

The community pillars project: engaging survivors as cross-cultural facilitators in Aotearoa/ New Zealand

Refugees as Survivors (RASNZ), Auckland, New Zealand¹

Key points of interest

- In Aotearoa New Zealand, some survivors (former refugees) have been engaged as Cross-Cultural Facilitators, providing cultural bridging services
- A co-designed pilot training programme has supported these Facilitators to become “community pillars”—individuals who can help enhance mental health by delivering information and providing direct support to their communities
- This model could be adapted in other countries as one method of supporting survivor engagement in addressing the impacts of trauma

Abstract

Introduction: Communities who have fled torture and persecution in their home countries can find it difficult to access services in new cultural settings. Past research has shown that it is helpful to provide cultural bridging services to form a connection between locally-trained professionals and newly relocated communities.

Method: This article presents, from a practitioner’s perspective, a case example of cultural bridging involving a pilot programme to train individuals with refugee-like backgrounds (including torture survivors, former refugees, forced migrants) to become Cross-Cultural Facilitators supporting mental health services for displaced communities.

Results: The Cross-Cultural Facilitator role has become an integral part of the case example agency’s services. Internal agency reviews of the Cross-Cultural Facilitators’ work shows that they have been continuing to operate successfully through challenging times, including the many societal disruptions and stressors entailed in the Covid-19 pandemic. The agency has also gathered notable anecdotal evidence that the pilot training programme has been positively impactful and supportive not only for the Cross-Cultural Facilitators but for the communities they serve.

Discussion: Healthcare workers and civil society organisations have an important role

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to play in supporting survivors to engage in this form of cultural facilitation aimed at addressing the consequences of traumatic experiences at a community level. In doing so, they must balance efforts to empower survivors and former refugees to participate as agents of change with a duty of care not to push individuals into roles or settings that may diminish their own wellbeing.

Keywords: Mental health, Survivor engagement, Cultural bridging, Community services

In-depth community knowledge, cultural understanding, and skills in effective communication are essential for providing high-quality health and social services (e.g., see O’Keefe et al., 2021). For communities who have fled torture and persecution in their home countries and been relocated to a new and very different cultural setting, it can be difficult to locate professionals with the requisite skills and knowledge to adequately serve their needs. In such settings—in particular, in countries such as Aotearoa New Zealand that provide refuge and asylum for forcibly displaced people—past research has shown that it is helpful to provide cultural bridging services to form a connection between locally-trained professionals and newly relocated communities (e.g., Salami et al., 2018). In this article, we describe, from a practitioner’s perspective, an example of such cultural bridging involving a pilot programme to train individuals with refugee-like backgrounds (including torture survivors, former refugees, forced migrants) to become Cross-Cultural Facilitators supporting mental health services for displaced communities. We reflect on the role of healthcare workers and civil society organisations such as the mental health agency described in this case (Refugees as Survivors New Zealand—RASNZ), in supporting survivors to engage

in this form of cultural facilitation aimed at addressing the consequences of traumatic experiences at a community level. In particular, we note the importance of balancing efforts to empower survivors and former refugees to participate as agents of change in their communities and of holding a duty of care not to push individuals into roles or settings that may diminish their own wellbeing.

Background: refugee context in Aotearoa New Zealand

Aotearoa New Zealand has a quota of UN-designated refugees whom it admits for in-country resettlement each year (recently increased to 1500 from a former cap of 750). The country also receives approximately 300–400 spontaneous refugees each year who seek asylum (Ferns et al., 2022) and status as refugees under the 1951 UN Convention Relating to the Status of Refugees and its 1967 protocol, which New Zealand is a signatory to. Records on the proportion of these refugees who have survived torture (as defined by the UN Convention Against Torture) are not readily accessible, but one locally based study estimated that 20 percent of the so-called “quota refugees” arriving during 2007–08 were survivors of torture (Poole & Galpin, 2011); the proportion among more recent arrivals, and among those seeking status as “convention refugees” may be higher.

Refugee experiences for those resettled in Aotearoa New Zealand are diverse. Some refugees, such as those from Southern Sudan, have endured years of warfare. Others, such as the Hazara from Afghanistan, have suffered internal displacement or repression within their own countries for long periods. Still others have been subjected to siege conditions in their hometowns and cities, as in Myanmar and Syria, or have lived through the terror of total anarchy, as in Somalia.

It is estimated that 40 percent of refugees have experienced severe trauma, such as witnessing killings – often of their own family members (Abu Suhaiban et al., 2019). Many have survived detention, physical violence, rape and perilous journeys to countries of asylum, only to endure a hand-to-mouth existence in dangerous overcrowded camps or urban refugee environments.

Families from refugee backgrounds are overrepresented in poor health and social statistics in Aotearoa New Zealand (Marlowe et al., 2023). Many live in poverty and hardship, with difficulties covering basic needs, financial uncertainty and dependency on income support. Post COVID 19, family coping skills have been further challenged with high unemployment, overcrowded housing, the effects of digital exclusion on education for children and youth, and access barriers for poor and older people to timely health, social and income support services (Mortensen, 2020).

Brief overview of RASNZ

Although experiences differ across countries of origin, most former refugees have been exposed to war, violence, persecution, extreme resource limitation, and many years of displacement prior to their arrival in Aotearoa New Zealand. Most do not require specialist services to support their mental health as they transition to life in Aotearoa New Zealand—and indeed, may be influenced by strong stigma against seeking such support. However, there is a need for culturally-appropriate support for those who face challenges in processing their trauma and adjusting successfully in the face of ongoing stressors, which mainstream services have struggled to provide (Mortensen, 2020; Ward et al., 2018).

Refugees As Survivors New Zealand (RASNZ), a member of the International Rehabilitation Council for Torture Victims

(IRCT), was established in 1995 as a small charitable trust to fill this need for mental health and wellbeing services to former refugees, from the time of their first arrival in Aotearoa New Zealand and beyond. It is a politically neutral, non-denominational organisation governed by an elected Board of Trustees. RASNZ is largely government-funded, although philanthropic individuals and organisations, and global sources such as The United Nations Voluntary Fund for Victims of Torture, have also provided financial support. The additional funds are particularly important for extending RASNZ's services into areas that may not receive mainstream public health funding but that are effective in, and essential for, meeting community needs (such as the community pillars programme).

RASNZ is based in Tāmaki Makaurau, Auckland—the largest city and first point of arrival for most people entering Aotearoa New Zealand. The nature and shape of its services have changed over time, often shaped by funding streams and policy priorities (RASNZ 2021). Currently, the organisation works from two main locations: (i) Te Āhuru Mōwai o Aotearoa (TAMA), the Refugee Resettlement Centre in Māngere, where former refugees first arrive and are welcomed and oriented as new New Zealanders during a 5 week stay, before being resettled in towns and cities around the country; and (ii) a community clinic that is more centrally-located in Auckland for former refugees to access, and from which staff can also arrange to travel out to community venues around the city (e.g., halls, libraries, and other local organisations with private meeting spaces) to meet with clients. Both sites provide mental health clinical services, including assessment, psychotherapy, and outward referrals, as well as body therapy, social work, psychiatry, youth-focused activities supporting psychosocial development, and

cross-cultural facilitation as appropriate. Staff speak multiple languages, but also work closely with professional interpreters to ensure clear communication with clients.

Much of RASNZ's work is focused on supporting clients as they adjust to a new way of life in Aotearoa New Zealand. Service users often request pragmatic solutions rather than psychological assistance. The process of integrating into New Zealand society involves: addressing language barriers; adapting to the new culture while attempting to maintain one's own culture; changing family roles and dynamics; navigating health, education and social services; and facing racism, discrimination, loneliness and isolation. Many experience survivor guilt, anxiety about family members still in home countries, and the expectation of family obligations to support family and friends offshore.

Effectiveness of cross-cultural bridging in refugee-background communities

Internationally, research with refugee-background populations, including survivors of torture and other displaced persons, has pointed to the importance of including individuals who can "broker", bridge, translate, and navigate between cultural communities as an integral part of health and social service provision. For instance, in a recent study of immigrant service providers in Canada, Salami and colleagues (2018) identified that frequent barriers to refugee-background populations accessing mental health services included stigma and linguistic difficulties, and one of the approaches most commonly seen as mitigating these barriers was to give interpreters and "cultural brokers" an increased role. In a meta-review of published research, Herati and Myer (2020) also found that cultural brokers and interpreters in school settings were important for improving outcomes for refugee-

background youth. Using a thematic analysis of data collected from a series of workshops with diverse migrants and former refugees in a region of Aotearoa New Zealand, Ward and colleagues (2018) identified six overarching themes among participant needs: language and communication support, easier-to-navigate systems and services, opportunities for employment and more affordable living situations, inclusion and a sense of connectedness, support with acculturation challenges, and support for improved health and wellbeing. Participants also identified key opportunities for better meeting their needs, including more community initiatives such as support groups, community exchanges, and a refugee council, more information and training to help with practical skills and intercultural understanding, and increased availability of interpreters and culturally congruent mental health services. All of these opportunities appear well-suited to cross-cultural brokers or facilitators.

O'Keefe and colleagues (2021) have proposed that it is important to ensure clients are served by culturally-matched community mental health workers who have a good understanding of clients' community history and who are able to communicate culturally-relevant / traditional models of mental health and wellbeing, focusing in particular on North American indigenous communities. Importantly, however, Liu (2013) cautions that culture or language matching alone is not sufficient for culturally competent care. Drawing from a qualitative study of bilingual social workers, Liu identified that participants varied in their approaches to managing mental health concerns in the ethnic communities they were working with, and benefited from appropriate supervision that could help them grow their skills, reflect on their unique perspectives, and adjust their services to most effectively meet client needs.

Incorporating such guidance, and drawing from their recent qualitative study of refugee, torture survivor and migrant health needs in a metropolitan area of the US, Sheth and colleagues (2021) recommended that health and social service providers increase staff cultural humility through regular training. They also recommended that agencies increase engagement with—and from within—the communities they serve, including by recruiting providers with the same gender, language, or culture as clients, including cultural brokers or “health navigators” who could help increase community engagement through regular outreach.

Case example: training cross-cultural facilitators at RASNZ

Drawing on models of best-practice from around the globe, as well as local knowledge on how best to provide holistic care to help communities thrive (including indigenous conceptions of health in Aotearoa; e.g., Durie, 2011), RASNZ has included cross-cultural facilitators among its key personnel from its early days as a mental health organisation. Although not all of these cross-cultural facilitators—nor indeed, all of the communities that RASNZ serves—would identify as survivors of torture, RASNZ works from the understanding that torture is among the many traumas that refugees have endured and operates from a trauma-informed model.

Challenges with Western Biomedical Models

The western biomedical model maintains that mental health disorders are brain diseases and emphasizes pharmacological treatment to target presumed biological abnormalities (Deacon, 2013). Western models of mental health care focus on medical symptoms management and rehabilitation; whereas culturally-informed models view physical and

mental health holistically, as an equilibrium model (Lee & Armstrong, 2016; Marques et al., 2021). Explanatory models may include mystical, personal, or naturalistic causes (Benning et al., 2019). The basic logic of traditional models of health and illness consist of prevention (avoiding inappropriate behaviour that leads to imbalance) and curing (restoring balance). These systems are oriented to moderation. For example, in Chinese and Indian cultures, rather than talking about depression, Traditional Chinese Medicine (TCM) and Ayurvedic Medicine practitioners talk about balance and harmony in health, e.g. yin, yang and qi in TCM and Traditional Indian Medicine (TIM) (Gopalkrishnan, 2018; Patwardhan et al., 2005). If balance is maintained, then a disease-free state of mind and body can also be maintained. Hence, many non-Western cultures integrate the entire body, mind, and relations with family and society in the treatment of mental health disorders (Jimenez et al., 2012).

Seeking counselling for psychological issues is a western therapy. For many from refugee backgrounds it is an unfamiliar process which will need explanation. Counselling requires high levels of engagement and investment of time by the client, who may be preoccupied with the immediate challenges of resettlement. The client’s priorities need to be respected. Some clients may not want counselling, fearing that talking about their experiences may make them feel worse. As well, counselling, with its focus on the individual, may be unacceptable in some cultures in which greater emphasis is placed on whole families or communities working through a problem together. Many clients are wary about a referral to counselling services, seeing this as reserved for people they deem “mad” or “crazy”- a highly stigmatised group in many cultures. Clients may fear that confidential-

ity will be breached by the counsellor and or the interpreter.

The Cross-Cultural Facilitator Role at RASNZ

In seeking to find balance between a western clinical service model and a more community-development-oriented approach, RASNZ has worked to integrate both modes of care into its practice model (RASNZ, 2021). A key part of this integration has involved seeking to employ people from refugee backgrounds in both clinical and community-oriented roles, with an attempt to have staff matched to the different ethnic origins of former refugees settling in Aotearoa New Zealand—although this has proved challenging with an increasing diversity among the different groups of refugees arriving in the country over time.

Likely reflecting a range of factors—including educational and training disparities and inequities, the difficulty of having international qualifications in mental health recognised in Aotearoa New Zealand, and cultural/national differences in the way that mental health and wellbeing may be conceptualised and prioritised in career decisions—more refugee-background individuals seek positions and are employed as interpreters or as part time Cross-Cultural Facilitators (CCFs) at RASNZ than as full-time clinical staff. Nevertheless, in the small number of paid hours that CCF are allocated (and often working well beyond these hours out of their own drive and dedication), CCFs undertake invaluable work in community health education and resettlement support, drawing from their own experiences with resettlement and the knowledge they have acquired to successfully establish new lives in Aotearoa New Zealand.

The CCF role was established in 2000 (under the name “community facilitators”) when RASNZ first expanded its services

beyond the initial resettlement space and into the community to provide ongoing support to refugee-background individuals over time. By 2000, with the increasing numbers of refugees being settled in the Auckland region, RASNZ was aware that while its clinical work at the Mangere Refugee Resettlement Centre was vital, there was no mental health promotion or prevention work to respond to the stressors of resettlement once people left the centre. The need to train bilingual community-based staff led to the employment of ten Community Facilitators from different refugee communities for eight hours a week. Each facilitator had a refugee-like background (with lived experience of migration and direct or indirect trauma) and was identified as being active in their community already, thus well-placed to provide mental health support and leadership.

Community Facilitators were given the opportunity to undertake a six-week community development training programme. The programme was driven by community needs and together the team decided what issues to address. The subsequent community groups were language based, offering practical support and psycho-education in neighbourhood locations that were accessible to communities. As trust developed within the groups, they began to function as a support network, crucial for people who were socially isolated. The Community Facilitators were encouraged to enrol in tertiary education and were supported financially to study counselling, interpreting, social work and community development (Hood, 2021). The Community Facilitators team received regular training and supervision related to their community work roles and practice.

Since 2018, the team of CCFs (currently representing Afghan, Iraqi, Iranian, Burmese, Rohingya, Colombian, Eritrean, Burundian, Sri Lankan, and Rwandan communities) has

been managed by a Cultural Director from a refugee background, who oversees community-based work with a holistic, culturally informed approach. Over the years that CCFs have been in operation their work has included providing educational groups at TAMA on social and health-related topics, including smoking cessation and positive parenting¹; offering driver safety education and computer training under targeted, government-funded programmes; facilitating community-based empowerment groups for specific ethnic or gender groups in different parts of Auckland, often with a practical activity focus (e.g., sewing, job skills) to bring people together; and working directly with individuals and families to offer guidance on practical topics (e.g., good nutrition) and connect them with ongoing support in the community (often including supporting access to government financial support, health services, immigration guidance, safe and healthy housing, social groups, ongoing education and language tutoring, and jobs).

CCFs are seen as strong figures in their communities who can help newly arrived families break down social barriers and make

changes towards healthier lifestyles as they cope with the stressors of adjustment. The CCFs liaise with clinical staff when additional support may be needed for mental health or family violence concerns. Clinical staff also reach out to CCFs for cultural insights and to coordinate in meeting client needs as appropriate.

Community Pillars—“Train the Trainers” programme

To support them in their roles, the 11 current CCFs are asked to attend regular training meetings on topical mental health and wellbeing issues, both as their own group and with the wider body of RASNZ staff and are offered individual and group supervision to discuss challenges faced in their work. To further deepen their knowledge and expertise, RASNZ recently developed and piloted a two-phase Community Pillars professional training programme, in which CCFs were identified as metaphorical “pillars” and cross-cultural wellbeing “trainers” for their broader communities. The main purposes of the programme were to help CCFs to reduce stigma and discrimination towards people with mental health challenges, and to develop CCF confidence to recognise, relate and respond to people experiencing mental health challenges. To achieve these aims, the training was delivered in a way that encouraged critical thinking and explored influences on community beliefs about mental illness and mental distress.

The development of the Community Pillars, mental health destigmatisation train-the-trainers program is shown in Figure 1 below. Each phase organically built on the previous one. The first phase of Community Pillars, delivered in 2020, offered 20 hours of instruction in mental health models and guided discussion and group planning around adaptation of these models to best fit com-

1 These groups are part of a programme called “Health introduction Programme (HIP)”, which CCFs during former refugees’ 5-week initial stay at TAMA. The HIP aims to provide the families in the centre with relevant and useful information for their resettlement in New Zealand, in addition to promoting RASNZ services. During each intake there are around 8 sessions with the residents on the following topics: Introduction to New Zealand, Healthy Living (Mental health and Physical health), Addiction Prevention and Smoking Cessation, Nutrition and Vitamin deficiency, Building Healthy Families (Parenting Session), and the New Zealand Health System. These sessions are run by every CCF in their own language with their community, thus promoting a safe and culturally appropriate space.

munity needs. The focus was on increasing early interventions to support community wellbeing and to identify potential concerns that community members could proactively work on to decrease the need for clinical services further down the track. The training involved five modules, covering: a framework for thinking about the learning process and the impacts of stigma on mental health issues; an understanding of the mind-body connection in responses to stressful events and situations; opportunities and challenges for CCFs to use their language skills and cultural knowledge in mental health discussions in community and family settings; culturally appropriate ways to maintain health and well-being; and an opportunity for feedback and evaluation. CCFs were provided with a manual of simple but powerful visual tools for communicating key ideas around mental health and wellbeing. These tools included calming activities, simple breathing exercises, suggestions for increasing social connection and activity, and *Tē Whare Tapa Whā* (Durie, 2011), a Māori (indigenous) mental health model from Aotearoa New Zealand that asserts the importance of balance in each of the four *taha* (walls)—*tinana* (physical), *wairua* (spiritual), *hīnengaro* (mental), and *whanau* (family)—resting on a firm foundation of connection to *whenua* (land, place) in supporting a strong overall metaphorical *whare* (house) of *hauora* (health).

In the second phase of Community Pillars, CCFs and other RASNZ staff involved in training drew from phase 1 ideas and plans to co-design activities that could be used to de-stigmatise mental health within their different communities. CCFs creatively incorporated the content they had been introduced to during their training into their various community empowerment groups (including making mental health connections when talking about spirituality, or about cooking and

eating), which any community members experiencing stress and anxiety or feeling isolated were invited to attend. They also integrated mental health content into their more instructional and “coaching” type roles, such as in relation to smoking cessation and guidance on parenting in the Aotearoa New Zealand context, and in one-on-one interactions. During Covid-19 “lockdowns”, in which the New Zealand government mandated venues to close and individuals to stay home to stem potential spread of disease, CCFs creatively adapted their content to deliver online programmes with material especially relevant to the stressors of the pandemic and of increased physical isolation.

RASNZ clinician engagement with CCFs to support clients increased over the course of phases 1 and 2, facilitating the development of a short series of psychoeducation groups run by CCFs at TAMA for newly-arrived individuals. In these large, gender-and language-separated groups, often including more than 50 people at a time, CCFs provide information on key wellbeing topics such as breathing and movement, sleeping well, and raising children in a healthy way. These groups provide an important form of early intervention for potential mental health and relational issues, and can be a reference point (either in terms of the skills learned, or the special trusting relationships with CCFs that are initially developed) for individuals who later engage in more intensive or targeted community support.

The third phase of Community Pillars, rolled out in 2022, involved additional specialised training for CCFs on addressing family violence and ensuring child protection, which in turn enabled them to incorporate this content into their groups. CCFs had requested further training in these areas due to their concerns that the stressors of Covid-19 appeared to be exacerbating family strug-

gles and straining relationships in sometimes harmful or destructive ways, and their observations that existing mechanisms for responding to family harm were not always culturally responsive or adaptive. The additional training supported CCFs in better understanding risk factors for harm and abuse, cultural perspectives on family violence among different ethnic and national groups, dynamics impacting disclosure of harm and help-seeking preferences and actions, and safe and sensitive ways to screen for and provide support around family harm concerns.

A fourth phase of training for CCFs is being provided in 2023 which focusing on mental health and wellbeing support for youth from refugee-backgrounds. Based on outcomes from all phases of the pilot, the Community Pillars model may be rolled out more widely and integrated in a more sustainable way into ongoing services.

The Phases of the Community Pillars Training Program are shown in Figure 1.

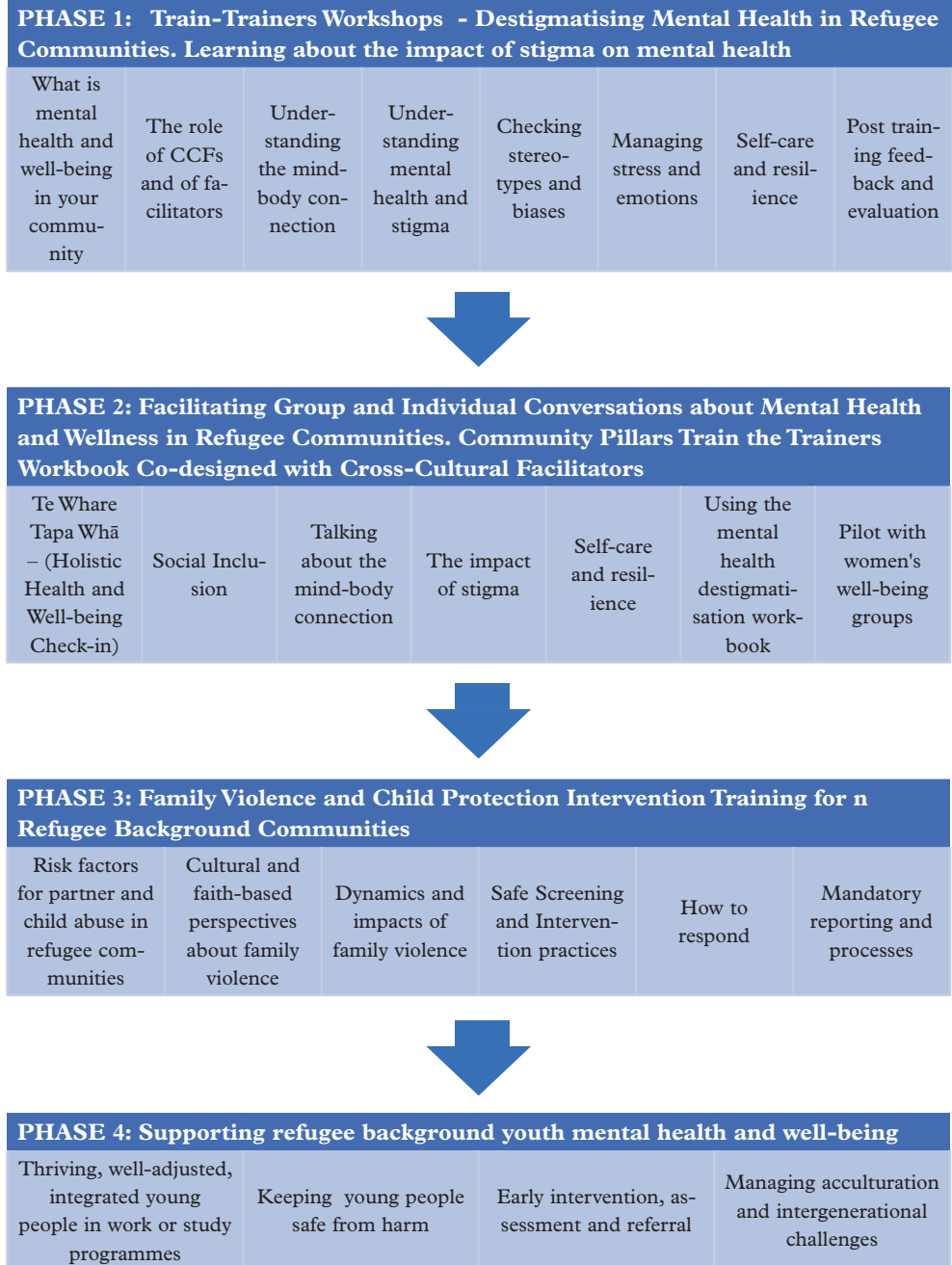
Outcomes

RASNZ has attempted to assess the outcomes of the CCF's work through collection of anecdotal reports from clients used to inform regular supervision and training, through reviews prepared for funding agencies (including internally-assessed descriptions of outcomes and illustrative participant quotes), and through a more systematic external review of RASNZ's various forms of community support that drew from direct participant feedback, collection of staff observations, and interviews with external agencies (Dawnier & Trotman, 2021).

On the training side, RASNZ initially assessed the effectiveness of the first two phases of the Community Pillars pilot through a structured internal feedback session with CCFs. During this session, CCFs identified several

of the analogies and metaphors presented in the training as being particularly helpful for explaining concepts to community members in a culturally congruent way, as well as for deepening their own understanding. These included the "stress bucket" (representing an increasing load of stress, built up by accumulating experiences, that needs to be drained / lightened regularly to enable us to continue carrying it) and the "iceberg" model (representing ways in which visible behaviour can be only part of the picture of someone's mental health, and that there can be a lot more happening below the surface). CCFs also reported appreciating information on the mind-body connection, common unhelpful thought patterns, and ways in which their body language and verbal communication could be influential in helping to address mental health issues in a calm way. They noted practices such as paced breathing and doing a regular health "check in" using the *Te Whare Tapa Whā* model were important for themselves to experience and practice together as well as being useful for the clients they worked with. They stated that having the workbook or manual to take away was very valuable for them, providing an ongoing resource and source of reference, and requested further training in the future that would bring them together in a similar way (allowing open discussion about mental health and ways to engage in self-reflection and self-care to ensure the sustainability of their work) and that could further deepen their understanding of the psychological impacts of trauma for their communities.

Interviews undertaken as part of the 2021 external review (Dawnier & Trotman, 2021) identified that many clients found community empowerment groups run by CCFs as safe, supportive, inclusive, and helpful for connecting socially with people who spoke the same language and had similar life experiences. The

Figure 1: Phases 1 to 4 of the Community Pillars Training

review also reported that one-on-one support from CCFs (including regular phone calls) was highly valued by more isolated and vulnerable clients, particularly during COVID-19 lockdowns when many locations in Auckland were closed and movement was restricted for extended periods of time. In addition to providing such social support, the review also identified ways in which CCFs provided valuable information about services available around the city (e.g., health, education, other social supports), and support and guidance in connecting with these services. Feedback collected from clients at the end of specific programmes run by CCFs, such as the Computer in Homes programme, showed a high degree of satisfaction with the programme and an increase in specific skills and knowledge (e.g., knowing how to use the computer and internet, ability for children in the family to use the computer for schoolwork and to access resources).

The 2021 review (Dawnier & Trotman, 2021) concluded that CCFs played a key role in helping former refugees and survivors of torture in feeling safe and supported, feeling welcome, included and connected, being able to access opportunities equitably, and being able to heal and experience wellbeing. However, it also noted a potential positive bias in client / participant evaluations (e.g., consistently choosing the highest ratings on Likert scales seeking to measure various potential outcomes such as skill acquisition or sense of confidence), making it difficult to identify which elements of groups and programmes were most successful and which elements could be improved. The review also reflected that, as noted above, CCFs often worked substantially beyond their paid hours, and thus the impact and scope of their work was not necessarily being accurately captured.

An internally-generated report on phase 3 of the Community Pillars programme, pre-

pared for an external funding agency (RASNZ, 2022), solicited CCF feedback on their training experience and identified several key benefits. These included increased understanding of the impacts of family violence and the dynamics that maintain silence about it within communities, increased skills in assessing for and reporting family harm, and increased knowledge about services and supports available to protect women and children from family harm (including more personal familiarity with the agencies providing such support). The 2022 report also summarised feedback from refugee-background participants in the psychoeducation and informational groups run by CCFs at TAMA, collected via the interpreters for various language groups. The interpreters stated that participants found the sessions interesting and useful, and felt that receiving answers to many of their questions and concerns helped to instil hope and alleviate some anxieties.

Role of CSOs in supporting survivors to engage in community roles

Reflecting on their roles, CCFs have identified that to do their work well they need to have a passion for community service (including humility and a willingness to do a lot of volunteering), an ability to listen deeply to each individual or family's concerns, and the good judgement to take a practical approach to solving problems. CCFs understand what the communities they are supporting are going through and how they perceive the challenges they are currently facing, because they have had similar experiences and are survivors themselves. These qualities are valuable strengths, but also come with risks: CCFs can experience vicarious trauma, whether acting in more of a cultural brokering or an interpreting role, and need emotional support and opportunities for debriefing on a regular basis.

Community Service Organisations (CSOs) such as RASNZ can play an important role in offering support to the CCFs working with them by providing both formal and informal spaces for CCFs to connect with clinicians to process emotionally difficult content or to discuss strategies for coping with trauma and stress, and to experience being part of a supportive team working together. Support offered between and among CCFs is important, as well as working alongside other professionals in a mutually respectful way to provide holistic support. CSOs operating in other country contexts, such as the Tree of Life organisation in Zimbabwe, have described similar forms of peer support and appropriate supervision for survivors engaged in offering healing and group facilitation for other survivors (Reeler et al., 2009).

CSOs also bear responsibility when recruiting CCFs into their roles to be sensitive to the unique demands of the role, and consider carefully who is motivated, ready, and well-placed to undertake it—for instance, as RASNZ does, individually inviting CCFs to come on board based on observed experience and well-cultivated relationships, rather than an impersonal competitive recruitment process. Actively offering ongoing learning and development comes as a next step, supporting CCFs to build up to taking on other roles within the organisation, while also being mindful of the strains on CCFs of “wearing many hats” (e.g., running groups and interpreting and providing community-based support) and the fact that professional development paths may look different, as the CCF role is more integrally connected to personal and social identity than many careers or jobs. For instance, part of a CCFs development may involve building wider connections, facilitated by their organisation’s reputation, giving them increased status and authority both within

their communities and with other professional agencies. The sustainability of their involvement also needs to be considered in light of the considerable time and emotional demands.

Future directions

As described above, the Cross-Cultural Facilitator (CCF) role has become an integral part of RASNZ services, actively engaging survivors of forced migration in efforts to address the consequences of trauma and displacement at a community level. The Community Pillars training pilot programme has been rolling out successfully through challenging times, including the many societal disruptions and stressors entailed in the Covid-19 pandemic, and has gathered notable anecdotal evidence of being positively impactful and supportive not only for CCFs but for the communities they serve.

A more comprehensive evaluation of the programme’s impact, including qualitative and quantitative studies, could be a valuable next step in further substantiating its benefits and gathering insights to shape further programme development. However, we note that such research can be very resource-intensive and requires careful development to ensure it is inclusive and culturally-safe and serves to address rather than unintentionally perpetuate the mechanisms of power that can inflict trauma. Participatory action research type models, led by communities themselves, may be the most appropriate approach (Hall & Tandon, 2017), but have not generally been as closely linked to securing ongoing funding for services as more traditional Westernised models of research. It can be difficult to find appropriate research partners or time for community practitioners to undertake action research directly.

With respect to future development of Community Pillars and similar programmes involving survivor engagement in community healing,

Foundation House (2017), a CSO working in Victoria, Australia with people of refugee backgrounds who have experienced torture and other traumatic events, has recommended a number of trauma-informed, best-practice approaches for community capacity building that others can learn from. They emphasise building community relationships and creating spaces for ongoing dialogues as a core component of wider capacity building efforts to address systemic factors and promote healing and recovery. Thus, training and service provision should not be a one-off or one-directional offering, but a continued process of mutual engagement with and within communities.

Funding, of course, is important for growing the role of CCFs, enabling ongoing training and development opportunities and further formalising pilot models such as Community Pillars training, providing more resources directly to communities (e.g., as in the case of the computer training efforts CCFs have been involved in, providing devices as well as instruction on how to use them; or offering community members scholarships to engage in further education that would equip them to fill more of the service roles as CSOs such as RASNZ). With a sustainable resource backing, the Community Pillars model could be embedded as an ongoing training programme both for training new CCFs and for expanding the skills and knowledge of existing facilitators.

We hope that by sharing the RASNZ model of enduring and evolving survivor engagement in community wellbeing in Aotearoa New Zealand we have offered an example that other communities internationally can feel connected to as they engage in similar work, can draw useful lessons from, or can be inspired by. We encourage further international connections and knowledge sharing to foster mutual support.

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