-seeking, promote social support, and reduce sense of isolation (O).

IPT6: Sustainable and access

The provision of mental health and psychosocial services in emergencies aim to strengthen capacities of individuals, families, and societies to cope with trauma on their own (C). When G-PFA is built on existing mental health resources and integrated into existing wider support services (R1) more individuals are able to access support and support is more sustainable (O).

*C= context, R1=resource, R2=reaction, O=outcome

Appendix 4: Detailed Finalised Programme Theories

A total of seven programme theories emerged from the literature and expert panel. The supporting literature that supported the development of each PT is cited within. This is comprised of literature from the included systematic search, and additional literature specific to youth.

The first programme theory revolves around natural reactions and adaptive coping:

> *Following an acute crisis or period of prolonged distress, if GPFA is delivered early and appropriately, it provides a space to discuss natural reactions, normalise relationships, and address expectations. If this occurs, participants will be better equipped to process experiences early, feel their reactions are natural, and to continue supporting their mental health. This can lead to improved healthy coping strategies, self-awareness, and the management or prevention of distress escalation or re-escalation. (1-10)*

The nature of humanitarian work often results in workers and volunteers prioritising others' well-being before their own. The group format of GPFA may encourage this workforce to attend to support their peers, and through this they may also receive benefits. GPFA provision can help facilitate the recognition of stress reactions as normal and reduce hesitancy on care-seeking among the workforce. Skill building is also a critical component for youth (11), many of whom are still learning and developing their own coping strategies. Provision of these practical tools and space may be especially important in settings with limited or disrupted services.

The second programme theory addresses the meeting of basic needs:

> *Acute crises and periods of prolonged distress affect individuals differently depending on exposure levels or previous life experiences. Basic resource needs may be disrupted, requiring different levels of physical and psychological support. If GPFA is provided in a comfortable location, using a layered system of complementary supports, this can help meet an individual's basic physical and/or psychological needs, which can increase their sense of stability, safety, and control. If this occurs, individuals are able to be more emotionally expressive, self-efficacious, and recognise their reactions as natural. This helps to prevent distress escalation through emotional stabilisation, reduced secondary stressors, and helping individuals cope on their own. (1-3, 7, 10, 12, 13)*

In an ideal situation, basic needs would be met during GPFA. However, practical challenges may arise, particularly in meeting physical needs, based contextual factors. This is especially true in low-resource settings. Setting clear expectations prior to the meeting is important to the well-being of both beneficiaries and facilitators. Emotional stabilisation and reduced secondary stressors may help establish a sense of control, facilitating recovery among youth (14).

Programme theory three focuses on responses matched to individual needs:

> *Acute crises and periods of prolonged distress affect individuals differently depending on exposure levels or previous life experiences. When there is an existing social support/resource system, if GPFA is linked with this system[1] and facilitators can gauge individual reactions and needs, this can enable an open space for members to share reactions, coping strategies, and resources. This can also support individuals to be referred for additional support appropriate for them. Supporting service connections in group formats can reduce stigma associated with care-seeking and increase access to needs-matched services, reducing secondary stressors and strengthening an individual's ability to cope on their own. (1-3, 5, 8-10, 12, 15)*

GPFA may facilitate youth recovery through reduced stigma of care-seeking. The group format provides an opportunity for members to listen, without pressure to share or participate in a discussion (16). Reducing this stigma and pressure to share can facilitate recovery among youth (14, 16).

Programme theory four focused on fostering support and cohesion of group members following an acute crisis or periods of prolonged stress:

> *When GPFA is provided to a small group of individuals who already know each other and share similar experiences and stress levels, it provides an opportunity to discuss reactions and emotions. This helps individuals feel more supported by peers, strengthens group cohesion, validates reactions, and opens communication about mental health. The outcome is the fostering of relationships, reduced isolation, increased sense of safety and belonging, and improved coping. (1-3, 5-7, 9, 10, 12, 17)*

For youth, the provision of GPFA among peers supports their natural tendencies to share with peers and request support in groups (6). GPFA can also be provided to members who do not know each other beforehand. However, an icebreaker and/or group activity aligned with the culture should take place prior. This approach may be useful in circumstances where individuals are disconnected or separated from their families or communities:

> *When GPFA is provided to a small group, who may not know each other but share similar experiences and stress levels, this can develop or strengthen sense of belonging to communities, fostering relationships, communication, and helping group members feel less isolated. (1-3, 5-7, 9, 10, 12, 17)*

The group nature of GPFA may be particularly important in collectivist cultures that naturally feel comfortable in group settings. Given that social relationships are important to the development of youth (14, 16, 18), group interventions are well suited to this age group (16, 18), and have been shown to be effective across a broad range of mental disorders (19). Providing an activity before and/or during GPFA with youth may also increase participation and build connections with peers (18). These connections facilitate recovery (14). Additional informal or social group spaces beyond GPFA may support ongoing dialogue and support among members. Online platforms such as WhatsApp or Facebook groups may be especially relevant to reaching youth, who frequently use and are often comfortable with these medias (14), and can also be useful in events interrupting social gatherings (like epidemics).

Group composition and stigma was addressed in programme theory five:

> *When people experience a similar acute crisis or prolonged stress, and GPFA is provided with members and facilitators working at similar levels (or if different, neither holding direct authority), power imbalances can be reduced, supporting open and accessible sharing. This can also develop a sense of comradery and group cohesion, increasing communication, participation, and attendance. (2, 3, 5-7, 9, 10, 13, 17)*

Balancing power dynamics is heavily context specific. Considerations are especially important in cultures with strong social, gender, and/or age hierarchies, where heterogeneity may influence individuals' participation in the group session. With youth, both age groups (20) as well life stages, which may differ between cultures and contexts, should be considered when composing groups. Youth often process trauma differently than their older counterparts. If grouped together, understanding natural reactions may be especially difficult or confusing (21). This may also be particularly relevant in humanitarian workforces with national and local staff both coming from diverse backgrounds and cultures, though again is highly context specific.

Programme theory six focused on sustainability and accessibility of GPFA:

> *Following an acute crisis or period of prolonged distress, when GPFA is linked into complementary supports safely and with cultural competence, it can improve support and access to these support services through increasing visibility and reducing stigma of care-seeking. The outcome may be more individuals access ongoing support, reduced secondary stressors, decreased isolation, and support becomes sustainable. (1-3, 12, 13, 17)*

These linkages may be especially important in contexts where individuals may be displaced or have lost access to prior services. In a few cases, tools learned from previous GPFA sessions have supported early management of reactions among previous participants experiencing new or re-occurring traumas. Individuals in this instance may be more likely to seek out support or additional GPFA for themselves or others.

The facilitators were addressed in programme theory seven:

> *Acute crises and periods of prolonged distress affect individuals differently depending on exposure levels or previous life experiences. When GPFA is provided by appropriately trained facilitators (ideally two) able to gauge individual reactions and needs, groups can be composed based on similar distress levels or needs. A second facilitator supports severely distressed members by taking them aside and providing or linking to more specialised care. This protects individuals' dignity, reduces exposure of members to secondary trauma, and ensures needs-matched care.(1, 3, 5, 8, 10, 12, 15, 17)*

Facilitators should be accessible for continuation of care through further informal, interpersonal discussions (particularly in low-resource settings) and/or linking to ongoing support where available. It is also important that the facilitator is relatable to the members, particularly for youth, though again is context specific.

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