Online Implementation of Dance Movement Therapy and Other Creative Processes for Psychosocial Support During COVID-19 Pandemic

Kolkata Sanved's Guideline on Risk Mitigation and Emergency Response

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Introduction:

The information in this guideline is based on learning and insights gained over the lockdown period, during the COVID-19 crisis. We felt that it is important to have a guideline on how to give psycho-social support through the online medium, which enables us to stay mindful of context and risks, and which lays down a strategy for responding to emergency situations when we do not have the opportunity to be present in-person. We recognize that the guideline outlined below is based on our knowledge of Dance Movement Therapy (DMT)-based interventions; but we also want to make clear that this document is an effective guideline for implementing online programmes based on Dance Movement Therapy (DMT) and other creative processes for psycho-social support. We encourage you to use this document when implementing your online psycho-social support initiatives, with due acknowledgement to Kolkata Sanved. You can translate this into your own language as well.

Please note that, when implementing your own programme, you may learn new information or find other useful practices based on the particular context. What we seek to present through this document is a roadmap: something from which to guide your own actions and activities in the crisis situation.

If you are following this guideline, please inform us and send your feedback at kolkatasanved@gmail.com .

Acknowledgements:

Kolkata Sanved is very thankful to our partner organizations for their immense support and cooperation, which has helped us in gathering experiences and information to build this guideline. Further, we wish to extend our heartfelt gratitude to the participants of our programme, who have given us the space to learn through and with them.

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Purpose of this Guideline:

DMT and creative-art based forms of psycho-social support are experiential processes. It is not easy to provide this kind of support online. To mitigate risk to programme participants who are receiving the process it is important to follow a set of guidelines that maintain the "Do No Harm" principle.

Guideline for Online Implementation of Dance Movement Therapy and other Creative Processes for Psychosocial Support during COVID-19 pandemic

A. Mode of Session

1) The mode of the session will differ, depending on the context. Factors such as: extent of safety in the current surroundings, availability of internet and phone network, amount of space available, participants' schedule etc. will determine the mode.

2) The mode will be decided collaboratively by Kolkata Sanved and the partner organisation (involving care providers and programme participants).

3) Based on the context, Kolkata Sanved is conducting sessions through the following modes (in some settings a combination of these is being applied as well)
    i. Online Live DMT sessions over Zoom Call/video call
    ii. Playing videos of movement activities on the Zoom Call/video call (by sharing screen) for participants to try out and taking feedback via the call
    iii. Sending videos of movement activities to partner organisation via WhatsApp, for participants to try out, with care providers or assigned participants acting as leaders, feedback on the experience to be sent in writing to KS by the leaders
    iv. Checking in through regularly scheduled phone calls
    v. Creation of a WhatsApp group of participants for communication, checking in and sending helpful movement videos

4) The first one or two sessions for each context can be considered as trial rounds and changes made accordingly

B. Preparations: Resource and Material Creation

1) Videos of movement activities

2) Orientation of practitioners to use of technology while conducting an online session- this should involve practice or trial sessions

3) Discussion with practitioners on feasible backup ideas for what to do if the technology stops working during the session

4) Clarifying basic facts on COVID-19, precautions to be taken and myths/fake news being circulated with corresponding facts with practitioners- so that they can disseminate verified information when required

5) Giving practitioners a basic orientation on safe Sexual and Reproductive Health practices in the context of the COVID 19 pandemic, so that they can disseminate this information when required

C. Communication with Partner Organisations: Processes to be followed before sessions begin:

1) Understanding the current needs of participants from the partner organisation, through discussion with care providers and participants

2) Collaboratively deciding mode of online psycho-social support with partner organisation based on context, internet access etc.

3) Orienting partner organisation employees/care providers to DMT, basic structure of a session, music requirements etc.

4) Discuss the possibility of doing sessions with care providers for self-care and coping with the stresses of the current situation- this will enable them to experience the DMT process, and will strengthen our collaboration

5) Discussion on possibility of contacting specific parents/guardians of participants in community settings, so that they understand why these sessions are being done and do not pose challenges to their taking place

6) Discussion on referral resources and how to address emergencies collaboratively

D. Session Planning, Monitoring and Documentation

1) It is very important to note that the sessions will NOT be focused on processing trauma. Due to the current crisis situation and the lack of in-person presence of facilitator, this could result in more harm to the participant and even in re-

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traumatisation. This is especially significant for trauma survivors, who may experience a resurgence of distress due to the helplessness and sense of being stuck due to the COVID-19 outbreak and lockdown.

2) The focus of the sessions will be on **enhancing well-being** through: general warm up, activities on strength, hope, positive energy, balance, fun, relaxation, meditation and dreams etc.

3) Each week will have a theme, and all videos/sessions by KS will be done according to that theme. (This can change in case a particular batch has a very different specific need).

4) Check all activities for triggers before they are done, as well as a discussion on how to respond if participants get unintentionally triggered

5) A project meeting will be done after each session in order to understand what is working, what is not, changes that need to be made and to follow up on emergencies.

6) Coordination with the partner organisation to be done at regular intervals

7) Documentation
i.   Attendance list
ii.   Written report containing: activity description, participants' feedback, facilitators' observations, analysis of situation and how to move ahead
iii.   Audio-visual documentation methods will be decided in collaboration with the partner organisation, depending on context

E. Maintaining a Therapeutic Approach: Protocols for Designing Movement Activities and Responding in a Trauma-Sensitive Manner

1) Do No Harm:
i.   Check all activities for triggers before they are done
ii.   While responding to emergency situations, the participant's safety is paramount. Carefully consider how responses could affect how safe participants are. For example, in cases of abuse, it may not be always safe to urge a participant to stand up against the abuser, as this could lead to risk of further violence, as well as lack of basic essentials in cases where the participant is financially dependent on the abuser.

2) Be cautious with self-touch movements: for example, avoid movements involving touching of eyes, nose, mouth and face, since these are ways COVID-19 spreads. (At

the same time, it is also important to explain that these body parts should not be seen as 'bad'- rather, it is to protect them that we are doing this)

3) Because of the crisis of space, focus on movements that do not require a large space

4) Balancing physical distance and social solidarity, in order to avoid stigma and labelling:
i. Where participants are present in the same location, make sure adequate space is maintained between participants and avoid activities involving touching other people
ii. While doing this, it is important to make clear that this does not mean that we should look upon each other with suspicion or label others' bodies as unclean or dirty. It is simply a way of preventing the virus from spreading.
iii. Emphasise that even though we have to maintain physical distance, we can still maintain social solidarity. One way to do this is to be aware of use of language-instead of 'physical distancing', use 'social distancing'

5) In contexts where there is friction between care providers and participants, one possibility is to suggest activities that have potential to create a sense of positivity between them. Other possibilities include having care provider orientations and changing the mode of sessions to avoid interaction that can be harmful.

6) Pay attention to contextual factors. For example, in some centres, it may be necessary to minimise the use of sound as this can cause disturbance in the neighbourhood.

7) Adopt a Strengths Based Perspective: This involves the recognition that all human beings have inherent strengths and resources, and a focus on amplifying these strengths (This does not mean that adversity and difficulties are overlooked- but there is the acknowledgement that inner strength and resources exist alongside these)

8) Practicing Trauma Informed Care:
i. Non-judgement and non-blaming
ii. Be aware that people are always responding to violence, highlight and build on this. People are always trying to keep themselves safe.
iii. Responses might not fit our ideas of effective responses. This is because not everyone has access to the same resources in order to respond.
iv. It is important for us not to get stuck on the behaviours resulting from the violence. These are often understandable reactions to highly oppressive situations.
v. We must trust the person consulting us as an expert in their own situation and work in collaboration.

vi.   Sometimes, before we can think of reaching out to external sources of support or reporting, we might need to work on safety and stabilization.

9) In some situations, people might be unable to speak openly on the phone, using yes or no questions or coded questions might be helpful. For example, "If you are not safe right now reply with a yes or a no" or "If you require an emergency response please say the name of a colour or your favourite food". However, in the case of the latter there should be shared agreement on what the emergency response is.

10) Maintaining confidentiality:

i.   In the beginning of the session/call, it is important to have a discussion with our participants on the limits and extents of confidentiality. It might be helpful to discuss this with them and collaboratively decide on how to navigate this. This discussion should be revisited from time to time.

ii.   Even if we decide to break confidentiality, the participant needs to be kept in the loop. The participant's sense of safety and trust depends on this. For example, if a participant discloses an incident of abuse and says that she does not want anyone else to know, we cannot tell authorities without the participant's knowledge and permission. If we need to tell the authorities, we have to speak to participants about why this is important and get their consent. We can also work on ways to frame the issue so that the participant remains safe, and keep the participant in the loop about what we are telling the authorities. If we break confidentiality without consent, the participant will feel a sense of betrayal of trust, which will compound their trauma, especially since abuse has already led to loss of trust.

11) When clients do not want to share details with us, we must work on creating a safe space for sharing and then let the person tell us in their own time.

12) In cases of child marriage, from a therapeutic stance, it might be helpful to explore why the young person feels the marriage is important. Then working on discussing the possible effects in collaboration with the young person might be helpful. Reporting over here should also be done keeping the principles of no harm and best interest in mind.

13) We must make sure our messages on health and hygiene are contextualized. Being mindful that for many communities, safety may not primarily be equated with keeping COVID away. For many families, food has become the main priority. Therefore, it is important to contextualize our understanding of safety as well.

14) Be mindful that this is a complex situation that will take long term support to be resolved

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F. Emergency Responses

I. <u>Preparation of referral list collaboratively- project wise- based on locality</u>

1) List of referral resources is required for the following:
i.   Food and other essentials
ii.   Health and hygiene resources
iii.   NGOs working around violence and abuse, child marriage
iv.   Counsellors
v.   Psychiatrists
vi.   Resources giving accurate information about the situation in local language

2) Points to remember while considering a resource as part of the list:
i.   Is it locally available?
ii. Are communications done in a language the participant is familiar with
iii. Is it safe? – based on what we know or have heard about it
iv. Is it reliable? – based on what we know or have heard
v.   What is the time frame for getting the service after referral?
vi. Can we speak to them about the same beforehand?
vii. Is it possible to get some level of follow up after the referral is done?

3) Steps for Referral List Creation
i.   Project wise internal discussion of referral list
ii. Discussion with partner- how can we collaboratively face emergencies? What can they do and who do they use for referral?
iii. Finalising list

II. <u>Response plan for acute mental distress: including having faced abuse or conflict, suicidal ideation/self-harm, clinical symptoms or any others</u>

Step 1: Identify participants needing individual attention- immediate reporting to team

Step 2: Rapid risk assessment by team (on a very emergency basis)- How is the participant coping currently? Is this safe? What is the level of risk? What more do we need to know?

Step 3: Further risk assessment- this could be done by practitioners/internal mental health professions calling up the participant.Brief the practitioner beforehand and do a follow up call after they are done talking in order to assess risk.

Step 4: Have an internal meeting of team (led by Safeguarding Committee) about steps to be taken. Two levels of decisions need to be made in this meeting:

1) Internal follow up plan (based on DMT/creative processes/phone calls):

i.   Can we address this through DMT/our services or do we need outside help?

ii. Even if we need outside help, what are the things we can do through DMT to support them during this time? (For example, ways to calm oneself and cope through movement, for self-harm there have been suggestions of self-care movement, inner strength and positivity discussions)

iii. Is this an issue we can address, with help by consulting outside consultants? Eg. psychiatrists etc. Who can we consult?

2) Decisions on informing others and referral

i.   Has the participant expressed reluctance about disclosing this information to anyone else?

ii. Does the participant want us to share this with any particular person? Has the participant already identified resources that they want to refer to?

iii. Is it safe to inform the partner organisation directly?

iv. If not, how can we inform partner in a way that it doesn't put the participant at risk?

v.   What resources from our referral list can we use?

vi. How do we follow up after referral?

Step 5: Take steps decided and follow up

Step 6: In situations where referrals are not possible, think of ways in which we can be most useful within the constraints. Collaborate and brainstorm as a team.

III. Response plan for basic needs issues

Step 1: Immediate reporting to team

Step 2: Find out how they and family are currently dealing with the issue- Consulting those in the community and finding out what are local ways in which they are trying to safeguard their health. For example, can home-made masks be used?

Step 3: Inform partner organisation about the issue: discuss resources available in the immediate community of the participant and how we can jointly enable them to access these

Step 4: If resource access in immediate community is difficult- collaboratively deciding to give a referral to an authority/organisation

Step 5: Follow up on referral

Step 6: Inform Senior Leadership Team about the existence of the need, in case funds become available in the future which can be used for this

IV. In case we are not able to reach/connect with a particular participant (especially in community settings)

Step 1: Having a participant list/database so that we are able to identify participants we cannot connect with

Step 2: Communicating to partner organisation that we cannot connect and understanding why and if the partner organisation can connect with them

Step 3: In collaboration with partner organisation, understanding if anyone else in the group of participants is in touch with the participant we can't connect to and capacitating that participant to do a peer check in

G. **Protocol for Use of Audio-visual Media and Devices**

1) Due to the crisis, we are all using personal devices to connect to participants and document the sessions. We need to be careful with our use of these, in order to protect safety and confidentiality of the participants.

2) When we have participants' phone numbers, make sure that there is an organised way of keeping and operating participants' phone numbers and these are not shared unless required. Inform the partner organisation about the number of participants whose phone numbers we have and the contexts in which we can reach out to them.

3) Audio-visual (AV) documentation:

i.   All AV documentation should be in consonance with the ethic of dignity of the individual. No individual should be stigmatised or labelled.

ii. An internal discussion needs to be held on the kind of AV documentation that is required in specific contexts

iii. Have a discussion with the partner organisation about what kind of audio-visual documentation a session may require and seek permission for the same. This should be confirmed in writing via email and sent to the Safeguarding Committee

iv. If any interaction with participants is being AV recorded, inform and seek consent from them before the recording begins

v.   If any AV clips that participants send are stored for documentation purposes, take their permission before storing

vi. Clear procedure should be followed on saving and storing AV clips. To avoid too much space being taken up on practitioners' phones, concerned AV clips can be forwarded to the AV Team or the Project Coordinator (as agreed upon for the project), and then they can be deleted by practitioners. AV team or Project Coordinators can store these on laptop/pen drive and transfer them to official databases when office opens.

4) If any disclosure of sensitive or confidential information takes place through audio or video, delete the AV clip and, based on the participant's consent, arrange for an alternate form of documentation like writing.

5) Make it clear on WhatsApp groups that, if a participant shares photographs, audio or videos on WhatsApp groups, other participants need to take the original sharer's permission before sending these to anyone else

6) In video material being created and shared online, make sure that all due citations are given to outside sources- for example, credits for music used

7) When video material is being shared by us (Kolkata Sanved) with partner organisations, it should be clear whether these can be shared further with others (with due acknowledgement) or are meant only for the participants/care providers they were sent to. This would need to be clarified with the partner organisation via email.

8) Make sure participants are informed about the protocols.