Task-shifting Psychological Interventions for Common Mental Disorders: The Training and Supervision of Non-traditional Providers

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List of abbreviations

AIDS	Acquired immunodeficiency syndrome
APA	American Psychological Association
ASHAs	Accredited social health activists
CBT	Cognitive behavioural therapy
CHW	Community health worker
CMD	Common mental disorder
CQC	Care Quality Commission
cRCT	Cluster randomised controlled trial
DSM	Diagnostic and Statistical Manual for Mental Disorders
HIC	High-income country
HIV	Human immunodeficiency virus
IAPT	Increasing Access to Psychological Therapies
ICD	International Classification for Disease
LHW	Lay health worker
LMIC	Low- and middle-income country
LTC	Long-term condition
LTPP	Learning Through Play Plus
MANAS	MANAshanti Sudhar Shodh
mhGAP	Mental Health Gap Action Programme
mhGAP-IG	Mental Health Gap Action Programme – Intervention Guide
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NTP	Non-traditional provider
PM+	Problem Management Plus
PRISMA	Preferred reporting items for systematic reviews and meta-analyses
PTSD	Post–traumatic stress disorder
PV	Peer volunteer
RCT	Randomised controlled trial
THP	Thinking Healthy Programme
THPP	Thinking Healthy Programme Peer Delivered
WHO	World Health Organisation

Abstract

Background: The high prevalence of common mental disorders (CMDs) and barriers to accessing treatment has created a need for the task-shifting of psychological interventions to non-traditional providers (NTPs). For successful task-shifting to occur, the training and supervision that is provided to these individuals are of utmost importance, but little evidence exists on their training and supervision. This thesis addressed this issue by identifying the essential components of training required for successful task-shifting.

Methods: This research consisted of four studies. Firstly, this thesis explored the evidence available on the training and supervision provided to NTPs task-shifting psychological interventions through two systematic reviews, one of which examined task-shifting in high-income countries (HICs) and the other in low- and middle-income countries (LMICs). A qualitative review was also conducted to explore the experiences of lay health workers (LHWs) on their training, supervision and intervention delivery. Lastly, a qualitative study using semi-structured interviews with NTPs (n=19) and experts (n=13) from four exemplars in Pakistan and the UK was conducted to explore their experiences during training, supervision and implementation of the intervention.

Results: Eighteen papers were included in the systematic review conducted in HICs, thirty papers in the LMICs and fourteen papers (thirteen studies) in the qualitative review. In general, recommendations from all three reviews included the need for training to incorporate a mixture of didactic and experiential learning. Furthermore, sufficient time should be spent on learning about mental health conditions, and opportunities should be provided for skills practice. However, the reviews highlighted the limitations to drawing conclusions on the training due to poor reporting and a lack of documentation. Framework analysis of the semi-structured interviews led to the development of five key themes each for NTP and expert interviews. Synthesis of the findings from the reviews and interviews resulted in identifying essential components of training, leading to the eventual development of a taxonomy of essential training components divided into three phases: pre-training, training delivery and post-training. Lastly, a checklist for reporting training and supervision in papers was also developed to allow researchers to report their training with sufficient detail.

Conclusions: Recommendations identified through this thesis can be used by researchers when developing training for NTPs in both HICs and LMICs. Furthermore, the reporting checklist may help researchers to improve the quality of documentation of training within papers, further adding to the database of evidence on effective training for NTPs. Improving the quality of NTP training may lead to an improvement in the quality of the interventions they deliver, which has potential to improve mental health outcomes. Further research should build on the current findings to develop the science of training and supervision in task-shifting.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or institute of learning.

Copyright statement

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Chapter 1. Introduction

The introduction section for this thesis is divided into two chapters that aim to highlight the need for alternative methods for delivering psychological therapies to improve access to mental healthcare for CMDs. This chapter addresses the following: the conceptualisation of CMDs, the prevalence of CMDs, the management of CMDs, barriers to accessing mental health treatments and research into attempts at increasing human resources within mental health.

1.1. Common Mental Disorders

According to the World Health Organisation (WHO), CMDs refer to a range of depressive disorders which include:

- All severities of depression
- Anxiety disorders including:
    - Generalised anxiety disorder,
    - Panic disorder,
    - Obsessive-compulsive disorder,
    - Phobias,
    - Social anxiety disorder,
    - Post–traumatic stress disorder (PTSD)

Source: WHO (2017a)

Although less disabling compared to severe psychiatric disorders such as schizophrenia and bipolar disorders, they have greater prevalence within the population with Steel et al. (2014) estimating a global lifetime prevalence of 29%, leading to greater impact and cost on society. The symptoms of depression are characterised by an overwhelming feeling of sadness, low mood and a wide range of biological, psychological and social factors (National Institute of Heath and Clinical Excellence; NICE, 2009). Depression has been associated with a range of negative outcomes, including decreased physical (Kessler et al., 2003) and social functioning (Hirschfeld et al., 2000), high healthcare utilisation (Bock et al., 2014) and poor quality of life (Brenes, 2007). Additionally, the condition has been found to be associated with an increased risk of mortality (Ensinck et al., 2002) and is also the major contributor to suicide deaths, with approximately 800,000 per year (WHO, 2017a).

Anxiety disorders are characterised by excessive worry and fear, with symptoms including muscle tension, fatigue, irritability and disturbed sleep (Roemer et al., 2014), and similar to depression have also been associated with a decrease in quality of life and psychosocial functioning (Olatunji et al., 2007). Moreover, depressive and anxiety disorders commonly occur together and compared to either disorder alone, comorbid anxiety and depression have been associated with poorer outcomes, greater severity of symptoms, poorer quality of life and higher suicide risk (Zhou et al., 2017).

1.2. Classification of Common Mental Disorders

Mental disorders can be classified through a categorical approach or a dimensional approach. In the former, a specific number of symptoms is needed to obtain a clinical diagnosis whereas in the latter, the symptoms occur in a continuum in which an individual can have varying levels of severity, with a greater number of symptoms representing greater severity of the disorder (Kraemer et al., 2004). With a few exceptions, the Diagnostic and Statistical Manual for Mental Disorders (DSM-V) (American Psychiatric Association, 2013) and the International Classification for Disease of Mental and Behavioural Disorders (ICD-10) (WHO, 1992) adopt such categorical systems to diagnose mental disorders both in research and in clinical practice. Whilst there is a lot of convergence between the two systems of classification and the main groups of psychiatric disorders are diagnosed similarly (Tyrer, 2014), it is important to note the various differences between the two, which are described in Box 1.1. This thesis will focus on CMDs diagnosed by the ICD-10 criteria, which can be seen in Box 1.2.

Box 1.1. Differences between ICD and DSM

ICD	DSM
Official world classification	U.S. classification
Available in all widely spoken languages	English version only
Intended for use by all health practitioners	Used mainly by psychiatrists
Special focus given to primary care and low- and middle-income countries	Focus is mainly on secondary psychiatric care in high-income countries
There is a plan to focus on clinical utility with a reduction in the number of diagnoses	The number of diagnoses increases with every succeeding revision
Provides diagnostic descriptions but does not employ operational criteria	Diagnostic system depends on operational criteria using a polythetic system where descriptions are a combination of criteria that need not all be the same for diagnoses.
Guidelines and criteria do not include social consequences of disorders	Diagnostic criteria usually include significant impairment in social functions

Source: Adapted from Cowen, Harrison & Burns (2012); Tyrer (2014)

Box 1.2. ICD-10 criteria for CMDs

ICD-10 classification	ICD-10 criteria
Depressive episode (all forms of severity)	In all severities of depressive episodes described below, the individual usually presents depressed mood, loss of interest and reduced activity. Other symptoms include: - Reduced concentration and attention - Reduced self-esteem and self-confidence - Ideas of guilt and uselessness - Bleak and pessimistic outlook - Ideas of self-harm or suicide - Disturbed sleep - Decreased appetite
Mild depressive episode	Depressed mood, loss of interest and enjoyment, and increased fatiguability are usually the most typical symptoms of depression, and at least two of these, plus at least two of the other symptoms described above should usually be present for a definite diagnosis. The individual will probably be able to continue with most activities.
Moderate depressive episode	At least two of the three most typical symptoms noted for mild depressive episode should be present, plus at least three or four of the other symptoms. The individual is likely to have great difficulty in continuing with ordinary activities.
Severe depressive episode without psychotic symptoms	All three of the typical symptoms noted for mild and moderate depressive episodes should be present, plus at least four other symptoms, some of which should be of severe intensity. It is very unlikely that the individual will continue with ordinary activities.
Generalised anxiety disorder	A condition marked by excessive worry and feelings of fear, dread, and uneasiness that last six months or longer. Symptoms include persistent nervousness, trembling, muscular tensions, sweating, light-headedness, palpitations and dizziness.
Panic disorder	Recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or circumstances and are unpredictable. Symptoms include sudden onset of palpitations, chest pain, choking sensations, dizziness, and feelings of unreality.

Box 1.2. ICD-10 criteria for CMDs

ICD-10 classification	ICD-10 criteria
Post–traumatic stress disorder (PTSD)	Exposure to a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause distress in almost anyone. Symptoms include repeated reliving of the trauma in intrusive flashbacks, dreams or nightmares, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma.
Obsessive-compulsive disorder	Obsessional symptoms or compulsive acts that are present for most days for at least two successive weeks and are a source of distress or interference with activities. They are almost invariably distressing and the individual often tries, unsuccessfully, to resist them. They are, however, recognised as his or her own thoughts even though they are involuntary.
Phobic anxiety disorders	Disorders in which anxiety is evoked in certain situations. As a result, these situations are avoided or endured with dread. The individual's concern may be focused on individual symptoms like palpitations or feeling faint and is often associated with secondary fears of dying, losing control or going mad.

Source: WHO *(1992)*

1.2.1. Criticisms surrounding the categorical approach

Although widely used by mental health professionals to guide diagnostic decision-making, much controversy surrounds the use of the DSM and ICD for diagnosis, as they apply a medical model that focuses on symptoms rather than the realms of thoughts, feelings and behaviours. For example, the DSM-V diagnosis of major depressive disorder includes the requirement of five or more symptoms to be present within a two-week period, one of which should, at least, be either a depressed mood or anhedonia (loss of interest or pleasure) (American Psychiatric Association, 2013). However, extensive research has shown the multidimensional nature of major depressive disorders, which is composed of a number of emotional, cognitive and behavioural dimensions and is associated with a wide variety of risk factors, symptoms and variables such as demographic characteristics, personality traits and comorbidity (Chen et al., 2000; Vrieze et al., 2014). Furthermore, it is thought that these classification systems may represent views that (a) mental disorders are distinct diseases with defined boundaries in the same way that cancer and HIV are distinct diseases; (b) the causes of mental disorders are clearly defined and (c) through proper classification and treatment, the mental disorder will disappear once the cause of the disorder is discovered (Clark et al., 2017).

The DSM-V, in particular, has been the subject of much criticism regarding its validity, clinical use and influence on society (Thomason, 2014), with the British Psychological Society's, Division of Clinical Psychology publishing a critical response, stating that service users are 'negatively affected by the continued medicalisation of their natural and normal responses to their experiences' (Allan, 2011, p.2). In 2013, the Division of Clinical Psychology released a position statement highlighting the key conceptual issues and concerns of the current classification systems such as the DSM and ICD. These issues included:

- Interpretation of symptoms being presented as objective fact leading to limitations in validity and reliability, as well as restricting its clinical use.
- Placing a greater emphasis on biological interventions whilst minimising psychosocial and contextual causal factors.
- Being too embedded in a Western worldview which does not take into account a diverse range of groups.
- Ignoring the importance of service users' perspectives and the negativity that is associated with a psychiatric diagnosis including, discrimination, stigmatisation, disempowerment and an over-reliance on medication.

They addressed the need for a paradigm shift towards a multi-factorial approach to diagnosis which 'contextualises distress and behaviour, and acknowledges the complexity of the interactions involved in all human experience' (British Psychological Society, 2013, p.4).

1.2.2. Benefits of the categorical approach

Although the DSM may be a flawed system with epistemological, scientific and clinical failings, it has been widely accepted by mental health professionals, services users and the general public, as it is the best current way of communicating about mental disorders and can be a reasonably helpful tool in diagnoses if it is used properly and its limitations are understood (Frances & Widiger, 2012). Moreover, receiving a diagnosis can be extremely helpful for service users as it puts a name on their distress, allowing them to gain a greater understanding of their condition and can lead to appropriate management, as well as give the person access to support and services (Perkins et al., 2018). The Division of Clinical Psychology acknowledges that current classification systems have contributed to much research and theory into mental health and have played a substantial role in shaping the structure and delivery of current mental health services. However, classification systems based on categorical models provide a better measure for the more severe mental disorders but in the field of non-psychotic mental disorders correspond poorly to actual clinical syndromes (Goldberg, 1996). According to Goldberg (2000), clinicians are obligated to use categorical models, as they must decide who is sufficiently ill enough to justify treatment; however, the need to define clear-cut thresholds between presence and absence of disorders can lead to the undertreatment of mild symptoms in individuals. This can be concerning, as research has shown that symptoms of anxiety and depression that are below cut-off thresholds can impact functional

impairment, mortality, treatment and prognosis (Angst et al., 1997; Haller et al., 2014). Therefore, researchers suggest that diagnosis for anxiety and depression should be best described with dimensional symptom measures, as it will most probably increase sensitivity and can influence decisions on appropriate levels of care and the degree of improvement due to treatment (Bjelland et al., 2009). Furthermore, Goldberg (2000) suggested that to understand both the biological substrates of mental disorders and the effects of social variables, the use of a dimensional approach would be far more appropriate.

1.3. Global prevalence of Common Mental Disorders

Estimates of the prevalence of CMDs vary considerably depending on when and where the surveys were carried out and over which period the prevalence was measured. Reliable, up-to-date estimates of the proportion of a general population affected by different diseases are essential for the development of effective health policies. The latest global estimates of the prevalence of CMDs have been produced by the Institute for Health Metrics and Evaluation (2017) in their global burden of disease study, which includes regional and also country-specific estimates of deaths, years of life lost (YLLs) and years lived with disability. Furthermore, the disability-adjusted life year combines years of life lost to premature mortality and years lived with disability, with one disability-adjusted life year representing one lost year of healthy life and is the key measure used to assess global burden of disease (Whiteford et al., 2016). However, in the case of depression and anxiety disorders, there are no years of life lost attributed directly to the disorders in the analyses, and therefore, the total disability-adjusted life years also represent estimates of years lived with disability. Table 1.1 provides a brief summary of the global health data for depressive and anxiety disorders. However, mental health is often under-reported and under diagnosed, particularly amongst low-income countries where data is scarcer, and there is less attention and treatment towards mental health. Therefore, the true prevalence of mental health disorders globally remains poorly understood, and data presented in the table should be considered as estimates.

It is estimated that in 2017, 792 million people lived with a mental health disorder, which equates to approximately one in ten people globally (Institute for Health Metrics and Evaluation, 2017). Furthermore, it is estimated that 3.4% of the global population suffers from a depressive disorder and 3.8% from an anxiety disorder. This also varies by region with rates for depression varying from 3.6% in the Western Pacific Region to 5.4% in the African Region and rates for anxiety varying from 2.9% in the Western Pacific Region to 5.8% in the Region of the Americas (WHO, 2017a). Additionally, depressive disorders are ranked as the largest contributor to non-fatal disease burden, and anxiety disorders are ranked as the sixth largest contributor (WHO, 2017a).

Table 1.1. Global prevalence and years lived with disability in 2017

	Prevalence			**Health Loss/Disease Burden**	
Disorder	*Total cases*	*% of global population*	*Gender distribution*	years lived with disability *(per 100,000)*	*% change, 2007–17*
Depressive Disorders	264 million	3.4	4.1% Females 2.7% Males	43,100	14.3
Anxiety Disorders	284 million	3.8	4.7% Females 2.8% Males	27,100	12.8

Source: Institute for Health Metrics and Evaluation (2017)

1.4. High-income countries (HICs) vs low- and middle- income countries (LMICs)

The World Bank (2019) classifies economies according to their gross national income per capita (Table 1.2). The burden of mental disorders falls heavily upon LMICs, given that 85% of the world's population reside there (Bruckner et al., 2011), with estimates suggesting that more than 80% of depressive disorders occur in LMICs (WHO, 2017a; see Table 1.3). Furthermore, it is predicted that depression alone will likely be the third leading cause of disease burden in low-income countries and the second highest in middle-income countries by the year 2030 (Mathers & Loncar, 2006).

Table 1.2. World Bank's classification of countries in 2019

Income Classification	**Gross national income per capita (US$)**
High income	12,375 or more
Upper middle income	3,996–12,375
Lower middle income	1,026–3,995
Low income	1,026 or less

Source: World Bank (2019)

Table 1.3. Prevalence by income classification and disorder in 2017

World Bank Income Classification	**Depressive disorder**	**Anxiety Disorder**
High income	50 million	63 million
Upper middle income	99 million	98 million
Low middle income	97 million	102 million
Low income	18 million	21 million
Total low- and middle-income countries	214 million	221 million
Total World	**264 million**	**284 million**

Source: Institute for Health Metrics and Evaluation (2017)

1.4.1. Factors influencing differences in prevalence

1.4.1.1. Social determinants

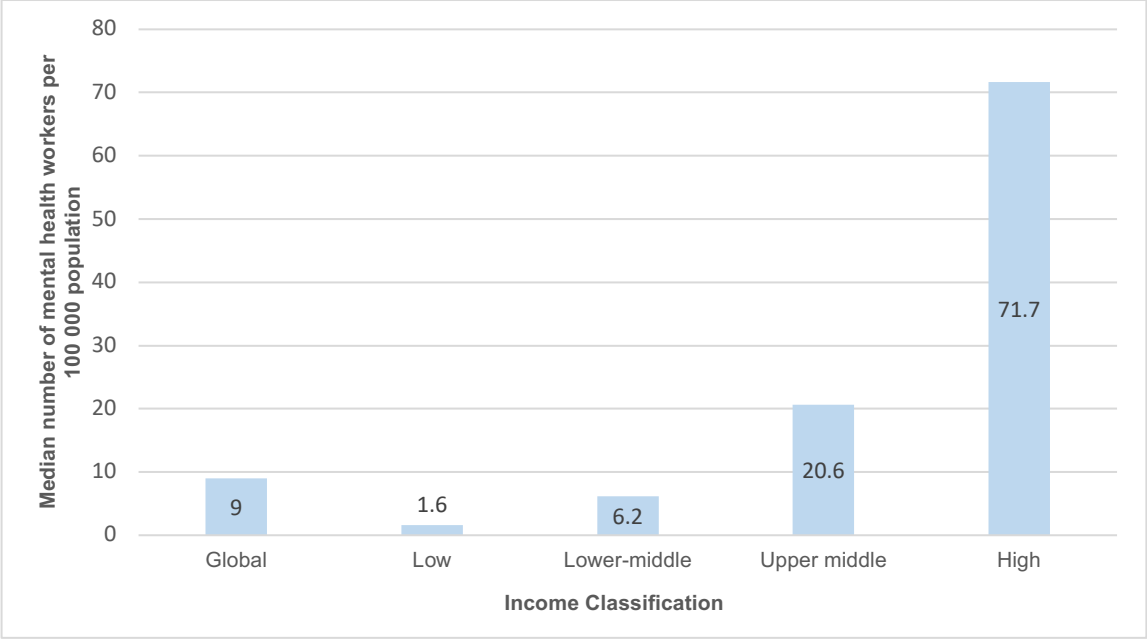
High prevalence rates can be attributed to a number of social determinants such as low socioeconomic status (Lund et al., 2010), income inequality (Patel et al., 2018) and gender, with women showing a higher risk of mental disorders, a key driver being their lower status in society (Cheng et al., 2016; Maselko, 2017). Additionally, loss, trauma and displacement as a consequence of both man-made and natural disasters, such as war, earthquakes, tsunamis, epidemics and famine, are common in LMICs and can result in the increased risk of emotional and mental health problems (Makwana, 2019; Pollack et al., 2016). Furthermore, the limited resources available may be directed towards addressing these issues rather than on mental health.

Access to treatment and mental health outcomes can also be influenced by cultural and religious beliefs with individuals in LMICs first seeking help from traditional and religious healers, which often results in delayed treatment (Burns & Tomita, 2015). One reason for this is the stigma surrounding mental health conditions, a common barrier to seeking care, as well as people's low levels of knowledge around mental illness (Henderson et al., 2013). However, whilst this poses a challenge, in their Mental Health Action Plan, the WHO suggested working more closely with 'informal' healthcare providers such as these healers to widen access to care (WHO, 2013). Although research into working with traditional and religious healers is limited, a recent review investigating the views of traditional healers and biomedical practitioners towards collaborative mental healthcare identified that both parties recognise that traditional and biomedical treatment could complement one another and benefit the patient (Green & Colucci, 2020).

1.4.1.2. Mental health expenditure

Globally, government mental health expenditure per capita is US$ 2.5, therefore making government spending on mental health to be less than 2% of the US$ 141 global median of government health expenditure. There is also a stark difference between regions, with Africa having a mental health expenditure of 10 cents per capita compared to Europe's US$ 21.7 (WHO, 2018). Generally, the proportion of funds spent on mental health tends to be low and inefficiently allocated, with the least effective and most cost-effective interventions receiving the greatest amount of money, especially in LMICs where funds are allocated towards specialised hospitals (Vigo et al., 2019). Moreover, it was found that Africa and the South East Asian regions had the largest rate for out-of-pocket expenditure where individuals will pay mostly or entirely out of their own pocket for access to mental health services and psychotropic medication (WHO, 2018). This will most likely be due to no social insurance scheme being available in countries or the scheme not covering mental disorders, therefore leaving individuals to pay for costs themselves.

Figure 1.1. Mental health workforce per 100,000 population by World Bank income classification



(WHO, 2018)

1.4.1.3. Shortage in the mental health workforce

There is also a large variation in the mental health workforce between HICs and LMICs, with data reporting estimates of below 2 mental health workers per 100,000 population in LICs compared to over 70 in HICs (WHO, 2018; see Figure 1.1). When broken down to individual staff categories, an even greater variation can be found with 11.9 psychiatrists per 100,000 population in HICs compared to less than 0.1 in LICs. This problem is accentuated by the unequal geographical distribution of resources with higher concentrations of psychiatrists and nurses working in larger cities in the lower-income countries, and also, the density of psychiatric beds is 6.4 times greater in the largest city (WHO, 2009). This unequal distribution suggests that those living in rural areas are less likely to access mental health treatment.

1.4.2. Global initiative to address the mental health gap

The large gap between mental health services and provision has received increasing attention in the past decade particularly amongst LMICs, with the WHO launching the Mental Health Gap Action Programme (mhGAP), which aims at scaling up services for mental, neurological and substance abuse disorders for countries especially with low and middle income (WHO, 2008a). This was followed by an intervention guide (mhGAP-IG), which is a clinical decision-making tool for the assessment and management of the priority mental, neurological and substance abuse conditions using evidence-based guidance in LMICs (WHO, 2010). Despite the development of this

initiative, according to Sashidharan, White, Mezzina, Jansen and Gishoma (2016), there is a common misconception that global mental health is about solely improving care in resource-poor countries, and although significant efforts have been made to scale up mental health services in LMIC, there are also increasing concerns in HICs about efficacy, efficiency and acceptability of their current mental health services.

1.5. Common Mental Disorders in the UK

The Adult Psychiatric Morbidity Survey carried out in England in 2014 and 2015 presents the most reliable data available on mental health in England (see Table 1.4). The survey found that around one in six (17%) individuals over the age of 16 is identified with symptoms of CMDs, with the largest category being CMDs not otherwise specified, followed by generalised anxiety disorder (5.9%), depression (3.3%), phobias (2.4%), obsessive compulsive disorder (1.3%) and panic disorder (0.6%) (McManus et al., 2016).

Table 1.4. Percentage of adults aged between 16 and 64 in England suffering from a CMD in the past week, by CMD and year

	Year			
CMD	1993	2000	2007	2014
Generalised anxiety disorder	4.4	4.7	4.7	6.6
Depressive episode	2.2	2.8	2.6	3.8
Phobias	1.8	1.9	2.1	2.9
Obsessive compulsive disorder	1.4	1.2	1.3	1.6
Panic disorder	1.0	0.7	1.2	0.6
CMD-NOS	7.5	9.4	9.6	8.5
Any CMD	15.5	17.5	17.6	18.9

Source: Adult Psychiatry Morbidity Survey (2016)

Whilst location and time of when the survey was carried out influence prevalence rates, other demographic and socioeconomic factors such as gender, age, ethnicity and employment status are all associated with a greater risk of disorders. A large amount of evidence has shown that CMDs are shaped to a great extent by the wide range of characteristics of the social, economic and physical environments in which people live (WHO & Calouste Gulbenkian Foundation, 2014).

CMDs tend to have a higher prevalence in females compared to males, with one in five women having symptoms of CMDs, compared with one in eight men. Furthermore, data from the past four Adult Psychiatry Morbidity Surveys show that mental illness has increased in women whilst

remaining largely stable in men (McManus et al., 2016). There are a number of factors that have been associated with a greater prevalence of CMDs in women including exposure to gender-based violence (Trevillion et al., 2012), gender role–related stressors (Leach et al., 2008; McBride, 1988) and income inequality (Platt et al., 2016).

Furthermore, this gender gap has become more pronounced in young people over the years, with women aged between 16 and 24 years reporting the most CMD symptoms (28.2%). CMD symptoms have been found to be associated with age with 17%–18% of individuals between the ages of 16 and 64 showing symptoms of CMD compared with 10.2% of 65- to 74-year-olds and 8.1% of individuals aged 75 and over (McManus et al., 2016).

CMDs also vary with ethnicity, with the Adult Psychiatry Morbidity Survey reporting that whilst the prevalence of CMDs in men did not vary significantly by ethnicity, in women, non-British white women were less likely to have a CMD compared to British white women, and overall CMDs were more common in black women (McManus et al., 2016). A number of factors are associated with a greater prevalence of CMDs in ethnic minorities, with research showing that exposure to racial or ethnic discrimination can have harmful effects on both physical and mental health (Lewis et al., 2015; Vines et al., 2017). Further reasons cited for increased rates are cited in Box 1.3. Moreover, there is evidence that individuals from hard-to-reach groups such as black and minority ethnic communities are less likely to receive appropriate mental healthcare, therefore influencing prevalence rates (Kovandžić et al., 2011). Factors such as living alone, being unemployed and receiving benefits have all been associated with a greater prevalence of CMDs (McManus et al., 2016), which is in keeping with research that suggests poverty and social inequality is associated with an increased risk of CMDs (Campion et al., 2013; Murali & Oyebode, 2004).

Box 1.3. Reasons for higher rates of mental illness in ethnic minorities

- Poor housing
- Unemployment or low-paid work
- Racism, discrimination and abuse
- Low literacy levels and lack of English language skills
- Lack of social support
- Marital and family relationships (different cultural values and traditions, including beliefs regarding marriage, divorce, widowhood and family honour)

Source: Gask, Kendrick, Peveler & Chew-Graham (2018)

1.6. Management of Common Mental Disorders

Several effective pharmacological and psychological treatments exist for CMDs. Pharmacological interventions include antidepressant drugs for depression (Cipriani et al., 2018) or selective

serotonin reuptake inhibitors for anxiety (Cassano et al., 2002). However, the use of such drugs can come with risks, and often patients will discontinue treatment due to experiencing adverse events (Gartlehner et al., 2008). Furthermore, patients are often reluctant due to concerns over the addictiveness of antidepressants (Van Schaik et al., 2004), as well as the stigma that often surrounds it (Givens et al., 2007). Such scepticism reflects a general trend towards alternative treatments for mental disorders, with a meta-analysis by McHugh et al. (2013) finding that adults were three more times likely to express preference for psychological over pharmacological treatments for depression and anxiety.

Psychological therapies are widely used in the management of symptoms of CMDs and are recommended in the National Institute for Clinical Excellence (NICE) guidelines (NICE, 2011; see Box 1.4). A number of psychological therapies exist such as different forms of cognitive behavioural therapy (CBT), including interpersonal therapy, brief behavioural activation and common elements treatment approach, to name a few. CBT assumes that psychopathology is a result of biased cognitions and unhelpful behaviour and aim to improve symptoms by using a combination of cognitive components that identify and challenge negative thoughts and behavioural components that aim to alter the way an individual will do certain things (Purgato et al., 2018). Evidence has shown the efficacy of CBT in reducing symptoms of anxiety (Hofmann & Smits, 2008; Watts et al., 2015) and depression (Cuijpers et al., 2009; Linde et al., 2015).

Box 1.4. NICE recommended treatments for CMDs

Intervention	Description
Cognitive behavioural therapy	Targets problematic thinking and behaviours that may be associated with depression. Patients are taught skills to change maladaptive patterns of thinking, increase activities that improve mood and solve life problems (Dimidjian & Goodman, 2009)
Interpersonal psychotherapy	Targets a patient's social functioning with an emphasis on interpersonal disputes, role transitions, grief and interpersonal deficits (Dimidjian & Goodman, 2009)
Psychodynamic psychotherapy	Helps patients resolve depression by enhancing their understanding, awareness and insight into unconscious conflicts (Shinohara et al., 2013)
Behavioural activation	Helps patients make contact with potentially reinforcing experiences by increasing access to pleasant events and consequences, activity scheduling and social skills development (Shinohara et al., 2013)

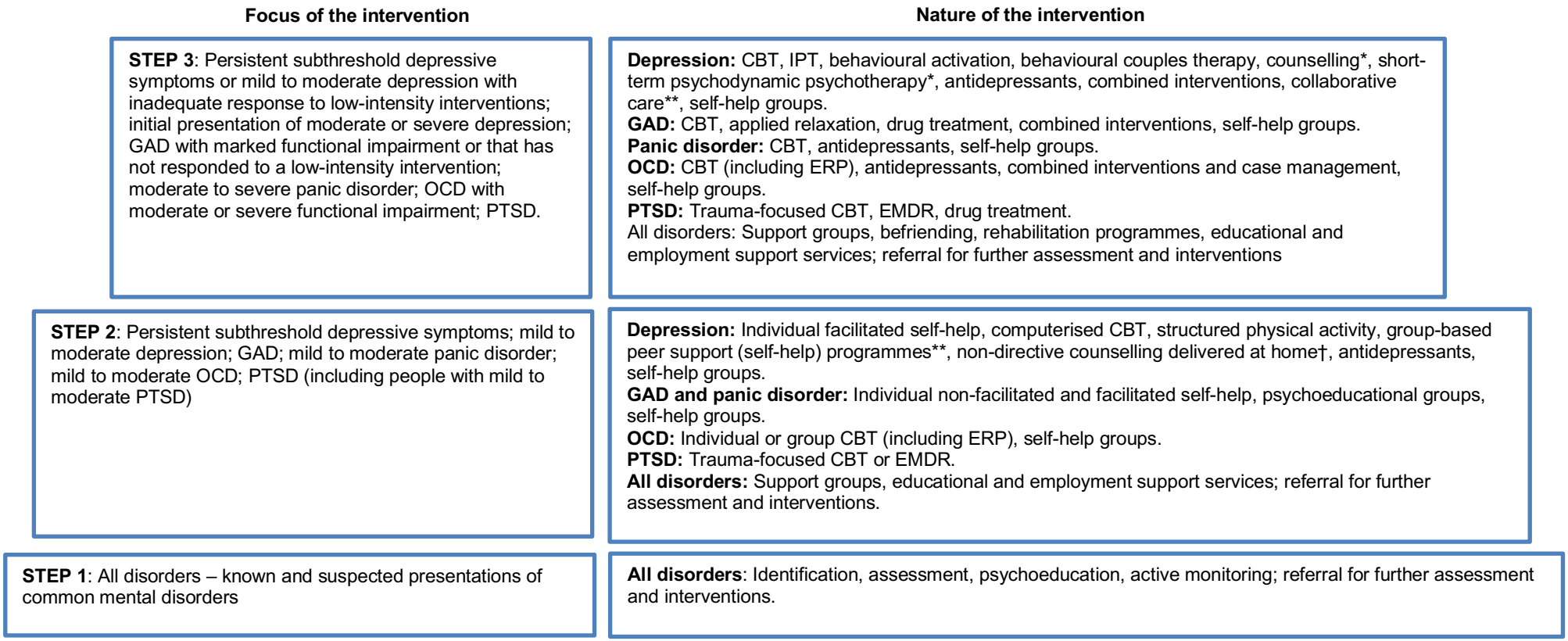
Box 1.4. NICE recommended treatments for CMDs

Counselling	Unstructured therapy which allows the patient to ventilate their experiences and emotions and achieve relief from their personal problems through discussion and empathy from the therapist (Cuijpers et al., 2009)
Eye movement desensitisation and reprocessing	The patient's attention is directed towards an external stimulus, whilst he/she simultaneously concentrates on an identified source of emotional disturbance (Shapiro, 1996)

1.6.1. Current approaches in the delivery of therapies

In the UK, NICE provides recommendations to improve the identification of CMDs and improve access to services and pathways to care based on evidence for efficacy and cost-effectiveness. NICE recommends a stepped-care model that provides a framework which aims to organise the provision of services and supports service users including carers and practitioners in identifying and accessing the most effective treatments (NICE, 2011; see Figure 1.2). Each step represents increased complexity of the intervention, in which the least intrusive intervention is provided first, with appropriate interventions from the next step being offered if the initial intervention does not benefit the user. Support for a stepped-care model in increasing access to psychological therapies and reducing symptoms of CMDs have been reported, with van't Veer-Tazelaar et al. (2009) finding that a stepped-care programme for reducing depression and anxiety symptoms was more effective than usual care. Moreover, in 2008, the Increasing Access to Psychological Therapies (IAPT) service was developed as a systematic way to organise and improve the delivery of, and access to, NICE-recommended psychological treatments for people with CMDs. The key characteristics of the IAPT services are outlined in Box 1.5, and the service pathway can be seen in Figure 1.3. Depending on the nature and severity of the CMD, NICE recommends pharmacological interventions, low-intensity interventions such as computerised cognitive behaviour therapy, high-intensity psychological interventions such as behavioural activation as well as a combination of treatments.

Figure 1.2. The stepped-care model for CMDs recommended by NICE (2011)



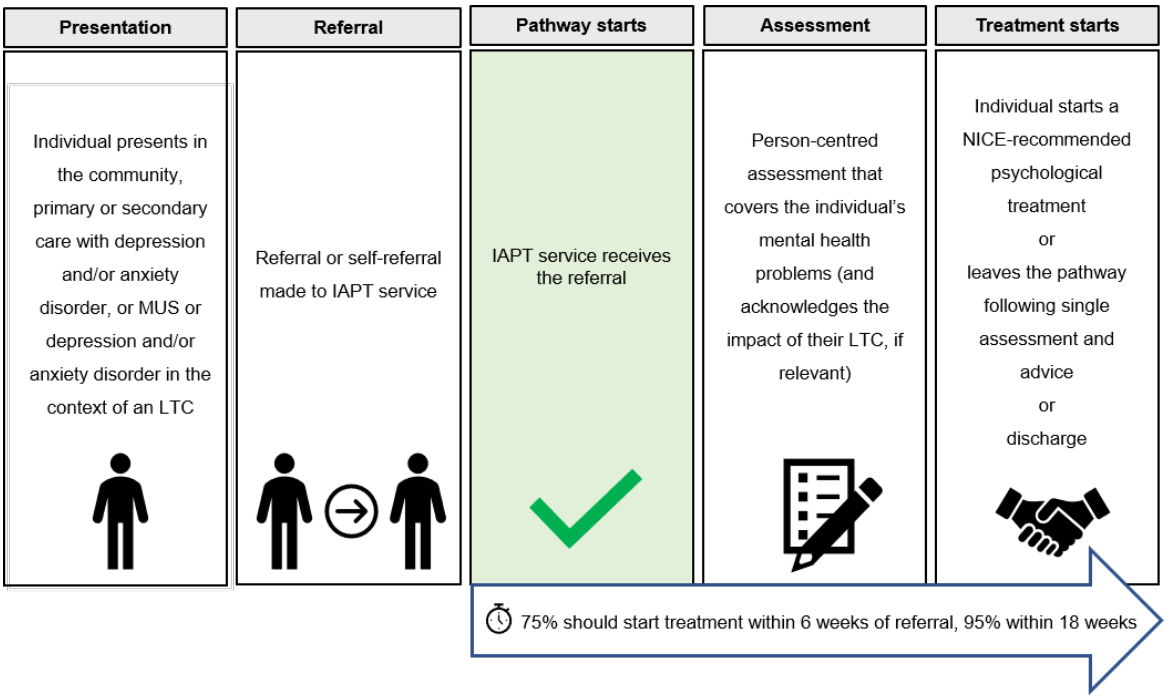
* Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.
** For people with depression and a chronic physical health problem.
† For women during pregnancy or the postnatal period.
CBT, cognitive behavioural therapy; ERP, exposure and response prevention; EMDR, eye movement desensitisation and reprocessing; GAD, generalised anxiety disorder; OCD, obsessive compulsive disorder; IPT, interpersonal therapy; PTSD, post–traumatic stress disorder

Box 1.5. Key principles of the IAPT services for effective treatment and stepped care

A minimal wait where no patient is waiting longer than necessary for treatment
Treatment should be guided by the patient's key problems
NICE-recommended psychological therapies should be provided (see Figure 1.2)
The least intrusive intervention should be offered first where there is evidence of its effectiveness
Treatment should be guided by the patient's choice when NICE indicates that a number of different therapies are effective for a particular condition
The intensity and duration of treatment should be designed to optimise outcomes
Treatment should follow a stepped-care model which includes stepping up when there is no improvement, stepping down when a less intensive treatment becomes more appropriate and stepping out when an alternative treatment or no treatment becomes appropriate (see Figure 1.2)
Treatment is provided by trained and accredited workforce, who are receiving weekly, outcome-focused supervision
Routine outcome monitoring measured on a session-by-session basis which allows for both the patient and clinician to have up-to-date information on the individual's progress, guiding the course of each patient's treatment

Source: National Collaborating Centre for Mental Health (2018)

Figure 1.3. IAPT services pathway



MUS, medically unexplained symptoms; LTC, long-term health conditions

Source: National Collaborating Centre for Mental Health (2018)

In recent years, the delivery of mental health services has significantly changed (Cummings et al., 1997; Kiesler, 2000). Most patients with CMDs are receiving treatment from primary care practitioners rather than mental health specialists, with Goldberg and Huxley (1992) reporting that 90% of people receive treatments for CMD solely in primary care settings. Furthermore, a survey conducted in 2014 reported that 44% of people with a CMD contacted their general practitioner for help (Mental Health Foundation, 2016). Indeed, WHO and the World Organisation of Family Doctors (Wonca) suggest that integrating mental health services into primary care is the most practical way of closing the treatment gap and ensuring that people get the mental healthcare they need (WHO & Wonca, 2008). However, due to limited consultation times and a high workload, general practitioners are limited in their ability to provide the best mental healthcare. Furthermore, they are often underprepared to deal with mental health issues and lack awareness of the available specialist mental health services (British Medical Association; 2017). Often general practitioners will have little training in mental health, with a general practitioner mental health training survey revealing that out of all general practitioners who completed their training in 2017, fewer than half completed a psychiatry placement (Mind, 2018). Moreover, 72% of general practitioners expressed a desire to have more continuing professional development training related to mental health, with doctors expressing their need for further information on services available to support their patients (Mind, 2018).

An explanation for the common occurrence of CMDs in primary care patients is the high prevalence of coexisting long-term physical health conditions and mental health problems. Data from the World Health Surveys indicate that those with a long-term condition (LTC) are two or three times more likely to develop a mental health problem, and patients with two or more LTCs are seven times more likely to experience depression compared to those who do not suffer from a LTC (Moussavi et al., 2007). Other reasons for the expanding role of Primary Care Practitioners in mental healthcare include a shortage of mental healthcare providers, patients' reluctance to access psychiatric services due to the label attached to a mental illness diagnosis and the stigma associated with seeing a psychiatrist (Faghri et al., 2010). Furthermore, in countries in which free or universal healthcare is not provided such as the United States, Primary Care Practitioners may be the only point of access for patients to receive treatment due to limited insurance to cover psychiatric treatment (Cunningham, 2009).

1.6.2. Barriers to accessing treatment

Despite the extensive evidence supporting the effectiveness of psychological therapies and the evidence-based guidelines published by NICE, the mental health sector is often unable to deliver the same quality of care as physical care. Many people are unable to access treatments due to long waiting lists and limited access to formal mental health services (Layard, 2006). For example, a community mental survey in 2016 found that 54% of respondents felt that they had not seen someone from the mental health services often enough for their needs (Care Quality Commission,

2016). Furthermore, it has been reported that three in four people with a mental health problem receive little or no treatment for their condition (The King's Fund, 2015). To solve this problem, National Health Service (NHS) England aimed to deliver rapid improvements in services by 2020/21 by ensuring that 1 million more people with mental health conditions are able to access high-quality care (NHS England, 2016). Furthermore, since the development of the IAPT initiative, the number of people receiving psychological therapies through IAPT services has more than doubled from around 435,000 in 2012/13 to over 1 million in 2017/18 (NHS Digital, 2019), and the NHS long-term plan is committed to increasing this by an additional 380,000 adults per year to reach 1.9 million by 2023/24 (NHS England, 2019). Although this initiative has greatly improved overall access to psychological interventions, there is an inconsistency in the percentage of patients recovering, with data from 2017 reporting recovery rates ranging from 86% to 23% in some areas (NHS Digital, 2018). Additionally, it has been reported that only approximately 60% of the population has access to an IAPT service (Clark, 2011). Furthermore, whilst reports show that IAPT services see over 1 million people each year (NHS Digital, 2019), this only accounts for 17% of the community prevalence of CMDs (McManus et al., 2016).

Despite this focus on increasing access to psychological therapies, the prevalence of depression and anxiety is not decreasing (Jorm et al., 2017) due to reasons including inadequate funding, a lack of focus on prevention and early intervention, inadequate provision and quality of services and a shortage in the workforce and insufficient training (British Medical Association, 2017). Although in 2018/19, IAPT achieved its commitment of seeing 75% of people referred to IAPT services within 6 weeks of referral and 95% within 18 weeks of referral (NHS Digital, 2019), there are often ‘hidden’ waiting lists once patients have had their first appointment with the number of people facing long waits for their second appointment increasing. In 2018/2019, out of the 580,000 people who went on to have a second appointment, almost half had waited more than 28 days from their first appointment, and 1 in 6 patients (approximately 95,000) waited over 90 days, a number which has doubled in 3 years (Triggle, 2019). This is a concern when considering that the first session is often dedicated to carrying out assessments and gauging the patient’s concerns and expectations, with the second appointment marking the start of the main treatment.

Furthermore, barriers to accessing mental health services are even greater for ethnic minorities residing in the UK with inequality in the standard of mental healthcare they receive. The Adult Psychiatry Morbidity Survey found that only 7% of people from ethnic minorities reported that they were currently receiving mental health treatment compared to 14% of individuals with a white British family background (McManus et al., 2016). Recovery rates also differ, with individuals identifying as white more likely to move to recovery and see an improvement in their conditions compared with ethnic minority groups (Baker, 2020). A qualitative study exploring the perceived barriers to accessing mental health services among black and ethnic minority communities highlighted factors influencing access to mental health services which included:

- Long waiting times,

- Language barriers,
- Cultural insensitivity and discrimination towards black and ethnic minority communities,
- Inadequate recognition of mental health needs,
- Poor communication between services users and providers.

Source: Memon (2016)

The long waiting times and the inability to gain access to psychological therapies have led to an increase and overreliance in the use of antidepressants with prescriptions for antidepressants doubling between 2006 and 2016 from approximately 31 million to 65 million (NHS Digital, 2017). Psychological therapies are widely recognised as effective treatments for a number of mental health disorders; however, if treatment is not accessed as soon as possible, it can lead to even greater mental health problems, which may spiral into a crisis. Therefore, it is necessary to find alternative methods of delivering these treatments to address the high demand.

1.7. Chapter Summary

- CMDs are highly prevalent globally, yet they are undertreated due to a global shortage in the mental healthcare workforce.

- There are many barriers that inhibit the delivery of mental healthcare for CMDs, many of which could be resolved by increasing the number of mental health workers.

- Therefore, alternative methods for delivering psychological therapies needs to be investigated.

Chapter 2. Innovations in delivering psychological therapies

The first part of the introduction examined CMDs, the treatments available and the barriers to accessing them. This next part will investigate the approaches that exist to address issues related to health worker shortages and limited resources.

According to Singla, Raviola and Patel (2018), there are three major barriers preventing the delivery of psychological treatments: (1) limited access, (2) high demand for mental healthcare and (3) a shortage in the skilled workforce. An evidence-based solution to the first barrier suggested by Singla et al. (2018) is the delivery of psychological treatments at a time and location that is convenient for the patient. Furthermore, treatments can be delivered through digital technology such as computers and smartphones (Fairburn & Patel, 2017) and can be just as effective as face-to-face treatments when accompanied by support (Andersson et al., 2014). Additionally, whilst guided self-help interventions, in which the patient is guided by a professional, have been found to be effective for reducing symptoms of depression (Cuijpers et al., 2010), self-guided interventions are also effective, in which the patient has no contact with a therapist or a coach (Cuijpers et al., 2011). These solutions may increase access to care for individuals who are not able to afford private treatment or for individuals who do not have the social or physical capacity to travel for treatment.

Second, although the need for psychological treatments is high, there is less willingness to engage in talking therapies, which is reflected by the low retention rates, with data in the UK showing that only 41% of white British patients completed a course of treatment, and rates are even smaller for other ethnicities (34%–36%) (Baker, 2020). To address this problem, Singla et al. (2018) suggest considering the community when designing and developing mental health services, for example, by avoiding the use of mental health labels, addressing social factors that may be linked to psychological symptoms and engaging the patient's relationships and resources to aid in treatment.

Lastly, the shortage in the mental health workforce is a global concern (WHO, 2018). Whilst IAPT has aimed to address this concern in the UK by training over 10,500 new therapists by 2021 and deploying them in mental health services (Clark, 2018), training high-intensity-CBT therapists and low-intensity psychological well-being practitioners takes significant time and resources. Training involves the individuals attending lectures at university alongside working in an IAPT service. Furthermore, the successful applicants to the high intensity CBT course are required to have worked for several years in mental health services and usually belong to a core mental health profession (e.g., counsellor, mental health nurse, psychological wellbeing practitioner). Similarly, even though psychological well-being practitioner trainees do not need to have a core mental health profession, they are required to have some experience of working in mental health care and are usually Psychology graduates (Clark, 2018). Therefore, the lack of skilled providers cannot be solely addressed by increasing the number of individuals specialising in the mental health

discipline as methods for training these individuals are expensive, time-consuming and require experienced therapists to provide training and regular supervision (Singla et al., 2018).

Furthermore, in the case of the IAPT therapists, studies have shown increasing levels of stress (Walklet & Percy, 2014), emotional exhaustion (Steel et al., 2015) and burnout (Westwood et al., 2017) as a result of high workloads, a greater number of hours of patient contact and hours of overtime, as well as a longer duration working in the current IAPT service (Scott, 2018; Westwood et al., 2017). However, burnout is not just specific to IAPT workers and has been found in other mental health professionals (O'Connor et al., 2018), with Morse et al. (2012) suggesting that 21%–67% of mental health workers may be experiencing high levels of burnout. Therefore, it is becoming increasingly necessary to look at alternative methods to deliver psychological treatments to relieve staff burden and also increase mental health provision.

2.1.1. Increasing human resources within healthcare

The magnitude of the mental health gap exacerbated by the shortage of the workforce has required the introduction of innovative strategies of treatment delivery. One such strategy is task-shifting, defined by WHO (2008b) as

> *a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications . . . [to] make more efficient use of existing human resources and ease bottlenecks in service delivery.*

The key principle therefore is that shorter training and fewer qualifications will allow for more workers to be trained. Task-shifting has been used globally, in a range of health services, as a solution to address the limited resources and increase provisions of care.

Bolton (2019) states that to fully appreciate the use of task-shifting within mental healthcare, it is important to consider its origins in physical healthcare. The Ding Xian experiment in rural China (1926–37) was one of the earliest studies to use a task-shifting approach within physical healthcare in which the basic treatment was provided by village health workers with limited medical education, who would then refer on any cases that were outside their expertise (Taylor & Taylor, 2002). Similarly, the task-shifting approach was also used in the 1970s to the 1980s in the Democratic Republic of Congo where auxiliary personnel were identified as a solution to address the shortage of fully trained health workers.

When examining the research into task-shifting within physical healthcare, it is necessary to consider the various forms that task-shifting can take, which can involve potential changes in skill mix within the healthcare setting (Sibbald et al., 2004). Roles can be changed through:

I) **Enhancement** - The depth of the job is increased by extending the role or skills of a particular group of workers

II) **Substitution/delegation** – Expanding the breadth of the job by exchanging one type of work for another or by breaking traditional professional divides. This may also involve moving tasks up or down the ladder.

III) **Innovation** – Creating new jobs by introducing a new type of worker.

The purpose of such changes is to enhance the efficiency and effectiveness of healthcare and has been adopted in a number of clinical settings. For example, the role of some nurses has been enhanced to include areas such as case management of chronic disease, with evidence showing that nurse-led clinics achieve better results than those led by physicians in the management of moderate chronic obstructive pulmonary disease (Smith et al., 2001). Similarly, the role of pharmacists has been enhanced to take on further responsibilities including the management of medicine regimes, supporting patient adherence and prescribing and monitoring effects of treatment. For example, pharmacist-administered diabetes education and management can lead to improvements in diabetes and blood pressure (Ragucci et al., 2005). However, the evidence for the effectiveness of skill change is mixed. For example, there is evidence that pre-hospital management of trauma through doctors is more efficacious than the management through other health workers (Wilson & Gangathimmaiah, 2017). Additionally, training paramedics in advanced life support training has shown no improvement in patient outcomes (Sethi et al., 2014). Substitution is also linked to enhancement, as it often involves a group of workers enhancing their skills and taking over roles, such as training nurses to prescribe routine medication (Martínez-González et al., 2015).

The development of new types of professionals has led to significant changes in the health system over the years. One such example is the introduction of phlebotomists to take blood samples, a task that was once carried out by doctors or nurses (Expert Panel on effective ways of investing in Health (2019). Another type of innovation that has been critical to the advances made in global healthcare is the use of community health workers (CHWs). CHWs are characterised as lay individuals of various backgrounds who come from or are based in the communities that they serve. Most commonly they will have minimal education and will have received training on the health problem that they are engaging in. A formal definition is provided by WHO (1989), who state that

> *CHWs should be members of the community where they work, should be selected by the communities, and be answerable to them for their activities, should be supported by the health system but not necessarily a part of its organisation, and have shorter training than professional workers.*

CHW-based care has taken origin in its delivery of care for HIV and maternal and child health in LMICs (Crowley & Mayers, 2015; Gilmore & McAuliffe, 2013; Zachariah et al., 2009) and has also been applied across other conditions and health settings (Maier, 2015). Evidence has shown the benefits of using CHWs, with a recent umbrella review concluding that services provided by community health volunteers in LMICs were not inferior to those provided by other health workers

and sometimes were better (Woldie et al., 2018). However, the volunteers performed less well in more complex tasks such as diagnosis and counselling. Additionally, a review of CHWs in HICs found that although they provide a wide range of health-related services, they are often under-recognised and therefore underutilised (Najafizada et al., 2015). The review concluded that CHW roles need to be better integrated within the healthcare system to fully realise their potential.

The comparison of operational practices from six implementing organisations that have developed high-impact CHW programmes has led to several factors being identified for effective CHWs and can be seen in Box 2.1 (Ballard et al., 2017). In the experience of the six organisations, these factors are the minimum viable elements needed for CHWs to succeed.

Box 2.1. Factors for an effective CHW

Accreditation	The health knowledge and competencies are assessed prior to the CHWs practicing. A minimum criterion must be met before carrying out their work.
Accessibility for service users	To improve accessibility, timeliness and equity of care, service user fees should be avoided.
Proactive	There should be a proactive approach to active case finding, where CHWs go door-to-door looking for sick patients and providing training on identifying symptoms and contacting a CHW.
Continuously trained	CHWs are trained through modules or other in-service learning techniques. Continuous medical education is required and available.
Supported by a dedicated supervisor	Frequent and regular supervision is provided by a supervisor who assesses patient experience and provides one-to-one support.
Payment	CHWs are compensated financially.
Part of a strong health system	CHW deployment is accompanied by investments to increase the capacity, accessibility and quality of the primary care facilities and providers to which CHWs are linked.
Part of data feedback loops	All data is reported by CHWs for monitoring and evaluation and used to improve programs and CHW performance.

Source: Ballard et al. (2017)

2.1.2. Task-shifting in mental health

The need to find alternative methods for delivering psychological treatments is even greater when considering the nature of psychological therapies which are more labour-intensive than physical care. Whilst most common physical disorders can be treated or managed by a few short outpatient

visits and medication, psychological therapies for CMDs often require weekly visits, with sessions usually lasting up to an hour or more, and usually the duration of treatment will depend on the progress of the patient and may even last up to 12 weeks (Bolton, 2019). Therefore, the availability of these therapies is even further beyond the workforce resources of most countries than for physical health. Although in some countries, doctors and nurses have been trained to provide these treatments, their time to carry out such tasks is limited, and physical care will often take priority, especially in settings where there is a smaller physician-to-population ratio and where the primary healthcare system is overburdened. For example, in Nigeria, the role of the Primary Care Practitioner has been enhanced due to the limited specialist workforce available to provide treatment for depression; however, due to the small physician density (3–4 per 10,000 people), the treatment of depression through physicians is not pragmatic (Ola & Atilola, 2019).

One feasible option to address this problem is through the use of NTPs who are dedicated to delivering mental healthcare such as community mental health workers (Inge Petersen et al., 2012). NTPs include a broad range of health providers without specialised mental health training and have been known by a variety of terms including CHWs, LHWs, promotoras, Primary Care Practitioners, paraprofessionals, lay health counsellors, lady health workers, village health workers and non-specialist health workers (Lehmann & Sanders, 2007). For the purpose of this thesis, NTPs refer to individuals who have not received advanced degrees in the mental health field (e.g., psychiatry, psychology, social work) or who have not received specialist training or a training course in mental health, and who have a role of increasing access to community mental health services (Barnett et al., 2018a).

The concept of task-shifting for the delivery of treatments within mental healthcare has existed as early as the 1970s, where the idea of using health workers, trained to deliver psychotropic drugs under the supervision of a trained psychiatric nurse, was proposed by Harding and Chrusciel (1975). However, in the 1990s, Mozambique was one of the first places to put the task-shifting approach for mental healthcare into practice by training psychiatric technicians to compensate for the severe shortage of psychiatrists (Zeitvogel, 2018). Research into NTPs delivering psychological therapies has mainly been in LMICs, where it has been found to be effective for a number of CMDs (Kaufman et al., 2013; I. Petersen et al., 2012). Furthermore, a Cochrane review investigating the effect of non-specialist health workers on people with mental health conditions found that compared with usual care, interventions delivered by non-specialist health workers may increase the number of adults recovering from depression or anxiety two to six months after treatment (Van Ginneken et al., 2013). An updated version of this review published in 2021 with 72 new trials found that compared with usual care, LHW delivered interventions may increase recovery, may reduce the number of people with anxiety or depression, may improve quality of life and may reduce the risk of suicide (van Ginneken et al., 2021). This is also supported by a review by Singla et al. that examined the effectiveness of psychological treatments for CMDs delivered through NTPs in LMICs, finding moderate to large intervention effect sizes in symptom reduction (Singla et al., 2017).

Whilst task-shifting is being used as a way to reduce the treatment gap within mental health in more resource-limited settings, the concept is also emerging within more affluent healthcare settings. In HICs, there are models of care where the role of specialists is being carried out within primary care or through non-professional lay workers or peers (Grant et al., 2018; Sashidharan et al., 2016). Furthermore, in the United States, psychiatric mental health nurse practitioners have been introduced to prescribe medication and are taking on increased clinical responsibilities in the treatment of individuals with mental illness (de Nesnera & Allen, 2016). Due to the growing evidence on the effectiveness of NTP-delivered care, a greater focus is being given to how this approach can be successfully implemented in HICs, with Barnett et al. (2018a) suggesting a model that includes:

- *Outreach and navigation* to increase referrals to formal mental health services;
- *Auxiliary care*, in which NTPs can support client engagement with the intervention;
- *Stepped care,* in which NTPs will provide low-level care or in under-resourced settings will be the primary provider of care.

Recently, the term 'task-shifting' has been linked to the term 'task-sharing'. Although in research the terms are used interchangeably, the term 'task-sharing' generally refers to health professionals working as a team to provide a service (Dawson et al., 2014), and has been favoured in recent work due to the notion that mental healthcare will usually be provided by a team. Furthermore, task-shifting has also been used to refer to a collaborative model of care in which tasks will be shared by a multidisciplinary team of health professionals. Collaborative care has been evaluated in more than 80 randomised controlled trials (RCTs) conducted mostly in HICs for a variety of CMDs with the majority of studies showing its benefits compared to usual care (Archer et al., 2012; Thota et al., 2012). Whilst in high-income settings the team of providers will often involve a Primary Care Practitioner, a care manager with mental health training and a mental health specialist, in low-income settings a collaborative stepped care led by LHWs has been found to be successful in the care of depression and anxiety (Araya et al., 2003; Patel et al., 2010). The effectiveness of this collaborative approach was demonstrated through the implementation of the MANAshanti Sudhar Shodh (MANAS) project in Goa, India (Patel et al., 2010). The collaborative team consisted of an lay health counsellor, a Primary Care Practitioner and a psychiatrist, in which the lay health counsellor acted as a case manager, taking overall responsibility for delivering psychoeducation and support under supervision of the Primary Care Practitioner and psychiatrist. Overall, the trial is the largest effectiveness trial of a primary care-based intervention to integrate CMD treatments into routine primary care in a developing country with results showing that patients with CMD were more likely to have recovered at six months.

Generally, the use of NTPs with no mental health background and relatively short training to deliver psychological treatments has been found to be effective in a number of studies, with a study in Uganda using trained community-based workers to successfully deliver group Interpersonal Therapy for depression (Bolton et al., 2003); a study in Pakistan demonstrating the effectiveness of

using lady health workers to deliver CBT to women with perinatal depression (Rahman et al., 2008) and Chibanda et al. (2016) reporting improved symptoms of CMDs at six months, following LHW-administered problem-solving therapy (PST). As these NTPs will usually come from the same community that they serve, they will often share common socio-demographic characteristics with the individuals that they are supporting.

The term 'peer' can be used to refer to individuals with these characteristics and is often utilised as a strategy to delivering psychological therapies (D. Singla et al., 2014). Peers can be individuals with lived experience of a similar mental condition to the patients they serve (Repper & Carter, 2011); however, in some studies, peers will be individuals who have similar life experiences such as refugees (Bolton et al., 2014) or have children with similar emotional, behavioural or developmental needs as the parents they are supporting (Hoagwood et al., 2010). Studies have found that peers can achieve the same or better outcomes as non-peer staff (Fuhr et al., 2014; Vayshenker et al., 2016). Reasons for this may include the notion that peers will have their own lived experiences which may give them insight into how the other person may be struggling with their condition or issues which can enable increased empathy and facilitate treatment (Mead et al., 2001). Furthermore, peer support offers a level of acceptance, understanding and validation which may not be found in many other professional relationships (Mead & MacNeil, 2006). Task-shifting psychological therapies through the use of NTPs and peers may often be favoured, as it can reduce stigma associated with CMDs. For many people, seeing a mental health professional is itself part of the stigma of a mental illness, and therefore, delivering treatment through a non-professional can increase access whilst also reducing stigma associated with CMDs (Bolton, 2019).

2.2. The importance of task-shifting within mental health

2.2.1. Sustainability of mental health workforce

Whilst stigma plays a major role in the importance of considering task-shifting of psychological therapies, it is also necessary to consider another factor as to why the task-shifting approach is becoming increasingly popular within mental healthcare. Task-shifting can contribute to the sustainability of the mental health workforce. As mentioned previously, there is a global shortage in the mental health workforce, with some groups affected more than others. Although in HICs, these shortages have been met, for example, by the migration of psychiatrists (Jenkins et al., 2010) and by increasing training capacity to train more therapists in the UK (Clark, 2018), challenges remain. In these situations, it makes little sense for scarce or overburdened workers to be undertaking roles that can be carried out by others. Furthermore, task-shifting may help address the issue of burnout, which is common amongst this cadre of workers (O'Connor et al., 2018). Evidence examining burnout amongst mental health professionals have identified stressors specific to these professionals (Payne & Firth-Cozens, 1987). These stem from the stigma that is associated with this profession, especially the demanding relationships they may have with patients, having to deal

with violent patients or their hostile relatives (Deahl & Turner, 1997; Rathod et al., 2000). Furthermore, mental health professionals from a community mental health team identified administrative demands, lack of resources and work overload as the top sources of stress (Reid et al., 1999).

However, task-shifting to NTPs will require training and supervision from mental health professionals. Therefore, rather than reducing the workload, there may be increased demand on mental health professionals due to their role as trainers and supervisors for these NTPs, which could possibly divert their time and attention away from their main responsibilities in direct patient care (Agyapong et al., 2015). Additionally, mental health professionals are not trained or paid to supervise NTPs, and often they will not have the time or skills needed to provide support. Professionals are trained as clinicians, not managers, and therefore, individuals who will provide a supervisory role need additional training to learn how to supervise and begin setting up the ongoing supervisory and monitoring processes (Kemp et al., 2019; Murray et al., 2011). A study examining the perceptions of researchers, programme managers and clinicians involved in designing, supporting, supervising or delivering task-shifted services found that although some professionals may be willing and eager to be trained to provide supervision, many are not, further mentioning that professionals are already overwhelmed with their current duties and are therefore unable to carry out the additional responsibilities of supervision (Kemp et al., 2019).

2.2.2. Financial sustainability

Task-shifting may also contribute to the financial sustainability of the mental health system. Many health professionals spend a large amount of time carrying out tasks for which they are overqualified; if these tasks were shifted to less qualified, less paid workers, then it would allow the mental health specialists to focus on the more important tasks at hand (Expert Panel on effective ways of investing in Health, 2019). However, as these NTPs will often have little to no mental health knowledge, they will often require training and supervision of up to a year (Murray et al., 2011), which can be costly. The health economic findings of a community-based intervention study for individuals with schizophrenia in India showed that costs in the intervention group were on average greater than usual care, a third of which were attributable to supervision (Chatterjee et al., 2014). In contrast, a study that evaluated economic costs of a task-shifted treatment for depression in India found that in public primary care facilities, the intervention appeared to not only be cost-effective but also cost-saving, with participants in the intervention arm using less money and also showing greater improvement in their mental health (Buttorff et al., 2012). However, some global mental health workers believe that training and supervision required for successful task-shifting is too great an effort and expense, which has led to the development of new simpler interventions such as low-intensity interventions that require less training and supervision for these NTPs (Bolton, 2019).

2.3. Concerns within task-shifting

In task-shifting, it is also important to consider how to retain these NTPs, as often these individuals will have a lack of formal recognition, job security and little or no pay. This leads to individuals who are less committed to work, causing high turnover, which consequently leads to higher training costs and decreases morale and service quality (Petersen et al., 2009; Strachan et al., 2015). Additionally, NTPs are sometimes treated as a 'means to an end', where they are not valued but simply used to improve access to care rather than as individuals who may need support (Bhattacharyya et al., 2001; Maes & Kalofonos, 2013). Furthermore, stigma attached to mental illness and the low prestige associated with mental health (Laugharne et al., 2009) may result in lower regard for those who treat them and greater associative stigma (Verhaeghe & Bracke, 2012), increasing worker turnover. Therefore, for successful task-shifting, these NTPs should be integrated into health services with appropriate pay and continuous supervision and should be regarded as individuals with unique skills, desires and perspectives (Maes, 2015).

Although task-shifting is an effective solution in addressing the health worker shortage, it carries significant risks. First, changing roles can threaten established hierarchies. Shifting tasks from specialists to non-specialists may not only lead to a reduction in the quality of the services but also undermine the professional distinction of those individuals who have spent years to earn their professional title (Munga et al., 2012). Specialists may feel protective of their skillset and of the work they carry out, acquired after years of training, and therefore may be resistant to the notion that these tasks can be carried out safely and effectively by NTPs (Kemp et al., 2019). This situation may be complicated even further when changing responsibilities is also attached to financial implications for those involved (Expert Panel on effective ways of investing in Health, 2019).

Second, there is a risk of a reduction in the quality of the intervention, especially if tasks such as medical judgment and decision-making are shifted to a lesser-trained professional. Even more, it can lead to the incorrect identification of a mental health condition, improper management and treatment, lack of proper follow-up and an inability to deal with complications that may arise (World Medical Association, 2009). Researchers have argued that when non-specialists apply the knowledge of specialists, there are dangers in missing signs and symptoms and missing opportunities to think creatively about new tasks that may help promote mental health and well-being (White, 2014). However, despite these concerns, task-shifting is becoming an increasingly popular approach to address treatment gaps within mental healthcare, and the use of NTPs has been advocated by WHO in areas where there are shortages in the mental health workforce (WHO, 2008a).

2.4. Training and supervision of NTPs

A method of ensuring high-quality of care is through the use of training, supervision and support from mental health professionals (Agyapong et al., 2015). A number of studies have shown that

effective training, supervision and monitoring by such professionals such as psychiatrists, neurologists and psychosocial workers allows for successful detection of mental health conditions, referral, treatment, psychoeducation and follow-up care, as well as positive patient outcomes (Araya et al., 2003; Chatterjee et al., 2009; Rojas et al., 2007). A review investigating strategies for increasing human resources for mental health highlights that short-term training and ongoing monitoring and supervision by mental health professionals for individuals with mental disorders can result in an overall increase in confidence, detection and treatment adherence as well as a reduction in caregiver burden (Kakuma et al., 2011). However, training for mental health is lacking and is often too short, theoretical and without sufficient booster sessions, with respondents from a qualitative review stating that even training involving a practical component rarely includes opportunities to practice within the community (Saraceno et al., 2007).

Training and supervision are essential aspects of task-shifting and one of the factors underpinning an effective non-specialist health worker and successful implementation of task-shifting (Ballard et al., 2017). Even one of the earliest studies on task-shifting within mental health identified that the successful introduction of a task-shifting approach would depend primarily on the appropriate and effective training of all the health workers involved (Harding & Chrusciel, 1975). Furthermore, the WHO (2008a) emphasises in the mhGAP that interventions can be delivered through non-specialists after specific training and necessary supervision and, as a result, developed an intervention guide (mhGAP-IG), a 121-page manual for a 35- to 40-hour training curriculum (WHO, 2010). To date, the guide has been used in over 90 countries and has been translated into more than 20 languages (WHO, 2017b).

2.4.1. Innovations in training

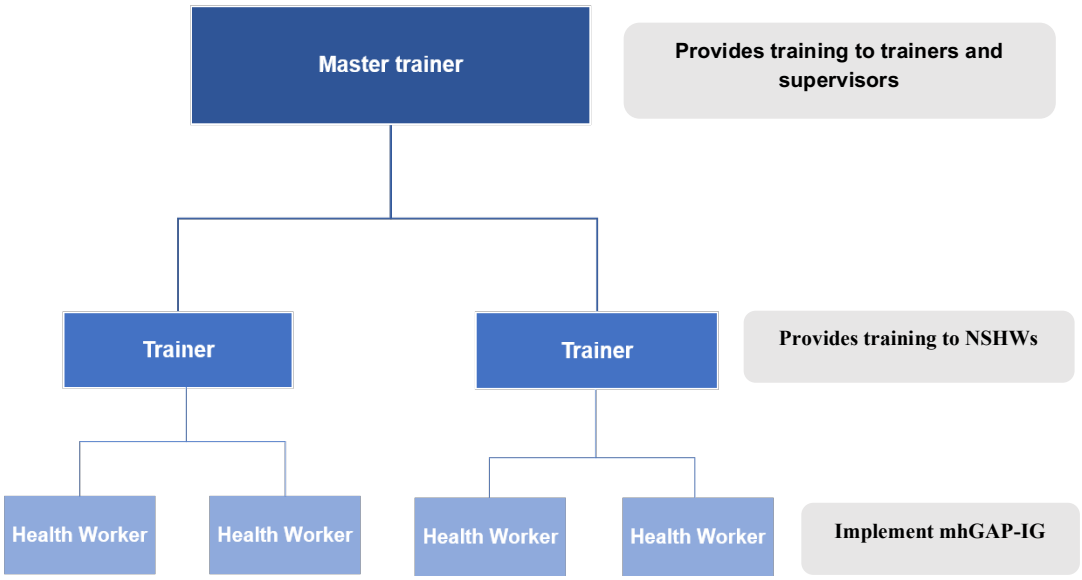
Furthermore, to support the implementation of the mhGAP-IG, the WHO has developed a manual on the training of trainers and supervisors and a manual on training NTPs (WHO, 2017b). The training manuals follow a cascade model of training with two levels: master trainers who will train trainers/facilitators, who will then train NTPs (see Figure 2.1). The training resources include session outlines, activities, learning outcomes and assessments and are aimed at being adaptable to the local context. The training of the NTPs is competency based, with assessments carried out through the use of role-plays and observations during supervision, written tests and skill assessment through practical sessions. However, the WHO (2010) clarifies that rather than seeing the competency assessments as a pass or fail, competencies should be seen as dynamic and contextual, where the individuals are continuously improving and developing in the area.

The cascade model of training has been widely used in health and social care settings where it is most commonly referred to as ‘train the trainers’ (Gask et al., 2019). For example, within physical healthcare, the approach has been used in the implementation of new interventions to support caregivers after a stroke (D. J. Clarke et al., 2013) and to train general practitioners in clinical skills

for managing patients with medically unexplained symptoms (Morriss et al., 2007). Furthermore, the use of the cascade model is further supported through evidence showing that cascaded training and supervision can be successfully implemented for delivering mental healthcare using NTPs, (Atif et al., 2019; Murray et al., 2011; Shields-Zeeman et al., 2017), with Atif et al. (2019) suggesting that competencies of NTPs increased overtime with experiential learning and supervision. Gask et al. (2019) suggested that for successful cascade implementation, extensive collaboration is required to take place between all key persons involved.

Similar to the cascade model, Murray et al. (2011) highlighted the benefits of using an apprenticeship model for NTP training and supervision, in which expert trainers who are outside the project area select local supervisors and help them build skills through modelling, training and coaching, allowing them to oversee the non-specialist health workers delivering psychological therapies. Furthermore, the expert trainers will provide the supervisors with additional coaching on supervision techniques and how to continue to promote the fidelity of the intervention through their supervisory role. The authors stated that when the apprenticeship model is applied, mental health interventions delivered by NTPs can lead to positive outcomes in a number of health domains, including mental health and functioning (Murray et al., 2011; Patel et al., 2010; Rahman et al., 2008).

Figure 2.1. Cascade model of training



Source: WHO (2017b)

Recent developments in mental health training have seen a shift away from the use of traditional, didactic strategies of learning in the form of lectures towards a more problem-based, experiential approach, allowing for more opportunities to practice. The experiential learning approach emphasises the central role that experience plays in the learning process and utilises activities

such as interactive discussions, role-playing and learning from others, group exercises and individual reflection (Sunderland & Mishkin, 2014). The WHO (2005) suggests that ideally, training in mental health should use a combination of training methods which includes both didactic and experiential methods as well as on-site training and supervision. For training mental health professionals, it has been found that training outcomes improve when there are opportunities to practice and receive feedback rather than through the use of didactic presentations or discussion (Bearman et al., 2013; Beidas & Kendall, 2010). Two reviews of mental health professional training suggest that training should be active, experiential and involve various learning techniques (Beidas & Kendall, 2010; Herschell et al., 2010), and keeping didactic training minimal may be particularly important when training NTPs with minimal education (Murray et al., 2011). Both reviews emphasised the importance of supervision, identifying studies that did not include some form of continuous supervision, which led to low levels of clinician fidelity and competency (Beidas & Kendall, 2010).

2.4.2. The importance of supervision within task-shifting

Regular supervision of NTPs has been cited as a critical element for the success of non-specialist-delivered interventions (Murray et al., 2011). Supervision is a continuous process and is essential in ensuring high-quality care, with everyone involved in the delivery of mental healthcare requiring some form of supervision either by a more senior staff member or by their own peers. Flahault et al. (1988; p.1) define supervision as

> *the overall range of measures to ensure that personnel carry out their activities effectively and become more competent at their work.*

Supervision allows for the individual to develop professional, organisational and personal skills which promote and maintain the quality and effectiveness of their work. According to the Social Care Institute for Excellence (2013), good supervision not only results in positive outcomes for the service user but also for the supervisor and the organisation as a whole as a result of an improvement in the quality of the service. Research demonstrates that initial trainings are necessary but will not result in behavioural change in practice and are insufficient towards building the confidence and competence of mental health clinicians (Herschell et al., 2010). In HICs, supervision has been widely recognised as critically important for the development of a clinician's skills (James et al., 2008). Without ongoing supervision, interventions may not be sustained over time, with significant risks to attenuation in service delivery within two to four years (Tibbits et al., 2010).

Supervision within the context of task-shifting of psychological therapies, not only allows the trainers to ensure the fidelity of the treatment and promote learning, but it also allows the NTPs to discuss their successes and problems, brainstorm solutions and improve confidence and self-esteem (Atif et al., 2019). Furthermore, as NTPs will not have clinical training, supervision is

important to address clinical issues and manage risks of harm to themselves and others (Barnett et al., 2018a). Considering that many NTPs will often have experienced the same adversities as the individuals they are supporting, they may be particularly vulnerable for becoming emotionally exhausted or experiencing trauma by providing interventions (Jain, 2010). Jain (2010) suggests that to address this, it is important to anticipate and provide solutions for burnout, stress and any negative reactions when training and supervising NTPs. This is supported by evidence that suggests that supervised mental health professionals receive essential emotional support and are less likely to experience symptoms of burnout (Edwards et al., 2006).

Supervision is also an essential component within mhGAP-IG training, with the WHO (2010) suggesting that without proper supervision, there would be no significant changes in NTPs' attitudes, knowledge and skills. According to the WHO (2010), post-training supervision has multiple goals including:

- *Clinical,* to ensure fidelity to the intervention and enhance further development in its use;
- *Administrative*, to address any difficulties and monitor the implementation of the intervention;
- *Personal growth and support*, to ensure ongoing commitment of the NTPs whilst also ensuring their well-being to reduce stress and burnout.

The WHO (2010) suggests models of supervision (see Box 2.2) to suit every context, and the model used should be based on the preferences and resources of each setting. In addition to these models, supervision of NTPs can vary by frequency, tools used and the training of the supervisor; nevertheless, there is limited evidence on the effectiveness of each of these variables (Kemp et al., 2019). However, a review by Hill et al. (2014) examining the impact of supervision strategies for CHWs in LMICs found that quality of supervision is more important than frequency, with evidence suggesting that increasing the frequency of supervision alone does not necessarily contribute to increased effectiveness.

Box 2.2. Models of supervision

Apprenticeship model	Supervisee does a placement with the supervisor for a period of time. This involves the supervisee initially observing the supervisor in practice with opportunities to ask questions. The supervisee will then perform a clinical review which will be observed by the supervisor, followed with discussion, debrief and feedback.
On-site supervision	The supervisor will perform regular, scheduled on-site visits to the supervisee where they will conduct observations, hold de-briefing sessions, evaluate the implementation of the intervention and address any issues.

Box 2.2. Models of supervision

Case conference supervision	The supervisor will meet regularly with the supervisee. Rather than conducting direct observation, the supervisor will monitor the intervention through listening to recorded intervention sessions, case discussions, teaching, feedback, goal setting and reflection. This form of supervision can either be done face-to-face or remotely via digital technology.
Peer supervision	A method of supervision where there is no supervisor. Supervisees will form a small group and appoint or rotate a leader who will ensure the group stays on tasks. Cases, issues and challenges may be discussed, and supervisees will come together to find a solution. This form of supervision can be done face-to-face or remotely via digital technology.

Source: WHO (2010)

2.4.3. Limitations within training and supervision

A number of reviews have identified several methodological limitations and inconsistencies in the reporting of training methods in published studies involving NTP-delivered interventions for mental health (Barnett et al., 2018a; Barnett et al., 2018b; Kohrt et al., 2018; Singla et al., 2017). Therefore, it is difficult to draw conclusions about the amount of training or ongoing support that NTPs need to implement psychological therapies with fidelity because these descriptions often provide limited details (Barnett et al., 2018a; Barnett et al., 2018b). Murray et al. (2011) stated that published randomised trials of outcomes tend to focus their attention on reporting study procedures and outcomes, and the lack of focus on implementation processes makes it difficult to determine the best strategies to replicate and scale up efforts for NTPs to support or deliver psychological interventions.

Furthermore, there is scarce research evaluating the competency of NTPs following training. Nevertheless, a recent systematic review has been conducted assessing the effectiveness of mental health training for NTPs, collecting data on trainees' attitude, knowledge, clinical practice, skills, confidence, satisfaction and patient outcomes. Results found that in all the included studies, training led to some form of improvement in at least one area, with the authors concluding that training NTPs in mental healthcare is an effective strategy to increase provision and capacity (Caulfield et al., 2019). However, the review only included 29 studies which provided an evaluation of training; considering that a systematic review of research on LHW delivered psychosocial interventions conducted between 1990 and 2015 included 43 articles (Barnett et al., 2018b), it is highly likely that there is a large pool of unevaluated training which may contribute to the overall conclusion. Consistent with past reviews, the review by Caulfield et al. (2019) also highlighted the large variability in method, timings and outcomes for evaluation, making it difficult for them to compare data across studies and identify bigger trends; however, the authors went on to suggest

this may be a consequence of studies ensuring that their training remained culturally and context specific.

Gaps in the literature may be partly due to the lack of guidelines in place and are also not well addressed in the mhGAP due to its broader goals of scaling up mental health (WHO, 2008a). A meta-review by Kort et al. (2018) evaluating the roles, responsibilities and practices of NTPs delivering mental healthcare across 23 reviews identified the variability in what is reported about community mental health services. The authors recommended 12 domains for reporting of community mental health components, which included guidance on the cadres and increased attention to evaluating competencies. Furthermore, the lack of reliable and valid measures of therapist competence led to the development of the ENhancing Assessment of Common Therapeutic factors rating scale for training and supervision with features relevant to allow for use amongst cross-cultural task-shifting initiatives (Kohrt et al., 2015).

Furthermore, whilst research on the utilisation of NTPs in delivering psychological therapies has mainly been conducted in LMICs, it is still not clear which roles they should have in HICs to address disparities in mental healthcare. Although they have been effective primary providers of psychological interventions in LMICs (Patel et al., 2017; Rahman et al., 2008), their role within HICs will be considerably different, primarily due to HICs having a greater number of mental health professionals (Saraceno et al., 2007), which may limit their need to work as a primary provider. However, due to the inequalities in mental healthcare faced by ethnic minorities in HICs, it is still possible that NTPs may need to be deployed to provide culturally competent and linguistically appropriate care, which is often lacking in HICs (Memon et al., 2016). Furthermore, NTPs may be able to deliver psychological therapies for individuals with lower levels of need, such as those with sub-clinical symptoms who may benefit from prevention services. Utilising NTPs in prevention and early intervention would free up time for mental health professionals, allowing them to focus their attention on those who require more intensive treatment (Patel et al., 2010). This stepped-care model has been implemented within the UK through the IAPT initiative, but it is still resulting in greater demands, stress and burnout for the newly trained IAPT therapists (Westwood et al., 2017). Therefore, it is necessary to consider methods of deploying individuals with less training and qualifications to relieve some of this burden. Lessons should be drawn from studies in LMICs where psychological therapies have been successfully delivered for CMDs to identify the necessary variables needed to train and support these individuals to deliver low-intensity psychological therapies in HICs.

2.5. Chapter Summary

- Studies have shown that task-shifting the delivery of psychological therapies to NTPs can be an effective solution in increasing mental healthcare coverage.

- For task-shifting to be successful, continuous training and supervision is required from mental health specialists.

- Reviews have found major gaps in research relating to identifying the essential components for implementing NTP-based psychological therapies.

- Little is known about the training and supervision of NTPs in HICs; therefore, there is an important need for research that examines the important variables of task-shifting in LMICs and how that can be applied to HICs.

Chapter 3. Systematic reviews for identifying essential components of NTP training and supervision through task-shifted psychological interventions

Chapter 2 demonstrated the importance of needing to provide high-quality training to NTPs to ensure fidelity to the intervention. Furthermore, the lack of evidence on training and supervision for these NTPs highlights the need to identify these essential components.

3.1. Systematic Review rationale

It is often difficult for healthcare providers, consumers and researchers to access and interpret a large amount of data due to time constraints and lack of resources. Therefore, research synthesis is important, as it provides for a more accessible way of looking broadly at the current state of research, allowing for researchers and policymakers to keep up-to-date with the literature in their field and to make informed policy decisions (Schick-Makaroff et al., 2016). A systematic review aims to gather all empirical evidence that fits a pre-determined eligibility criterion to answer a specific research question. Whilst a number of approaches to research synthesis exist such as a literature review, a systematic review differs, as it involves a comprehensive review of literature and the methods used are clear and systematic and aim to minimise any bias, therefore increasing the reliability of the findings and conclusions drawn (Antman et al., 1992; Dempster, 2011; Oxman & Guyatt, 1993). According to the *Cochrane Handbook for Systematic Reviews of Interventions*, a systematic review has the following characteristics:

- 'a clearly stated set of objectives with pre-defined eligibility criteria for studies;
- an explicit, reproducible methodology;
- a systematic search that attempts to identify all studies that would meet the eligibility criteria;
- an assessment of the validity of the findings of the included studies
- a systematic presentation, and synthesis, of the characteristics and findings of the included studies'

Source: Chandler et al. (2017, p.1:5)

Previous systematic reviews on task-shifting of psychological interventions mainly focus on the effectiveness and acceptability of task-shifting psychological interventions through NTPs and do not explore the training and supervision provided to these non-specialists prior to intervention delivery. As training is an important aspect of task-shifting, it is necessary to explore the literature on the training and supervision provided to these NTPs to increase our understanding of the essential components of training for NTPs. A systematic review was therefore conducted to address this issue.

3.2. Systematic reviews of the thesis

As a large number of studies were identified for inclusion in the review, the review was split into studies conducted in HICs and LMICs. This decision was based on the knowledge that NTPs in LMICs will differ from HICs in terms of their education and awareness in mental health, and therefore, the training content may be largely different. Furthermore, psychological interventions in LMICs will differ due to a difference in the mental health population with many individuals presenting with comorbid illnesses that are more commonly found in LMICs such as HIV (Chibanda et al., 2014).

To increase our knowledge of the essential training components and to develop a framework for training NTPs, it is also necessary to explore the views of the trainees who have been involved in task-shifting psychological interventions. However, to date, no qualitative systematic review has been conducted on lay workers' experiences in training. Therefore, a qualitative systematic review was conducted with the aim to summarise evidence from qualitative research on the impact of training and delivery of psychological interventions by NTPs.

The next three chapters of this thesis will present the systematic reviews. The methodology and reporting for all three reviews were guided by the University of York's Centre for Reviews and Dissemination (Centre for Reviews and Dissemination, 2009), the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins, Churchill, Chandler, & Crumpston, 2017) and the Preferred Reporting Items of Systematic Reviews and Meta-Analyses (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009) and are fully described in each relevant chapter.

3.3. Chapter summary

- To date, no systematic review has been conducted to explore the training and supervision provided to NTPs who are task-shifting psychological interventions.

- This chapter provides the rationale for conducting a systematic review.

- Three systematic reviews were conducted for this thesis, which will be presented in the following chapters.

Chapter 4. Task-shifting psychological interventions for common mental disorders in high-income countries: A systematic review of the content and delivery of training for non-traditional providers

4.1. Introduction

Identifying the different characteristics of training for NTPs is essential to develop a greater understanding of what type of training is required for NTPs to deliver psychological interventions successfully and could contribute to the development of evidence-based training in this field. However, previous systematic reviews conducted on task-shifting have mainly focused on patient outcomes to reach conclusions about the effectiveness of delivering psychological interventions through non-professionals (K. Clarke et al., 2013; Fuhr et al., 2014; van Ginneken et al., 2021). Whilst some existing reviews have commented on the training of NTPs (Barnett et al., 2018b; Chowdhary et al., 2014; Padmanathan & De Silva, 2013; Van Ginneken et al., 2013), it has been brief and does not provide sufficient knowledge on the essential components of training. In addition, although a previous systematic review investigated the effectiveness of training of non–mental healthcare providers, the review only focused on healthcare providers such as nurses and physicians and did not explore studies that used lay providers, volunteers and peers (Painuly & Sharan, 2008). Whilst the most recent systematic review to be conducted on task-shifting in mental health has investigated the training for non-specialist health worker-delivered interventions, the aim of the review was to evaluate the effectiveness of the training courses and therefore did not include studies where no evaluation was conducted (Caulfield et al., 2019). This will therefore have resulted in a large number of studies excluded from the review, as for a majority of studies on task-shifting the focus is usually on the mental health outcomes; however, these studies may still be able to provide useful insight into their training and supervision methods. In addition, the review excluded studies that focused on only one mental health condition and those with comorbid physical health conditions.

Due to the severe shortage of healthcare workers, up until now reviews have primarily focused on task-shifting in LMICs (Mutamba et al., 2013; Rahman et al., 2013), and to our knowledge, no review has investigated task-shifting solely in HICs. Therefore, the aim of this review is to describe the content and delivery of training and supervision provided to NTPs delivering psychological interventions for CMDs in HICs. The review includes studies in which psychological interventions for depression and anxiety were delivered through NTPs, including those with comorbid physical health conditions. Studies were also included even if they only provided a brief description of the training processes so as to add to the pool of data generated from this review.

This chapter will specifically address the following questions:

(a) What were the types of psychological interventions for CMD delivered by NTPs?

(b) How was training of the NTPs delivered?
(c) What was the content of the training delivered to the NTPs?
(d) How were the NTPs supervised?
(e) How was fidelity of the intervention ensured?

4.2. Methods

4.2.1. Literature search strategy

A systematic review of studies that reported on the content and delivery of training for NTPs was conducted. The search was conducted from inception up to 13 May 2020. Studies were identified by a search on the following databases: Ovid Medline, Embase, PsycINFO and EBSCO CINAHL. A language limit was added to only search studies that were in English. Searches were conducted to specifically capture studies on task-shifting of psychological interventions. The task-shifting aspect of the search strategy was adapted from a Cochrane systematic review, which investigated non-specialist health worker interventions (Van Ginneken et al., 2013). Search terms included 'allied health personnel', 'community health aides', 'caregivers', 'voluntary workers' and 'community networks'. The mental disorders aspect of the search strategy was adapted from a systematic review investigating the effectiveness of peer-delivered interventions for severe mental illness and depression (Fuhr et al., 2014). The search strategy has been listed in Appendix 1. Furthermore, references of eligible papers were checked for additional relevant studies. In addition to this, a database search was conducted to identify any systematic reviews that had investigated task-shifting, and all papers included in the reviews were assessed for eligibility. All the searches were exported to EndNote X9 (bibliographic software), and duplicate references were reviewed and deleted.

4.2.2. Inclusion and exclusion criteria

4.2.2.1. Types of studies

There was no limit on the types of studies to be included in this review with the exception of reviews and meta-analyses. However, studies which did not provide any description of the NTP, and their training and supervision were excluded from the review. Furthermore, studies were also excluded if there was insufficient detail on the psychological intervention that was delivered or if it was unclear who delivered the intervention. Additionally, studies that outlined a training programme without delivering training to a set of NTPs were also excluded from the review. Multiple publications of the same study were treated as one single study; however, relevant data was extracted from all publications.

4.2.2.2. Type of settings

Studies that were considered HICs as defined by the World Bank (2019) at the time that the study was being carried out were included in the review. We included studies that were delivered outside the health sector, in a community setting. Any studies that were delivered in a setting of primary, secondary or tertiary care were excluded unless they were delivered by NTPs and not the clinical staff of that health facility. Studies where recruitment took place in primary care, but the intervention was delivered in the community were included.

4.2.2.3. Type of participants

We included studies in which interventions were targeted towards adults with depression or anxiety. Studies were also included if the participant had a comorbid health condition, where scores of depression or anxiety were one of the primary outcomes. Although PTSD is an anxiety disorder, a decision was made to exclude it from the review based on the fact that treatment for this condition will be often be trauma focused such as prolonged exposure therapy, built around the past experiences and trauma of the participant, which can warrant separate, more advanced training (Watkins et al., 2018). Furthermore, due to limited training LHWs are better suited to deliver low-intensity interventions, and, NICE (2011) guidelines suggest that for treating PTSD, patients should receive high-intensity treatments as the first intervention.

Additionally, studies conducted with children (aged below 18 years), participants with severe mental illness (i.e., schizophrenia, bipolar disorder), neurological disorders (i.e., epilepsy, dementia) and substance abuse disorders were excluded from the review. However, we included caregivers of people with these disorders, if the intervention was directed towards the carer rather than the patient.

4.2.2.4. Types of interventions

Psychological interventions delivered by NTPs in a non-clinical setting, aimed at reducing or preventing symptoms of depression and anxiety, were included in this review. Studies in which the intervention was some form of social support and did not include an evidence-based psychological intervention were excluded. Furthermore, studies on self-management or self-help, where the participant conducts the intervention on themselves, were excluded with the exception of some studies where an aspect of the intervention was delivered by an NTP. Studies in which the intervention was aimed at the management of a health condition or detection of a mental disorder without the delivery of a psychological intervention were excluded.

Interventionists were considered NTPs if they had not received advanced (i.e., post-baccalaureate) degrees in the mental health field (e.g., psychiatry, psychology, social work) or had not received specialist training or a training course in mental health and who have a role of increasing access to

community mental health services (Barnett et al., 2018a). Therefore, studies were excluded if the intervention was delivered by mental health professionals (i.e., psychiatrists, psychologists, psychiatric nurses). Furthermore, a decision was also made to exclude doctors, specialist nurses and medical students from this review, as their training may have involved some form of mental health training. Table 4.1 highlights the inclusion and exclusion criteria of the systematic review.

Table 4.1. Inclusion/exclusion criteria of studies in HICs

Field	Inclusion Criteria	Exclusion criteria
Language	English	Language other than English
Setting	High-income countries Community	Low- and middle-income countries Primary, secondary, tertiary care
NTPs	Community health workers, service users, volunteers, teachers, teaching assistants, allied health professionals, caregivers	Doctors, nurses, mental health professionals, medical students. Anyone with experience in delivering psychological interventions.
Interventions	Interventions which identify or diagnose common mental disorders or improve the symptoms of an individual with a common mental disorder. Interventions to promote mental health or prevent mental illness. Interventions to train the task-shifting workforce.	Self-help interventions, drug interventions. Peer support groups. Collaborative care interventions. Training to raise awareness or reduce stigma against mental illness.
Participants	Adults with common mental disorder, anxiety, depression	Children or adolescents. Individuals with severe mental illness, neurological disorders, substance abuse disorders.
Outcomes	Description of training procedures for NTPs delivering interventions.	Details about interventions are unknown. No description of the training or supervision.
Study Design	Any study design which reports on the content and delivery of the training received by the task-shifting workforce.	Meta-analysis, reviews. Studies that do not include training of the task-shifting workforce.

4.2.2.5. Data Extraction

Titles and abstracts were screened independently by two researchers (US[1] and CA[2]), and any study that did not meet the inclusion criteria was excluded. Screening of the full-text articles of the potentially relevant studies against the inclusion/exclusion criteria was conducted independently by US and CA. If there was a disagreement about the inclusion of a paper, a third researcher (WW[3]) adjudicated. Data were extracted by US using a standard data extraction form which addressed the key characteristics of the studies as well as details about the training, intervention and supervision. From studies in which the intervention was delivered by a combination of NTPs and professionals, only data concerning the NTPs was extracted. Furthermore, although this review was not investigating the effectiveness of the intervention or training, wherever possible, the outcomes of the NTP-delivered intervention were extracted to identify the patterns between positive outcomes and training. The data extraction form and corresponding key are listed in Appendix 2. Data regarding the training of NTPs were also extracted into a master table, which was checked against original papers by another reviewer (MWW[4]), a third-year medical student with past experience in conducting systematic reviews. Furthermore, including a reviewer from a different field allowed alternative perspectives to be considered and eliminated any selection and information biases. Furthermore, having another reviewer ensured that extracted data was cross-checked against the original papers allowing for errors to be minimised. The data extraction forms and master table were then used to create five tables to describe the study characteristics and training based on the research questions identified for the review. Due to the large tables, only the tables of characteristics of the NTPs, the content of the training and supervision will be presented in the main text, with the remaining tables presented in the Appendix.

4.2.2.6. Methodological assessment

Given the possible methodological heterogeneity based on the eligibility criteria, and to also assess the quality of the documentation of training within papers, a 10-point methodological quality assessment schema was created based on a framework by Liu et al. (2016). It examines the details reported on the documentation of the NTPs (i.e., number of NTPs, selection process and education level), training methods (i.e., details on the method and content of training, the trainer and evaluation of training) and supervision (i.e., details on the supervision and whether fidelity to the intervention was assessed) in each study. Studies are given a point for each of the criteria they satisfy. For example, studies in which the education level of the NTPs were stated were given a score out of 1, and those where it was not reported were given a score of 0. The author undertook this assessment, which can be seen in Appendix 3.

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4.3. Results

After removing duplicates, the initial searches generated 6,287 studies. A total of 18 articles met the eligibility criteria and were included in the review. Figure 4.1 presents the flow chart of searches.

The characteristics of the included studies are described in Appendix 4. Results are reported in line with PRISMA guidelines (Moher et al., 2009).

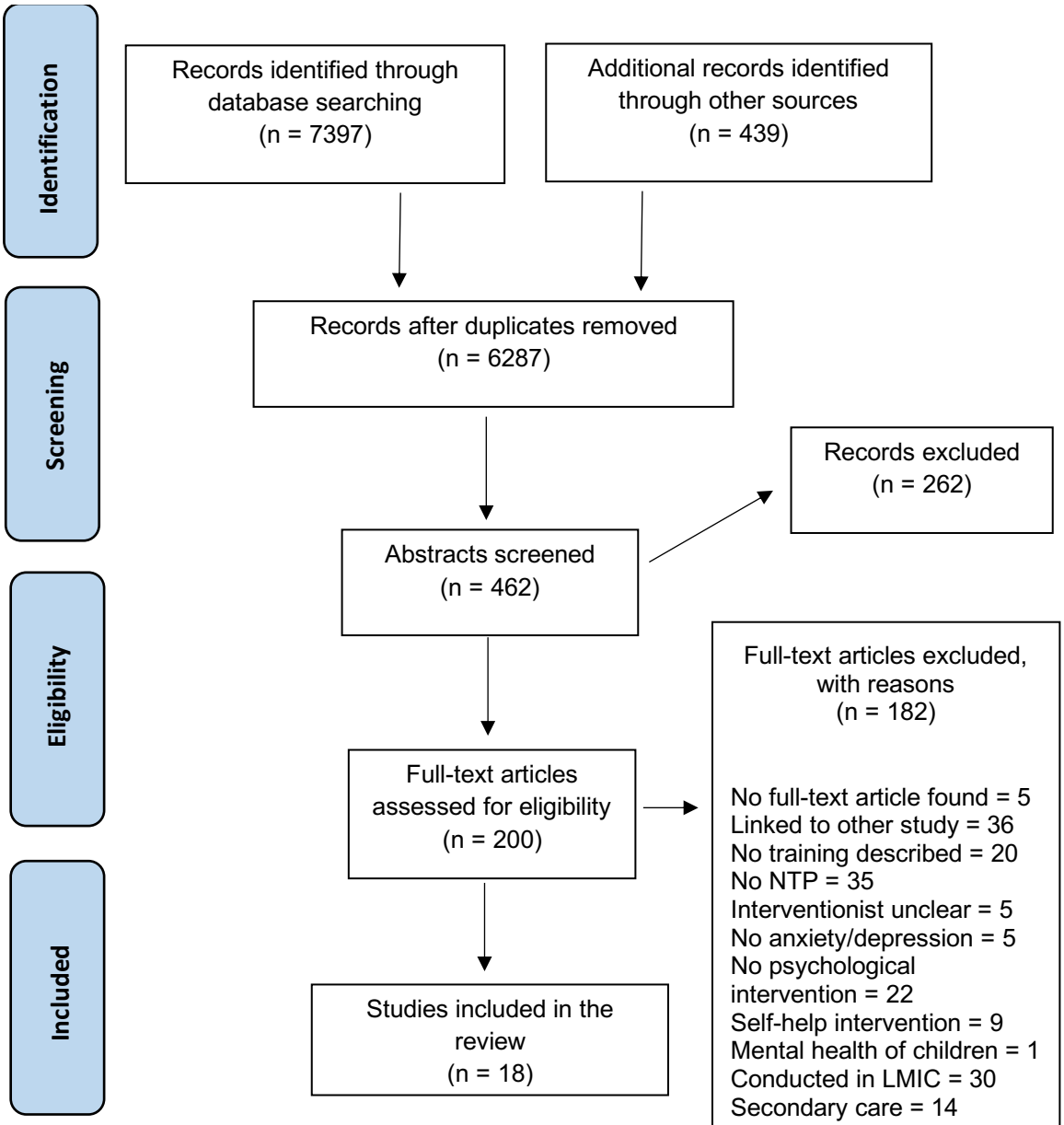
Out of the eighteen studies included, twelve studies were conducted in the USA (Bright et al., 1999; Buck, 2015; Burnett-Zeigler et al., 2019; Dobkin et al., 2007; Hovey et al., 2014; Mastel-Smith et al., 2006; Miyawaki et al., 2020; Pratt et al., 2017; Quijano et al., 2007; Roman et al., 2009; Stanley et al., 2014; Tran, Ornelas, Kim, et al., 2014), two in the UK (Armstrong, 2010; Livingston et al., 2014), and one each in Israel (Somer et al., 2005), the Netherlands (Prosman et al., 2014), Singapore (Wong et al., 2020) and Canada (Markle-Reid et al., 2014).

Two of the studies were RCTs (Livingston et al., 2014; Stanley et al., 2014). Two studies were quasi-experimental studies (Mastel-Smith et al., 2006; Somer et al., 2005), and the remaining studies used a pre–post study design.

In eleven studies, the outcome being investigated was depression (Bright et al., 1999; Buck, 2015; Burnett-Zeigler et al., 2019; Dobkin et al., 2007; Markle-Reid et al., 2014; Mastel-Smith et al., 2006; Miyawaki et al., 2020; Prosman et al., 2014; Quijano et al., 2007; Roman et al., 2009; Wong et al., 2020), anxiety was investigated in three (Pratt et al., 2017; Somer et al., 2005; Stanley et al., 2014), co-occurring anxiety and depression were investigated in one study (Livingston et al., 2014), two studies examined stress and depression (Hovey et al., 2014; Tran, Ornelas, Kim, et al., 2014) and one study investigated psychological distress (Armstrong, 2010).

In six studies, the intervention was targeted at older adults, two of which involved adults suffering from dementia (Livingston et al., 2014; Miyawaki et al., 2020). In seven studies, the intervention sample consisted of only female participants, which in four studies involved targeting the intervention towards ethnic minorities (Burnett-Zeigler et al., 2019; Hovey et al., 2014; Pratt et al., 2017; Tran, Ornelas, Kim, et al., 2014); in one, the intervention was delivered to pregnant women (Roman et al., 2009) and in another, abused women were the target population (Prosman et al., 2014). Three studies involved delivering interventions to participants who were seeking help from a mental health service (Armstrong, 2010; Bright et al., 1999; Somer et al., 2005). A further two studies included in this review focused on a training programme for NTPs to deliver a psychological intervention, where no subsequent intervention was delivered (Buck, 2015; Wong et al., 2020).

Figure 4.1. PRISMA flow chart representing the process of identifying relevant papers (Moher et al., 2009)



4.3.1. Types of psychological interventions

A number of studies (44%) were based on CBT techniques involving changing thoughts and attitudes (Bright et al., 1999; Hovey et al., 2014; Pratt et al., 2017; Somer et al., 2005; Stanley et al., 2014). One of which combined CBT and adaptive inferential feedback which involved the NTP suggesting to their partner that an event implies neither negative consequences nor negative characteristics about the person when that person may usually attribute the cause of a negative event to unstable and specific factors (Dobkin et al., 2007). Two studies (11.1%) with older adults provided an intervention which involved the participant reminiscing about their life with the NTP (Mastel-Smith et al., 2006; Miyawaki et al., 2020). Other studies used some form of psychosocial intervention such as counselling (Armstrong, 2010), psychoeducation (Livingston et al., 2014) or support groups (Prosman et al., 2014). Studies also included providing information on the use of community resources (Roman et al., 2009; Tran, Ornelas, Kim, et al., 2014). In two studies (11.1%), all or part of the intervention was delivered via telephone (Somer et al., 2005; Stanley et al., 2014), both of which involved teaching the participants breathing techniques to reduce stress. Furthermore, several studies (44.4%) provided education and awareness on the mental health condition (Burnett-Zeigler et al., 2019; Hovey et al., 2014; Livingston et al., 2014; Markle-Reid et al., 2014; Quijano et al., 2007; Roman et al., 2009; Stanley et al., 2014; Tran, Ornelas, Kim, et al., 2014). A further two studies that have been included in this review were targeted towards training NTPs to deliver CBT interventions (Buck, 2015; Wong et al., 2020).

All the interventions led to significant improvements in the participants' clinical outcome measures, with the exception of one which, although led to improvements, were not found to be significant (Miyawaki et al., 2020). Furthermore, three studies focused on comparing the effects of an intervention delivered by less experienced professionals to experienced professionals, all with mixed results. In one of these studies, symptom reduction was significantly greater in the less experienced professionals (Burnett-Zeigler et al., 2019) whereas in another, the NTPs were just as effective as the experienced professionals (Bright et al., 1999). However, in one study, whilst there were significant improvements, the NTPs were found to be less effective than their professional counterparts (Armstrong, 2010). Furthermore, the majority of the studies led to the conclusion that delivering an intervention through the NTPs can improve mental health conditions (Bright et al., 1999; Dobkin et al., 2007; Livingston et al., 2014; Mastel-Smith et al., 2006; Prosman et al., 2014; Quijano et al., 2007; Roman et al., 2009) and is an acceptable and feasible method of delivery (Markle-Reid et al., 2014; Miyawaki et al., 2020). Two studies also commented on how the success and response to the intervention were particularly due to the use of an NTP (Hovey et al., 2014; Pratt et al., 2017).

The characteristic of interventions from the included studies are presented in Appendix 5.

4.3.2. Characteristics of NTPs

Nine studies (50%) trained individuals already working within health centres, services or community organisations (Armstrong, 2010; Burnett-Zeigler et al., 2019; Prosman et al., 2014; Somer et al., 2005), which also included home care workers (Markle-Reid et al., 2014; Mastel-Smith et al., 2006) and CHWs (Pratt et al., 2017; Roman et al., 2009). In two studies (11.1%), the NTPs were volunteers (Armstrong, 2010; Somer et al., 2005), one study (5.5%) used NTPs who were peers (Prosman et al., 2014) and two studies (11.1%) used relatives or close loved ones of the participants (Dobkin et al., 2007; Miyawaki et al., 2020).

Fourteen out of eighteen studies (77.8%) described how the NTPs were selected. In two of these studies (14.3%), NTPs were identified through the community (Buck, 2015; Tran, Ornelas, Kim, et al., 2014), and in one study (7.1%), NTPs were recruited via an advertisement (Dobkin et al., 2007). In three studies (21.4%), selection of the NTPs involved an interview to assess communication skills, interpersonal qualities (Armstrong, 2010; Stanley et al., 2014) and psychological stability (Prosman et al., 2014). Furthermore, two studies (14.3%) selected NTPs based on their available time and willingness to spare time for training (Armstrong, 2010; Miyawaki et al., 2020). The selection criteria of studies with ethnic minority NTPs also required the NTPs to be English literate (Pratt et al., 2017; Wong et al., 2020). However, the selection of NTPs was poorly reported in some studies, with four studies providing no details on how the NTPs were selected (Hovey et al., 2014; Livingston et al., 2014; Markle-Reid et al., 2014; Roman et al., 2009).

Educational level and qualifications were poorly described, with no details given in four studies (22.2%; Dobkin et al., 2007; Mastel-Smith et al., 2006; Pratt et al., 2017; Somer et al., 2005) and two studies (11.1%) stating that the NTPs had no experience in mental health treatment without providing information on their level of education (Armstrong, 2010; Bright et al., 1999). Out of the twelve studies describing the education of the NTPs, two studies (16.7%) used NTPs with a 'relevant' degree (i.e., psychology or sociology) (Livingston et al., 2014; Stanley et al., 2014). Four studies (33.3%) used NTPs with a diverse range of education levels ranging from just completing high school to others who had completed university degrees (Buck, 2015; Miyawaki et al., 2020; Tran, Ornelas, Kim, et al., 2014; Wong et al., 2020), and in one study (8.3%), NTPs who had only received a high school diploma were used (Roman et al., 2009). Some studies that used NTPs already working within health services or organisations, indicated that the NTPs had qualifications and some form of training in their relevant discipline, which mostly included a bachelor's or master's degree (Miyawaki et al., 2020). However, in most cases, the details were vague with no specific information on the qualification (Hovey et al., 2014; Markle-Reid et al., 2014; Quijano et al., 2007).

Table 4.2 presents characteristics of the NTPs as described in the study.

Table 4.2. Characteristics of NTPs delivering psychological interventions

Author (year)	NTP (No)	Selection	Job Role/Education and Experience
Armstrong (2010) [a]	Paraprofessional counsellors (6)	Volunteer counsellors working within the agency's counselling service. Interview-based selection criteria focused on the personal qualities of applicants and their ability to meet the practical (available time), emotional and other training requirements (willingness to engage in role-play/video work and self-exploration).	Did not have any prior counselling or helping experience at all.
Bright et al. (1999)	Paraprofessional therapists (6)	Recruited from community-based self-help organisations.	None of the paraprofessionals had advanced degrees in psychology or experience providing individual treatment.
Buck (2015)	Community leaders (38)	The main inclusion criterion was status as a community leader within the Burmese community, identified with the help of Karen pastors, Burmese Buddhist monks, local mental health professionals and volunteers and academics working with the Burmese community members.	Ranged from elementary school to high school to bachelor's and master's degrees.
Burnett-Zeigler et al. (2019)	Health educator (1)	Staff at the healthcare clinic.	Master's-level education (unknown), experience leading group exercise and providing supportive consultation for chronic health conditions such as diabetes.
Dobkin et al. (2007)	Partners (10)	Recruited from the community via newspaper ads as well as physician referral.	Not described.
Hovey et al. (2014)	Promotora (1)	Not described.	Current or former migrant farmworkers trained as health educators.
Livingston et al. (2014)	Psychology graduates (10)	Not described.	Psychology degree.
Markle-Reid et al. (2014)	Home care providers (13)	Not described.	Registered nurses, personal support worker (qualifications unknown).
Mastel-Smith et al. (2006)	Home care workers (14)	Home care workers of women consenting to participate were selected.	Not described.
Miyawaki et al. (2020)	Caregiver (19)	Caregivers selected had to (a) be family members or close friends of the care recipients who provided caregiving voluntarily; (b) see the care recipient at least twice per week for at least 8 hours per week; (c) complete a 6-hour C-PLR caregiver training and (d) commit to six LR sessions with the	High school (n=2), some university (n=8), university or higher (n=9).

Table 4.2. Characteristics of NTPs delivering psychological interventions

Author (year)	NTP (No)	Selection	Job Role/Education and Experience
		care recipient and participate in fidelity check-in calls and a post-intervention interview.	
Pratt et al. (2017)	CHWs (11)	Selection criteria included being bilingual and ability to read in both English and Somali.	Not described.
Prosman et al. (2014)	Mentor mothers (7)	Mentor mothers were recruited from welfare, healthcare and educational institutes. Interview assessed motivation, motherhood and psychological stability.	At least a middle social or healthcare education.
Quijanao et al. (2007)	Case managers (15)	Case managers in community agencies offering a range of services for older adults.	Social workers.
Roman et al. (2009)	CHWs (unknown)	Not described.	High school diploma or GED.
Somer et al. (2005)	Hotline volunteers (10) Paraprofessionals (10)	Volunteers from the emergency hotline's Haifa branch who had at least 1 year of hotline experience.	Not described.
Stanley et al. (2014)	Bachelor lay providers (5)	Selected based on interest in learning to deliver skills-based treatment. Interviewed to assess interpersonal and communication skills.	Bachelor's degree in a relevant field (i.e., psychology, sociology). No healthcare experience.
Tran et al. (2014)	Promotoras (48)	Inclusion criteria included being a woman, age 18 and older, who identified their ethnicity as Latina. Recruited through established community contacts including community activists, religious leaders, other formal community leaders and agencies.	Less than high school education (n=15), high school (n=13), some university/university degree (n=20)
Wong et al. (2020)	Foreign domestic workers (19)	Inclusion criteria included (a) Filipino domestic workers (all female), (b) 23 years old or above, (c) able to travel to the training site four consecutive weeks, (d) literate in English and (e) had at least nine years of formal education. Recruited from a non-governmental organisation advocating for migrant workers in Singapore.	Completed high school (n=15) Completed university (n=4)

[a] Data extracted from (Armstrong, 2003)

C-PLR, Caregiver-provided Life Review; GED, General Educational Development; LR, Life Review; CHW, Community Health Worker

4.3.3. Delivery of training

The processes involved in the development of the training was poorly reported and only fully described in two out of eighteen studies (11.1%). In Buck (2015), the development of the training programme involved discussions with community and religious leaders to gauge their interest in participating as trainers. Furthermore, the training manual was reviewed by native Karen and Burmese speakers to confirm its cultural sensitivity, appropriateness and compatibility with the community's cultural values. This training manual was also adapted for use in another study which trained foreign domestic workers in CBT (Wong et al., 2020). Adaptations included addressing issues faced by this cadre of workers that may contribute to depression and also incorporating culturally relevant examples and exercises.

Five out of eighteen studies (27.8%) did not indicate who delivered the training. Out of those that did, in six studies (46.2%), training of NTPs was delivered by a professional with expertise in the mental health field such as a psychiatrist or psychologist (Quijano et al., 2007; Stanley et al., 2014), which in a few studies also involved them being the principal investigator (Armstrong, 2010; Burnett-Zeigler et al., 2019; Dobkin et al., 2007). In two studies (15.3%), training was delivered by other members of the research team; however, it was unclear who provided the training and what their level of expertise was (Livingston et al., 2014; Miyawaki et al., 2020). Two studies (15.3%) also involved using trainers who were specialists in the intervention itself, where in one, the trainer was a mindfulness instructor (Burnett-Zeigler et al., 2019), and in another, the trainer was a consultant of the intervention (Pratt et al., 2017). Two studies (15.3%) provided training through collaboration of different organisations and health professionals, where in one study, training was delivered by a mental health centre and the principal investigator (Hovey et al., 2014), and in another study, training involved a collaboration between community agencies and the local community college (Roman et al., 2009). Another study also involved taking trainers from the community, with training being delivered by community leaders who could speak the native language of the NTPs and who had been specially trained themselves to deliver the training (Buck, 2015). Similarly, another study where the NTPs being trained were Latinas also used trainers who were bilingual or bicultural (Tran, Ornelas, Kim, et al., 2014).

Only two (11.1%) studies did not specify the duration of the training. Out of the studies that did, training varied in length from three hours (Mastel-Smith et al., 2006) to eight months (Somer et al., 2005). Training typically lasted between half a day and five days (56.3%). However, some studies indicated a longer duration of training, including ten days (Prosman et al., 2014), eleven days (Armstrong, 2010), and some lasted over months (Roman et al., 2009; Somer et al., 2005). Length of training also varied with the job role of the NTPs. In one study using both nurses and peer support workers, the peer support workers attended an additional eight-hour workshop, alongside attending a two-day workshop that was provided to the nurses and peer support workers separately, and a one-day workshop that was provided to them together (Markle-Reid et al., 2014)

Format of the training was poorly discussed, with eight studies (44.4%) not describing how the training was conducted. Of the studies that did, eight of them (80%) used a combination of didactic and experiential techniques which involved lectures (Quijano et al., 2007), role-play, discussions (Bright et al., 1999; Buck, 2015; Dobkin et al., 2007; Miyawaki et al., 2020; Prosman et al., 2014; Quijano et al., 2007; Wong et al., 2020) and the use of video and audio tapes (Armstrong, 2010; Stanley et al., 2014). Whereas, the remaining two (20%) used only didactic practices (Livingston et al., 2014; Miyawaki et al., 2020). Furthermore, in one study, the NTPs were given booster or refresher training sessions to prevent a drift in skills (Quijano et al., 2007).

Table 4.3 presents characteristics of training including content and methods of delivery.

4.3.4. Content of training

Only one study did not describe the content of training. In the studies that did, in eight of them (47.1%) this included information regarding the relevant mental health condition, its signs and symptoms (Bright et al., 1999; Buck, 2015; Dobkin et al., 2007; Hovey et al., 2014; Prosman et al., 2014; Tran, Ornelas, Kim, et al., 2014; Wong et al., 2020) and procedures for identification and assessment (Buck, 2015; Hepner et al., 2011; Markle-Reid et al., 2014; McCabe et al., 2008; Mellor et al., 2010; Strong et al., 2004; Symons et al., 2004; Wong et al., 2020). One study included training on the administration and scoring of paper-and-pencil psychological tests (Hovey et al., 2014). Some studies (23.5%) also included training on skill building, including training on communication skills (Bright et al., 1999) and listening skills (Livingston et al., 2014; Wong et al., 2020), which also involved training in research protocol, ethical and confidentiality matters (Bright et al., 1999). Studies in which CBT was the intervention being delivered included training on cognitive behavioural techniques (Bright et al., 1999; Dobkin et al., 2007; Somer et al., 2005; Wong et al., 2020); one study (Bright et al., 1999) focused on cognitive distortions, dysfunctional thought record use and techniques for dealing with them as well as techniques for debating automatic thoughts. A few studies (23.5%) also trained the NTPs on identifying risk and the steps to take in an emergency situation (Buck, 2015; Livingston et al., 2014; Prosman et al., 2014; Wong et al., 2020). Furthermore, two studies (11.8%) briefly described training in medication without detailing what the medication was (Hovey et al., 2014; Miyawaki et al., 2020). The two studies that were training programs for the NTPs to deliver CBT also included training on stigma and awareness in mental health (Buck, 2015), and the common misconceptions surrounding it (Wong et al., 2020).

4.3.5. Training evaluation

The evaluation of training is considered important to assess its effectiveness and efficiency and also identify ways in which it can be improved (Ellington et al., 1993). In-training evaluation may include the assessment of competencies, such as knowledge or the acquisition and development of skills (Turnbull et al., 1998). Furthermore, the effectiveness of interventions may be dependent on the skills of those delivering them (Mars et al., 2013). Despite the importance of evaluating the

effectiveness of training to ensure high standards of care, evaluation in the majority of studies was not documented and only described in five. In Armstrong (2010), the Counselling Self-Estimate Inventory was used to measure the counsellors' beliefs on their abilities to counsel effectively where there was a significant increase in skills competence, cultural competence, and the ability to handle difficult client behaviours. Furthermore, in this study, NTPs were assessed on their competence before they were permitted to start seeing clients, but details of this have not been described. Alternatively, Buck (2015) evaluated training using a programme evaluation form where it was found that NTPs were highly satisfied with the training. Training acceptability in Wong et al. (2020) was assessed through number of sessions attended, dropout rate, and the NTPs' level of satisfaction towards the programme, where only one NTP did not complete training, and all the NTPs reported feeling satisfied with the training programme. In Tran, Ornelas, Kim et al. (2014), the evaluation of the training was conducted in a linked study where the promotora role and stress management knowledge were assessed and was found to have a positive impact (Tran, Ornelas, Perez, et al., 2014). Lastly, in one study, the adequacy of the training was assessed through feedback of the trainees after each training session, but the results of this were not reported (Quijano et al., 2007).

Table 4.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Armstrong (2010) [a]	(1) The common factors philosophy of the course, the process of personal development, draw out and build on trainees' existing helping and relational skills; (2) provided trainees with an appreciation of the ways in which attitudes and assumptions and dominant theoretical perspectives develop, the ways of understanding mental distress, what shapes responses to clients' problems; (3) principles and skills of the solution-focused approach and the ways in which they could be used to tap into the common factors.	Short lectures, guided reading exercises, group discussion, role-play exercises, together with video and live (role-play) demonstrations of counselling sessions	Not described	11 training days (40 hours)	PI (CBT therapist)	Counsellors' beliefs or judgements of their abilities to counsel effectively: Counselling Self-Estimate Inventory, assessment of trainee competence to start seeing clients (not described)
Bright et al. (1999)	(1) Common interventions (characteristics of depression, components of group therapy, problems in conducting groups and research protocol issues); (2) CBT techniques (cognitive model of depression, cognitive distortions, dysfunctional thought record use, techniques for debating automatic thoughts, for dealing with core cognitive distortions); (3) MSG module (features of mutual support for depression, the use of rounds, feedback, communication skills, and group problem-solving).	Didactic-experiential workshop	Protocol and treatment manuals	2 days	Not described	None

Table 4.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Buck (2015)	(1) Recognise the signs and symptoms of depression and related problems, including intergenerational conflict, substance abuse, domestic violence and suicide; (2) reflective listening and CBT skills; (3) awareness of stigma toward treatment-seeking for depression and its related risk factors and to refer people to mental health workers in the community when encountering problems related to substance abuse, domestic violence or suicide.	Didactic, role-play, activities	Training manual translated into Burmese and Karen	4 sessions (12 hours)	Native Burmese speaker and community leader or native Karen speaker and community leader, specifically trained to deliver training	Programme evaluation form
Burnett-Zeigler et al. (2019)	(1) Foundational training – an 8-week, 2.5 h per week MBSR course developing a personal mindfulness practice; (2) basic teacher training – a 1-day professional training workshop including formal mindfulness practice and an overview on mindfulness theory, science, principles, pragmatics and techniques; establishing an ongoing personal mindfulness practice; teaching practicum.	Not described	Not described	8 weeks (2.5 hours/week), 1 day	PI (mental health professional), mindfulness instructor	None

Table 4.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Dobkin et al. (2007)	(1) Course and treatment of depression, prevalent symptoms, and common cognitive distortions, inferential feedback, differences between types of positive social support followed by role-playing; (2–4) recognise patients' depressogenic inferences and cognitive distortions. Partners practiced giving adaptive feedback to depressed patients between sessions.	Didactics, role-play	Handout with illustrative examples	4 sessions. 1st session, 60–75 min., others 30–45 min.	PI (psychologist) and postdoctoral fellow trained by clinical psychologists	None
Hovey et al. (2014)	Training on mental health symptoms and disorders, risk and protective factors for mental and physical health, child development and parenting issues, medication, therapy techniques and the administration and scoring of paper-and-pencil psychological tests.	Not described	Not described	Not described	Mental Health Centre staff and PI (professor of psychology)	None
Livingston et al. (2014)	How to deliver therapy, potential clinical dilemmas, working with interpreters, empathetic listening skills, effective use of supervision, safe working practice, when to ask for help and how to respond to any risks disclosed by carers.	Role-play	Training manual	Not described	Research team	None

Table 4.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Markle-Reid et al. (2014)	Training in prevention, recognition and management of depression and PST.	Not described	A depression care booklet	1-day workshop with the RNs and PSWs, 2-day workshops held for RNs and PSWs separately, an 8-hour workshop for PSWs	Not described	None
Mastel-Smith et al. (2006)	(1) Developmental stages – childhood and teenage years; (2) young and middle adulthood, topics to be delivered during the third and fourth weeks of the intervention; (3–4) the fifth developmental stage and life summary – older adulthood and integration, topics to be covered during the fifth and sixth weeks.	Not described	Not described	3 one-hour sessions	Not described	None
Miyawaki et al. (2020)	An overview of reminiscence and LR, a step-by-step instruction on conducting an LR session, considerations (e.g., care recipient activities, medications, meal times), skills of therapeutic listening and mindfulness, communication techniques (i.e., reframing and encouragement) and expectations of LR.	Small-group training, practice sessions, experiential exercises, didactics	Handouts of the slide, presentations, a checklist of the LR topics by week	1 day (6 hours)	Research team	None
Pratt et al. (2017)	Highly visual CBT-based content.	Not described	Translated slides and support scripts	3 days	Consultant from the LLTTF programme	None

Table 4.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Prosman et al. (2014)	Theoretical backgrounds of IPV, depression, children witnessing abuse, parenting support, practical skills on the protocols used and how to deal in emergency situations.	Didactic and practicum training	Not described	10 days	Not described	None
Quijanao et al. (2007)	Not described.	Group sessions, individual coaching, and follow-up booster training that were highly interactive, brief lectures, skill demonstrations and role-playing	Programme manual with scripts and client handouts, read articles and viewed videos	2 days (12 hours)	Academic mental health professionals with backgrounds in clinical social work or clinical psychology	Adequacy of training: participant feedback after each training session
Roman et al. (2009)	Relationship-building, problem-solving, goal-setting, stress management, self-esteem and assertiveness.	Not described	Not described	10 sessions, followed by monthly sessions	Community agencies and the local community college	None
Somer et al. (2005)	Hotline volunteers: CBT techniques to assist callers with worry and anxiety. Paraprofessionals: shorter-version training to identify callers worried about the pending war, to provide the standard hotline care and to refer these callers for data collection after the intervention was completed. Eight-month course: training in crisis intervention, client-centred counselling and compulsory monthly continuing education.	Not described	Not described	Hotline volunteers received 5-hour workshop, both attended an 8-month training course, mandatory continuing education and training	Not described	None

Table 4.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Stanley et al. (2014) [b]	Two didactic sessions including (1) CBT principles as they apply to anxiety and depression, empirical literature related to CBT for late-life anxiety and depression and the development of the treatment approach; (2) patient-enrollment procedures (recruitment, selection, screening, and diagnostic processes); course of treatment, including core and elective sessions and highlights of the readings.	Reading and didactics (11 hr), review of audiotaped sessions conducted by experts (20 hr) and role-plays of all skills (5 hr)	Reading materials on CBT, GAD, late-life anxiety, aging and cognitive disorders, programme procedures and the treatment manual and workbook	36 hours	Programme director (clinical psychologist)	None
Tran et al. (2014) [c]	Mental health, stress and coping skills and how to reach out to women in the promotoras' social networks. Topics include: Migration Journey, Life in NC and You, Ways of Adjusting to a New Place, Mental Health, Helping Others as a Promotora and Life in NC and Family: Difficulties Adjusting to a New Place	Not described	Information and tangible resources (e.g., handouts, resources guides, and self-care items) referred to as a comfort basket, a collection of items to enhance support and healthy coping	six 2- to 3-hour sessions	Bilingual/bicultural clinical social worker	Promotora role and stress management knowledge were assessed

Table 4.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Wong et al. (2020)	(1) Overview of training and objectives, signs and symptoms of depression, migration stress, introduction to CBT, reflective listening and redirecting conversation; (2) signs and symptoms of anxiety, simple relaxation strategy, calm breathing technique, ways to start first CBT session, SMART goal-setting, identify and examine automatic thoughts, unhelpful thinking styles, CBT thought record, cognitive restructuring; (3) signs and symptoms of abuse, assertiveness skills, problem-solving skills, the rationale of BA and examples of behavioural strategies (i.e., self-soothing activities, activity scheduling); (4) warning signs, risk and protective factors, common misconceptions of suicide, basic risk assessment and management.	Didactics, discussions and role-plays	Session handouts	4 weekly 3-hour sessions	2 master's-level clinical psychology trainees	Training acceptability was assessed in terms of (a) number of sessions attended, (b) dropout rate and (c) level of satisfaction towards the programme

[a] Data extracted from (Armstrong, 2003); [b] Data extracted from (Kraus-Schuman et al., 2015); [c] Data extracted from (Tran, Ornelas, Perez, et al., 2014)

IPV, Intimate Partner Violence; CHWs, Community Health Workers; CBT, Cognitive Behavioural Therapy; MSG, Mutual Support Group; LR, Life Review; NC, North Carolina; PST, Problem-Solving Therapy; GAD, Generalised Anxiety Disorder; LLTTF, Living Life to the Full; RN, Registered Nurse; PSW, Personal Support Worker; BA, Behavioural Activation; PI, Principal Investigator; MBSR, Mindfulness-Based Stress Reduction

4.3.6. Supervision of NTPs

Four studies (22.2%) did not report on supervision procedures, two of which were training programs and therefore there was no intervention delivered (Buck, 2015; Wong et al., 2020). In the remaining two studies, it is unclear whether supervision was provided and has not been documented or no supervision was provided to the NTPs (Mastel-Smith et al., 2006; Somer et al., 2005).

Out of the remaining fourteen studies, in four of them (28.6%), supervision was provided by a member of the research team (Burnett-Zeigler et al., 2019; Dobkin et al., 2007; Markle-Reid et al., 2014; Miyawaki et al., 2020) whereas in three studies (21.4%), supervision was provided by a mental health professional (Hovey et al., 2014; Livingston et al., 2014; Stanley et al., 2014), and in one study, psychology students provided supervision (Bright et al., 1999). Furthermore, in two studies (14.3%), supervision was conducted through individuals who also co-facilitated the intervention (Hovey et al., 2014; Roman et al., 2009). Although supervision was provided by a member of staff in a further two studies (14.3%), their qualifications or level of expertise were not stated (Armstrong, 2010; Pratt et al., 2017). Similarly, in another study using mentor mothers, supervision was provided by a mentor coordinator (Prosman et al., 2014), and in another study using promotoras, a curriculum facilitator provided supervision (Tran, Ornelas, Kim, et al., 2014). However, in both instances, the level of expertise is unknown.

Only nine studies of the fourteen studies (64.2%) indicated the frequency of supervision, which occurred weekly (44.4%; Bright et al., 1999; Livingston et al., 2014; Miyawaki et al., 2020; Stanley et al., 2014) or monthly. In one study, the frequency of supervision decreased as the NTPs gained more experience in delivering the intervention where after the first three months supervision decreased from twice a month to once a month (Quijano et al., 2007). Most supervision occurred in a group format (Armstrong, 2010; Livingston et al., 2014; Stanley et al., 2014; Tran, Ornelas, Kim, et al., 2014), whilst in one study, supervision also occurred via telephone (Miyawaki et al., 2020).

Although information regarding supervision was mostly incomplete, supervision was highly varied in terms of the content whereas in other supervisions, challenges in delivering the interventions and solutions to overcoming these were discussed (Markle-Reid et al., 2014). In one study, supervision involved the NTPs providing an update or presentation on their cases (Livingston et al., 2014), whilst other studies involved providing additional training (Bright et al., 1999; Pratt et al., 2017), support and guidance (Miyawaki et al., 2020; Quijano et al., 2007). In one study, supervision also allowed the NTPs to share experiences with delivering the intervention (Tran, Ornelas, Kim, et al., 2014). In some studies, the intervention sessions were audiotaped, and this was then discussed in the supervision with appropriate feedback given by the supervisor (Bright et al., 1999; Somer et al., 2005).

Details of the supervision are presented in Table 4.4.

4.3.7. Ensuring fidelity of the intervention

Intervention fidelity is the degree to which an intervention is delivered as intended and is key in ensuring successful implementation of the intervention into practice (Breitenstein et al., 2010). The fidelity of an intervention can be influenced by two factors: (a) the degree to which the intervention is conducted competently and (b) according to the protocol (Breitenstein et al., 2010). The competence of the interventionist and quality of the therapy are essential factors in the effectiveness of a psychological intervention (Fairburn & Cooper, 2011). Competence can be measured through knowledge or by assessing skill at the time of intervention implementation which can include evaluating the patient outcomes, treatment sessions or standardised role-plays.

Methods for ensuring competence and fidelity to the intervention were described in nine of the studies (50%). In two studies, fidelity was ensured through supervision (Prosman et al., 2014; Quijano et al., 2007), in which one study involved the supervisor providing feedback and addressing individual needs for further training (Quijano et al., 2007). In a few of the studies, the interventions were recorded and assessed by experts against the criteria of the intervention protocol (Somer et al., 2005) or by using a therapy compliance or fidelity checklist (Bright et al., 1999; Livingston et al., 2014; Miyawaki et al., 2020). The frequency of fidelity checking was also described in some studies. In a study in which the intervention was delivered via telephone, the intervention was recorded for every fifth call (Somer et al., 2005) whereas studies in which intervention sessions were audiotaped randomly reviewed 20% to 30% of the recorded sessions (Stanley et al., 2014). One study used an alternative approach to ensure fidelity, which involved NTPs recording intervention-specific activities that were carried out following each session, which were then used to conducted monthly audits by the principal investigator to assess the fidelity of the treatment (Markle-Reid et al., 2014).

Whilst fidelity control was reported in half of the studies, only two studies described how concerns regarding fidelity were addressed, which in each case was through supervision (Bright et al., 1999; Livingston et al., 2014). Two out of the remaining nine studies that did not describe how fidelity to the intervention was ensured, were training programs, and therefore, there was no intervention delivered (Buck, 2015; Wong et al., 2020). In the remaining seven studies (38.9%), it is unclear whether fidelity was monitored and has not been documented or no fidelity checks were carried out (Burnett-Zeigler et al., 2019; Dobkin et al., 2007; Hovey et al., 2014; Mastel-Smith et al., 2006; Roman et al., 2009; Tran, Ornelas, Kim, et al., 2014).

Table 4.4. Characteristics of supervision of the NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check
Armstrong (2010) †	Member of staff	Not described	Peer support and supervision groups	Not described	Assessment of trainee competence to start seeing clients (not described)
Bright et al. (1999)	Advanced psychology undergraduate and master's-level students	Weekly	Through feedback of audiotaped sessions	Observers indicated when therapists committed errors of omission (i.e., failed to accomplish any of the four general objectives for the intended condition) or errors of commission (i.e., included any of the four general objectives from the other treatment condition). When therapists failed to adhere to the appropriate protocol for a session, additional supervision was provided to ensure prompt return to accurate treatment delivery.	Sessions were audiotaped and observed by trained raters who completed a therapy compliance checklist to ensure that therapists adhered to the therapy protocols.
Buck (2015) *	N/A	N/A	N/A	N/A	N/A
Burnett-Zeigler et al. (2019)	PI (experienced mindfulness Instructor)	Regular (frequency unknown)	Not described	Not described	None
Dobkin et al. (2007)	PI and a postdoctoral fellow	Not described	Audiotaped supervision	Not described	None
Hovey et al. (2014)	Co-facilitating Psychologist	Not described	Not described	Not described	None

Table 4.4. Characteristics of supervision of the NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check
Livingston et al. (2014)	Clinical psychologist	One and a half hours every fortnight + weekly meetings	Group supervision and team meetings. The psychology graduates could approach one of the research team at any time if they had concerns or questions relating to their clients.	In group supervision sessions, each psychology graduate provided a brief update of his or her caseload, ensuring that clients and any related issues or concerns did not get overlooked. Procedural and clinical issues were addressed in team meetings.	Therapists recorded one therapy session per participant, which was rated for fidelity to the manual using a fidelity checklist. An overall fidelity score for each session was given. If fidelity scores were not high, the supervising clinical psychologist addressed this in supervision.
Markle-Reid et al. (2014)	An implementation team, consisting of the PI, the research coordinator and managers from participating care provider agencies	Monthly	Outreach visits with the intervention providers	Discuss progress of the study, provide feedback and education and discuss barriers encountered and possible solutions.	The RNs and PSWs recorded intervention-specific activities that were carried out following each home visit and case conference. The PI conducted monthly audits of this documentation to assess fidelity to treatment.
Mastel-Smith et al. (2006)	None	None	None	None	None
Miyawaki et al. (2020)	Research assistant	Weekly	Telephone supervision	Support and guidance when needed	Level of intervention fidelity was checked by supervision calls using a fidelity check-in sheet with two sections: (1) Getting Prepared and (2) LR Sessions
Pratt et al. (2017)	Bilingual project staff	N/A	N/A	Assisted with recruitment, provided additional training and supported the CHWs as required	None

Table 4.4. Characteristics of supervision of the NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check
Prosman et al. (2014)	Mentor coordinator	Fortnightly	Not described	Not described	Quality of intervention monitored through supervision
Quijanao et al. (2007)	Coach (master's-level social worker)	Twice a month for 3 months and then once a month	Face-to-face meetings	Feedback and support	Fidelity to the intervention was ensured through supervision. A group booster training session occurred semi-annually to address challenges identified by workers and to maintain quality of care.
Roman et al. (2009)	Co-facilitating nurse	Not described	Not described	Not described	None
Somer et al. (2005)	None	None	None	None	To ensure fidelity, the interventions were audio-recorded for every fifth call. Two trained psychologists assessed the extent to which each intervention had met the descriptive criteria of either the CBT protocol or the hotline's standard practice.
Stanley et al. (2014)	Senior experts in late-life anxiety	Weekly	Audiotape review and feedback for two non-study patients followed by weekly group supervision meetings.	N/A	Sessions were audiotaped, and a random 20% were rated by two independent treatment integrity raters.
Tran et al. (2014)	Curriculum facilitator	Monthly	Group	4–9 booster sessions to complete a log of activities and discuss their outreach	None

Table 4.4. Characteristics of supervision of the NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check
				experience and reinforce skills and provide opportunity to share their experiences.	
Wong et al. (2020) *	N/A	N/A	N/A	N/A	N/A

* The study was aimed at delivering a training programme to NTPs, and therefore, no intervention was delivered or described, and hence, no subsequent supervision or fidelity checks occurred.

† Data extracted from (Armstrong, 2003)

CBT, Cognitive Behavioural Therapy; LR, Life Review; RN, Registered Nurse; PSW, Personal Support Worker; PI, Principal Investigator

4.4. Discussion

4.4.1. Summary of results

To our knowledge, this review is the first to document the content and delivery of training that is provided to NTPs task-shifting psychological interventions for CMDs in HICs. A total of 18 studies were eligible for inclusion in this review. The content of the training and supervision provided was summarised.

NTPs trained were mostly professionals working in healthcare such as carers and individuals with degrees in the social sciences, with only two studies using peers and volunteers. Furthermore, various types of psychological interventions were delivered by these NTPs with the most common being CBT, psychoeducation and support.

Results showed that delivery of training also varied in duration; whilst most training ranged from between two days to one week in length, some training sessions were conducted over weeks and some months. The length of training also varied with the level of qualification of the NTPs with nurses being provided with less training than personal support workers. Furthermore, a few studies also provided booster sessions to prevent a drift in skills and maintain quality of care.

The format of most training was didactic with lectures and reading and also experiential with NTPs engaging in role-play. Content of training also varied, with some studies also including training in medication management; however, in the majority of studies, training included education on the relevant mental health condition, its signs, symptoms and methods of management.

Supervision was an important aspect of training in ensuring fidelity of the intervention and was most commonly provided by a member of the research team or a mental health professional. Supervision sessions occurred weekly in a group setting, and of the studies that described the content of the sessions, in most cases supervision was used for updating, debriefing and reviewing as well as for addressing any issues that may have arisen. Furthermore, evaluation of the training was an essential component to fidelity control and was conducted through assessments of knowledge or through interviews on the trainees' experiences. In most of the studies that reported on fidelity control, intervention sessions were audiotaped and randomly assessed by an expert for compliance with the intervention protocol.

Training was poorly documented in most studies. Information on the level of qualification and selection of the NTP, the development of the training course, its implementation, format and content were often lacking. Several studies did not discuss supervision of the NTPs; however, this may also be due to NTPs not being provided with supervision rather than incomplete information. Furthermore, whilst quality of the intervention and competence of the counsellor are essential components to ensuring the effectiveness of an intervention, fidelity control and training evaluation

were often inadequately reported. The lack of assessment methods is a major challenge in determining NTP competence and can affect the overall quality of intervention delivery.

4.4.2. Comparison with existing literature

Due to high demands and a shortage in the health workforce, task-shifting has seen increasing interest in recent years. Task-shifting has been adopted in Sub-Saharan Africa in the management of HIV and has been found to be cost-effective and of either equal or better quality of care (Callaghan et al., 2010). In low-resource settings, NTPs have been used to deliver a wide range of healthcare services including, non-physician clinicians and nurse-midwives being trained to perform obstetric surgery in Tanzania (Nyamtema et al., 2011) and lay nurse aides being trained to provide antenatal counselling in Benin (Jennings et al., 2011). In contrast, resource-rich countries such as the UK, USA and Australia have addressed their own workforce shortages by restructuring their workforce for better efficiency in healthcare. For example, nurse practitioners and physician assistants will provide care for people with minor illnesses or injuries (Wilson et al., 2009), a task which was performed only by physicians several decades ago. Compared to other fields in healthcare, fewer studies have used a task-shifting approach in mental health. However, studies adopting this approach have found it to be effective in achieving better mental health outcomes (Rahman et al., 2008).

Reviews have shown the wide range of cadres that have been used to task-shift psychological interventions from women from the local community (Chowdhary et al., 2014) to Primary Care Practitioners (Painuly & Sharan, 2008). However, these reviews have all been conducted in LMICs where there is a shortage of health workers, and therefore, this may not necessarily apply to developed countries, which is evidenced from this present review in which most studies trained paraprofessionals who were already working within the healthcare system or individuals with university-level qualifications. However, similar to this study, existing reviews that have briefly described the training of NTPs when investigating task-shifting have found that duration of training varies considerably across studies from a few hours to a few weeks (Painuly & Sharan, 2008). A review by Van Ginneken et al. (2013) found that training in most studies often involved a mixture of didactic and practical training whilst also highlighting the lack of information reported on the content of training. Furthermore, the focus of training can also vary from being disorder specific in some studies to general training on psychiatric disorders in other studies (Painuly & Sharan, 2008).

According to Agyapong (2016), regular supervision is important for successful task-shifting. Similar to this study, reviews describing supervision have found that it is highly varied, occurring weekly to monthly, and is mostly done by the principal investigator or specialists (Chowdhary et al., 2014; Van Ginneken et al., 2013). Furthermore, a review by Padmanathan et al. (2013) identified training and supervision as important factors in ensuring feasibility. Whilst task-shifting approach has been found to be effective, a number of studies have not reported adequately on the training of the

NTPs. One systematic review suggests that if a task-shifting approach is to be implemented on a large scale, then it is important to have scalable training, supervision and monitoring procedures to ensure NTP competence and treatment quality (Chowdhary et al., 2014).

Based on our findings, we propose a framework for training NTPs in delivering psychological interventions for CMDs. In the included studies, training was delivered by a mental health professional, and whilst the duration of training varied from study to study, in most, this consisted of at least a week. Therefore, it is recommended that these components be included in training in this area. Furthermore, training should incorporate both didactic learning through lectures and experiential learning in the form of role-plays, as this seems to be an effective method in delivering training in which skills can be learnt through theories and vicarious learning through peer observation. Whilst content of training depends on the mental health condition and the target population to whom the intervention is being delivered, it is recommended that basic training include education on mental health, identification and management. Training should also include building skills in communication and empathy, as well as information on maintaining confidentiality and ethical guidelines. In addition to the initial training period, monthly booster training sessions are recommended to prevent any drift in knowledge and skills which may be delivered by the supervisor.

Based on the practices of the included studies, it is recommended that supervision be conducted biweekly by a mental health professional. However, as this may be difficult due to their limited time availability, a less qualified and experienced professional (i.e., psychology graduate) can undertake training on a regular basis with monthly supervision carried out by the mental health professional. Supervision should be conducted in a group format in which any issues or difficult cases can be discussed. Furthermore, intervention sessions can be audiotaped, and 10% to 20% can be reviewed to ensure fidelity with feedback being given during group meetings.

Assessment of competency is also recommended prior to implementation of the intervention either through written assessment of NTPs' knowledge or through assessment of mock interventions. Whilst this training has been proposed based on the findings of this review, it is not possible to make conclusive assumptions about effective and ineffective training strategies due to a lack of reporting and missing information in many of the studies. Moreover, this lack of data, as well as heterogeneity in the existing data also makes it difficult to theorise about which type of training works best in training NTPs. More data on the evaluation of the training programmes such as pre- and post-assessments of knowledge are required to be able to theorise about which types of training strategies work best.

4.4.3. Strengths and Limitations

This review is the first to focus on the training and supervision of NTPs delivering psychological interventions. Moreover, to our knowledge, it is the first to focus on task-shifting in HICs. This review offers in-depth information on the training that is provided to NTPs as well as insights into the inconsistency in reporting within studies. Grey literature and unpublished studies were excluded from this review due to the limited amount of information provided on the training and supervision of the NTPs, which would have made it difficult to reach conclusions on the essential training components. However, it is important to be aware that grey literature can make important contributions to systematic reviews by providing data not found within published literature, reducing publication bias and facilitating a more balanced view of evidence (Paez, 2017). Furthermore, excluding grey literature, unpublished studies and studies which were in languages other than English can limit the potential number of studies included in the review and increases publication bias. Due to time constraints and a large number of studies included in the review, it was not possible to contact the authors of the included studies to request further information relating to the training of NTPs.

4.4.4. Implications for future research

Although the training and supervision of NTPs is an essential component of task-shifting, this review highlights multiple gaps in information. Despite there being a large number of studies using NTPs to deliver interventions, we are still unclear about the best way to deliver this training due to a lack of detailed reporting. Therefore, researchers need to thoroughly report the full content of training that is provided to NTPs to allow for full replication. Moreover, researchers should document any barriers or challenges encountered by the NTPs when delivering the intervention and how these may have been resolved. A possible solution to address gaps in reporting is by creating a set of guidelines or a checklist for describing training, which could be used by researchers when reporting trials. Future research should also examine the effectiveness of interventions delivered by NTPs alongside the training provided to investigate any possible correlations. Furthermore, interviews or focus groups should be conducted with NTPs, patients receiving the interventions and experts involved in training to highlight any barriers or facilitators in the training and intervention and how these may be addressed.

Though we have used the term ‘non-traditional provider’ to describe an individual with no experience in delivering psychological interventions for CMDs, this review highlights the wide variety of terms that can be used to describe this group. Therefore, the views of experts on their perceptions of the term ‘NTP’ should be investigated.

4.5. Conclusion/chapter summary

- Interest in task-shifting has been growing in recent years to increase access to treatments. Whilst a number of studies have demonstrated its effectiveness, little emphasis has been placed on the training of these NTPs, particularly in HICs.
- This review highlights the content and training of non-professionals in HICs, with no experience in delivering psychological interventions.
- Training is an essential aspect of task-shifting and is an important component in ensuring quality of care. For task-shifting to be successful, several conditions are required, such as regular supervision, booster training sessions and controlling fidelity of the intervention (Agyapong et al., 2015).
- Gaps in reporting this training exist; therefore, to ensure proper documentation of the training processes of NTPs, the development of guidelines or a checklist for describing training is essential.

Chapter 5. Lessons learnt from task-shifting psychological interventions for common mental disorders in low- and middle-income countries: A systematic review

The previous chapter summarised the training and supervision that has been provided to NTPs delivering psychological interventions in HICs. This chapter will focus on the training and supervision provided to these NTPs in LMICs and the lessons drawn that can be applied to HICs.

5.1. Introduction

More than 80% of people who have mental disorders are residing in LMICs, with mental conditions and substance abuse disorders accounting for 8.8% and 16.6% of the total burden of disease in low-income and lower-middle-income countries, respectively (WHO, 2004). Experts predict that by 2030, depression alone is likely to be the third leading cause of disease burden in LICs (4.7%) and the second highest cause of disease burden in MICs (6.7%) (Mathers & Loncar, 2006). Currently, unipolar depressive disorder accounts for 4.3% of the global burden of disease making it the third leading cause of disease burden. Furthermore, in LICs it represents almost as large a problem as does malaria (3.2% versus 4.0% of the total disease burden). Similarly, in MICs, unipolar depressive disorders are the first major contributor to disease burden and account for twice the burden of HIV/AIDS. Despite this, the funds being invested to address mental health are only an extremely small percentage of those allocated to fight malaria and HIV/AIDS, with the WHO (2014) reporting low expenditure levels on mental health in LMICs (less than US$ 2) compared with levels estimated in HICs (over US$ 50 per head of population).

Whilst a number of treatments have been found to be effective in reducing symptoms of CMDs, in LMICs access to mental health services is limited due to the scarcity of financial resources and qualified staff, with approximately 75% and 85% of people with severe mental disorders unable to access the treatment they need for their mental health problem, compared with 35% and 50% of people in HICs (Demyttenaere et al., 2004). Furthermore, utilisation of existing resources is poor due to cultural, financial and geographical barriers (Chibanda et al., 2015; Chowdhary et al., 2014; Van Ginneken et al., 2013). In LMICs, task-shifting has been a successful approach in addressing health worker shortages and strengthening mental health provisions, with a number of reviews supporting the use of task-shifting for mental health (Atif et al., 2015; Chowdhary et al., 2014; Padmanathan & De Silva, 2013; Rahman et al., 2013). Due to low resources and education, tasks are often shifted to persons with minimal education, and therefore, training and supervision is essential to maintaining high-quality care. However, to date, no review has explored the training and supervision provided to these NTPs. Whilst a review by Singla (2017) summarised the evidence on psychological treatments delivered through the NTPs in LMICs, the focus was on implementation processes and outcomes rather than on training and supervision. Furthermore, the

aim of existing reviews in task-shifting has been to address the health workforce shortage, and no review has examined how this information learnt can be applied to HICs. Therefore, the aim of this review is to identify lessons learnt from training NTPs to deliver psychological interventions in LMICs which can be used to develop training strategies in HICs.

This chapter will specifically address the research questions:

(a) What cadres of workers have been trained to deliver psychological interventions?
(b) How was their training delivered?
(c) What was the content of the training?
(d) How were they supervised?
(e) How was fidelity of the intervention ensured?
(f) What lessons can be learnt from task-shifting psychological interventions in LMICs?

5.2. Methods

The methods outlined in this section are a duplicate of section 4.2, with the exception of inclusion and exclusion criteria (section 5.2.2).

5.2.1. Literature search strategy

A systematic review of studies that reported on the content and delivery of training for NTPs was conducted. The search was conducted from inception up to 13 May 2020. Studies were identified by a search on the following databases: Ovid Medline, Embase, PsycINFO and EBSCO CINAHL. A language limit was added to only search studies that were in English. Searches were conducted to specifically capture studies on task-shifting of psychological interventions. The task-shifting aspect of the search strategy was adapted from a Cochrane systematic review which investigated non-specialist health workers interventions (Van Ginneken et al., 2013). Search terms included 'allied health personnel', 'community health aides', 'caregivers', 'voluntary workers' and 'community networks'. The mental disorders aspect of the search strategy was adapted from a systematic review investigating the effectiveness of peer-delivered interventions for severe mental illness and depression (Fuhr et al., 2014). The search strategy has been listed in Appendix 1. Furthermore, references of eligible papers were checked for additional relevant studies. In addition to this, a database search was conducted to identify any systematic reviews that had investigated task-shifting, and all papers included in the reviews were assessed for eligibility. All the searches were exported to EndNote X9 (bibliographic software), and duplicate references were reviewed and deleted.

5.2.2. Inclusion and exclusion criteria

5.2.2.1. Types of studies

There was no limit on the types of studies to be included in this review, with the exception of reviews and meta-analyses. However, studies which did not provide any description of the NTP, and their training and supervision were excluded from the review. Furthermore, studies were also excluded if there was insufficient detail on the psychological intervention that was delivered or if it was unclear who delivered the intervention. Additionally, studies that outlined a training programme without delivering training to a set of NTPs were also excluded from the review. Multiple publications of the same study were treated as a single study; however, relevant data was extracted from all publications.

5.2.2.2. Type of settings

Studies that were considered LMICs as defined by the World Bank (2019) at the time that the study was being carried out were included in the review. We included studies that were delivered outside of the health sector, in a community setting. Furthermore, studies conducted in primary care were included if the intervention was delivered by a CHW attached to the clinic and not a highly educated health professional. Any studies that were delivered in a hospital setting were excluded.

5.2.2.3. Type of participants

We included studies in which interventions were targeted towards adults with depression or anxiety. Studies were also included if the participant had a comorbid health condition, where scores of depression or anxiety were one of the primary outcomes. Although PTSD is an anxiety disorder, a decision was made to exclude it from the review, based on the fact that treatment for this condition will often be trauma focused such as prolonged exposure therapy, built around the past experiences and trauma of the participant, which can warrant separate, more advanced training (Watkins et al., 2018). Furthermore, due to limited training LHWs are better suited to deliver low-intensity interventions, and, NICE (2011) guidelines suggest that for treating PTSD, patients should receive high-intensity treatments as the first intervention.

Additionally, studies conducted with children (aged below 18 years), participants with severe mental illness (i.e., schizophrenia, bipolar disorder), neurological disorders (i.e., epilepsy, dementia) and substance abuse disorders were excluded from the review. However, we included caregivers of people with these disorders, if the intervention was directed towards the carer rather than the patient.

5.2.2.4. Types of interventions

Psychological interventions delivered by NTPs in a non-clinical setting, aimed at reducing or preventing symptoms of depression and anxiety, were included in this review. Studies in which the intervention was some form of social support and did not include an evidence-based psychological intervention were excluded. Furthermore, studies on self-management or self-help, where the participant conducts the intervention on themselves were excluded, with the exception of some studies where an aspect of the intervention was delivered by an NTP. Studies in which the intervention was aimed at the management of a health condition or detection of a mental disorder without the delivery of a psychological intervention were excluded.

Interventionists were considered NTPs if they had not received advanced (i.e., post-baccalaureate) degrees in the mental health field (e.g., psychiatry, psychology, social work) or had not received specialist training or a training course in mental health and who have a role of increasing access to community mental health services (Barnett et al., 2018a). Therefore, studies were excluded if the intervention was delivered by mental health professionals (i.e., psychiatrists, psychologists, psychiatric nurses). Furthermore, a decision was also made to exclude doctors, specialist nurses and medical students from this review, as their training may have involved some form of mental health training. Table 5.1 highlights the inclusion and exclusion criteria of the systematic review.

Table 5.1. Inclusion/exclusion criteria of studies in LMICs

Field	**Inclusion Criteria**	**Exclusion criteria**
Language	English	Language other than English
Setting	Community low- and middle-income countries Community and primary care	High-income countries Hospitals
NTPs	Community health workers, service users, volunteers, teachers, teaching assistants, allied health professionals, caregivers.	Doctors, nurses, mental health professionals, medical students. Anyone with experience in delivering psychological interventions.
Interventions	Interventions which identify or diagnose common mental disorders or improve the symptoms of an individual with a common mental disorder. Interventions to promote mental health or prevent mental illness. Interventions to train the task-shifting workforce.	Self-help interventions, drug interventions. Training to raise awareness or reduce stigma against mental illness.
Participants	Adults with common mental disorder, anxiety, depression.	Children or adolescents. Individuals with severe mental illness,

Table 5.1. Inclusion/exclusion criteria of studies in LMICs

Field	Inclusion Criteria	Exclusion criteria
		neurological disorders, substance abuse disorders.
Outcomes	Description of training procedures for NTPs delivering interventions.	Details about interventions are unknown. No description of the training or supervision.
Study Design	Any study design which reports on the content and delivery of the training received by the task-shifting workforce.	Meta-analysis, reviews. Studies that do not include training of the task-shifting workforce.

5.2.2.5. Data Extraction

Titles and abstracts were screened independently by two researchers (US and CA), and any study that did not meet the inclusion criteria was excluded. Screening of the full-text articles of the potentially relevant studies against the inclusion/exclusion criteria was conducted independently by US and CA. If there was a disagreement about the inclusion of a paper, a third researcher (WW) adjudicated. Data were extracted by US using a standard data extraction form which addressed the key characteristics of the studies, as well as details about the training, intervention and supervision. From studies in which the intervention was delivered by a combination of NTPs and professionals, only data concerning the NTPs was extracted. Furthermore, although this review was not investigating the effectiveness of the intervention or training, wherever possible, the outcomes of the NTP-delivered intervention were extracted to identify the patterns between positive outcomes and training. The data extraction form and corresponding key are listed in Appendix 2. Data regarding the training of NTPs were also extracted into a master table, which was checked by another reviewer (MWW). The data extraction forms and master table were then used to create five tables to describe the study characteristics and training based on the research questions identified for the review. Due to the large tables, only the tables of characteristics of the NTPs, the content of the training and supervision will be presented in the main text, with the remaining tables presented in the Appendix.

5.2.2.6. Methodological assessment

Given the possible methodological heterogeneity based on the eligibility criteria, and to also assess the quality of the documentation of training within papers, a 10-point methodological quality assessment schema was created based on a framework by Liu et al. (2016). It examines the details reported on the documentation of the NTPs (i.e., number of NTPs, selection process and education level), training methods (i.e., details on the method and content of training, the trainer and evaluation of training) and supervision (i.e., details on the supervision and if fidelity to the

intervention was assessed) in each study. Studies are given a point for each of the criteria they satisfy. For example, studies in which the education level of the NTPs were stated were given a score out of 1, and those where it was not reported were given a score of 0. The author undertook this assessment, which can be seen in Appendix 6.

5.3. Results

After removing duplicates, the initial searches generated 6287 studies. A total of 30 articles met the eligibility criteria and were included in the review. Figure 5.1 presents the flow chart of searches.

The characteristics of the included studies are described in Appendix 7. Results are reported in line with PRISMA guidelines (Moher et al., 2009).

Out of the 30 studies included, 8 studies (26.7%) were conducted in Pakistan (Ali et al., 2003; Ali et al., 2010; Hirani et al., 2010; Khan et al., 2017; Rahman et al., 2016; Rahman, Khan, et al., 2019; Rahman et al., 2008; Sikander et al., 2019), 6 studies (20%) were conducted in India (Fuhr et al., 2019; Joag et al., 2020; Patel et al., 2010; Patel et al., 2017; Shidhaye et al., 2017; Tripathy et al., 2010), 3 (10%) in Kenya (Bryant et al., 2017; Dawson et al., 2016; Musyimi, Mutiso, Ndetei, et al., 2017), 2 (6.7%) in Nepal (Jordans et al., 2019; Pokhrel et al., 2018) and 3 (10%) in South Africa (Lund et al., 2019; Myers et al., 2019; Rotheram-Borus et al., 2015). One study (3.3%) each was conducted in Indonesia (Bass et al., 2012), Uganda (Bolton et al., 2003), Thailand (Bolton et al., 2014) and Mexico (Edelblute et al., 2014).

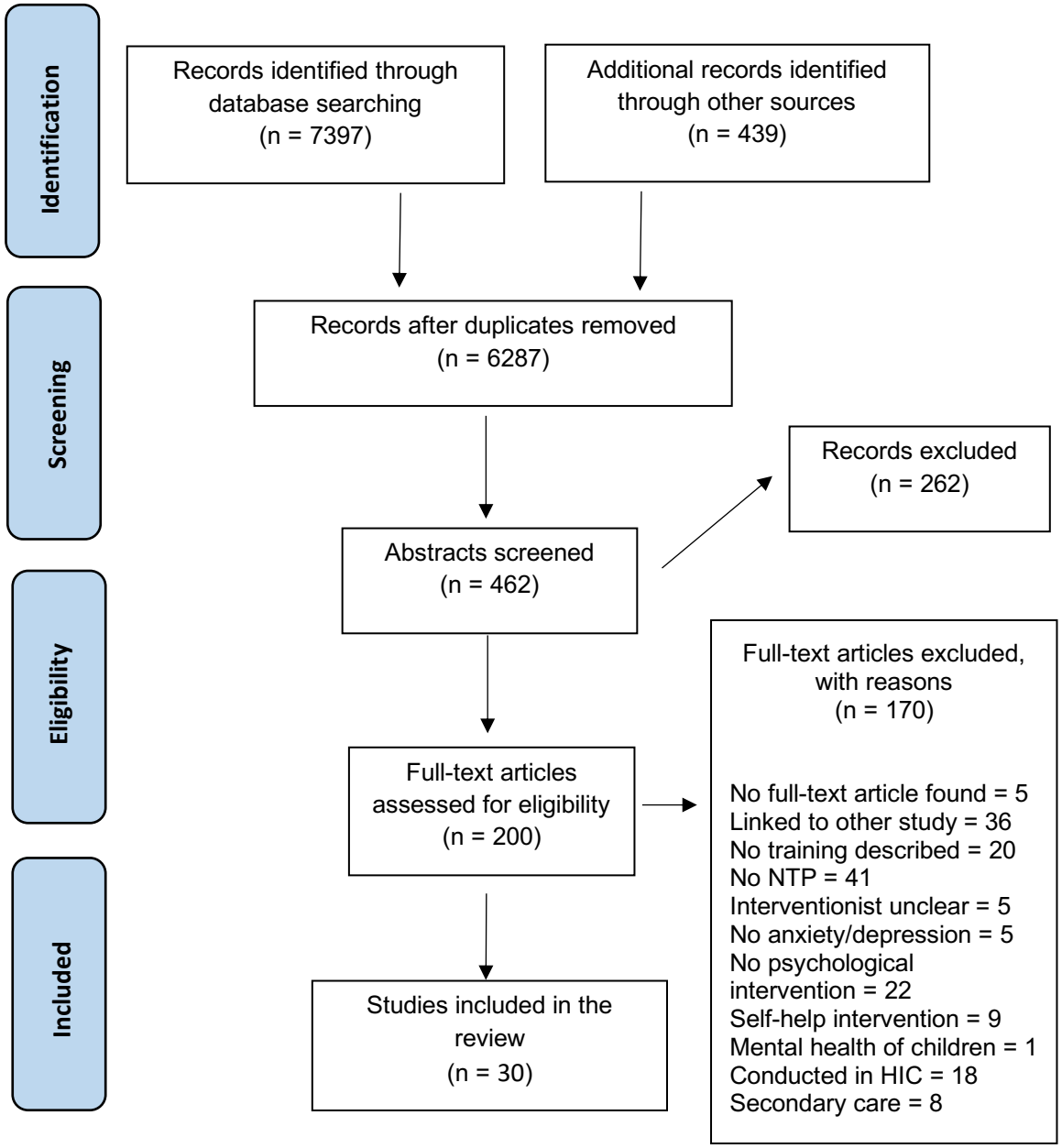
Four studies (13.3%) used a pre–post study design (Ali et al., 2010; Bass et al., 2012; Musyimi, Mutiso, Ndetei, et al., 2017), one of which was a mixed-method study where NTPs were interviewed on the barriers, facilitators and processes in the intervention implementation. Another study also used a mixed-methods approach where the feasibility of the intervention was assessed by examining the number of patients who were willing to be screened, met the inclusion criteria, provided consent, completed the intervention and were retained in the study. Furthermore, qualitative interviews were carried out with the NTPs to assess the acceptability of the delivery approach used. One study investigated the contact coverage of the intervention in a particular area using a cross-sectional population-based follow-up (Shidhaye et al., 2017). The remaining studies (40%) were randomised trials, of which one was non-controlled (Chibanda et al., 2011), and the rest were controlled trials, 11 (36.7%) of which were cluster randomised controlled trials (cCRTs).

In the majority of the studies (70%), the outcome being investigated was depression, which in three (10%) was co-occurring with anxiety (Ali et al., 2010; Bass et al., 2012; Khan et al., 2017; Lund et al., 2019) and in six (20%) focused specifically on perinatal depression (Fuhr et al., 2019; Lund et al., 2019; Rahman et al., 2008; Rotheram-Borus et al., 2015; Sikander et al., 2019; Tripathy et al., 2010). Four studies (13.3%) delivered an intervention to participants with psychological distress (Bryant et al., 2017; Dawson et al., 2016; Rahman et al., 2016; Rahman, Khan, et al., 2019), and four studies (13.3%) focused on adults with CMDs (Chibanda et al., 2011; Chibanda et al., 2016; Joag et al., 2020; Patel et al., 2010).

In 14 studies (46.7%), the target population were women who were pregnant (Rahman et al., 2008; Rotheram-Borus et al., 2015; Sikander et al., 2019), attending antenatal clinics (Fuhr et al., 2019;

Lund et al., 2019) or were in the postnatal period (Ali et al., 2010; Tripathy et al., 2010). Two studies (6.7%) also used women who had been affected by gender-based violence (Bryant et al., 2017; Dawson et al., 2016) and in one study (3.3%), the women had been affected by migration (Edelblute et al., 2014). Eight studies (26.7%) recruited participants from primary healthcare clinics (Chibanda et al., 2016; Jordans et al., 2019; Patel et al., 2010; Patel et al., 2017), two (6.7%) of which were adults living with HIV (Chibanda et al., 2011; Petersen et al., 2014) or adults suffering from chronic diseases (3.3%; Myers et al., 2019). Adults with HIV were also the target population in another study, where the intervention was delivered in community-based settings (Pokhrel et al., 2018). Furthermore, one study (3.3%) focused on Burmese refugees (Bolton et al., 2014), and another study targeted an intervention towards war-affected adults (Bass et al., 2012).

Figure 5.1. PRISMA flowchart representing the process of identifying relevant papers in LMICs (Moher et al., 2009)



5.3.1. Types of psychological interventions

Six studies (20%) focused on counselling the participants (Ali et al., 2003; Ali et al., 2010; Bass et al., 2012; Joag et al., 2020; Lund et al., 2019), which in one study involved comparing the effects of counselling to economic skill building (Hirani et al., 2010). Another study also focused on counselling and peer support which was delivered in a home-based setting (Pokhrel et al., 2018). Five studies (16.7%) delivered an intervention called Problem Management Plus (PM+), a brief multicomponent intervention based on behavioural activation and problem-solving techniques (Bryant et al., 2017; Dawson et al., 2016; Khan et al., 2017; Rahman et al., 2016; Rahman, Khan, et al., 2019). Similarly, PST was the focus of a further three studies (10%; Chibanda et al., 2011), one of which was combined with motivational interviewing (Myers et al., 2019), and the other was combined with weekly peer support groups (Chibanda et al., 2016). Furthermore, group support was also the focus of investigation in two other studies (6.7%) which examined the effects of women's group meetings on depression (Edelblute et al., 2014; Tripathy et al., 2010). Three studies (10%) delivered Interpersonal Therapy (Bolton et al., 2003; Petersen et al., 2014), which in one study was part of a collaborative stepped-care intervention that involved the NTP delivering psychoeducation and Interpersonal Therapy for all non-drug treatments in collaboration with the Primary Care Practitioner and clinical specialists (Patel et al., 2010). One study (3.3%) delivered an intervention specifically designed for use in low-income settings called Common Elements Treatment Approach, which combines psychoeducation with behavioural activation and cognitive coping and restructuring techniques (Bolton et al., 2014). Three studies (10%) delivered the Thinking Healthy Programme, an intervention which was based on CBT, which in two studies (6.7%) was adapted to be acceptable for delivery by peers (Fuhr et al., 2019; Sikander et al., 2019). Similarly, the Healthy Activity Programme delivered in two studies (6.7%) was based on behavioural activation (Patel et al., 2017; Shidhaye et al., 2017). Lastly, one study (3.3%) investigated the effects of delivering mhGAP-IG-recommended interventions such as CBT or problem-solving (Musyimi, Mutiso, Ndetei, et al., 2017).

Almost all the interventions led to significant improvements or modest effects in the mental health outcomes of the participants with the exception of five studies (16.7%; Bass et al., 2012; Fuhr et al., 2019; Lund et al., 2019; Tripathy et al., 2010). In one of these studies, significant improvements were found with economic skill building but not counselling (Hirani et al., 2010). Furthermore, a study by Bass et al. (2012) demonstrated the positive effects of a counselling intervention on functioning but not mental health symptoms, and another study by Lund et al. (2019) found that task-sharing was neither effective or cost-effective at reducing mental health symptoms. However, the majority of studies (83.3%) led to the conclusion that the intervention could be delivered successfully by minimally trained individuals (Bolton et al., 2014; Chibanda et al., 2011; Chibanda et al., 2016; Fuhr et al., 2019; Naeem et al., 2003; Petersen et al., 2014; Rahman et al., 2016) and may be a feasible and acceptable approach (Khan et al., 2017; Rahman, Khan, et al., 2019; Sikander et al., 2019). Furthermore, an evaluation by Chibanda et al. (2011) on the experiences of lay workers delivering the intervention found that 90% of them rated themselves as able to deliver

the intervention. Similarly, another study employing a mixed-method approach to assess the feasibility and acceptability of an intervention found that CHWs viewed the counselling intervention as highly acceptable but requested additional training and support to facilitate implementation (Myers et al., 2019). Lastly, one study concluded that an NTP-delivered intervention could reduce the treatment gaps for depression and improve mental health literacy (Shidhaye et al., 2017).

The characteristic of interventions from the included studies are presented in Appendix 8.

5.3.2. Characteristics of NTPs

Seventeen studies (57%) used paraprofessionals already working within the health system, such as CHWs, lady health workers, traditional health practitioners, social collaborators, lay health counsellors and lay HIV counsellors. Two studies (6.7%) also recruited staff from charity organisations (Bass et al., 2012; Bolton et al., 2003) or local service organisations (Bolton et al., 2014). A few studies used local women from the community (Edelblute et al., 2014; Khan et al., 2017; Tripathy et al., 2010), which in two studies involved them having a similar sociodemographic background to the participants and therefore can be considered as peers (Fuhr et al., 2019; Sikander et al., 2019). Furthermore, in these two studies, the NTPs were given the names 'Sakhis' in India and 'Razakaar' in Pakistan, which translated to 'volunteers'. Lastly, two studies (6.7%) used lay individuals without specifying who they were (Khan et al., 2017; Patel et al., 2017), and in five studies (16.7%), the lay individuals were referred to as counsellors (Ali et al., 2003; Bass et al., 2012; Bolton et al., 2003; Jordans et al., 2019; Shidhaye et al., 2017).

Out of the twenty-four studies describing the selection of the NTPs, seven studies (29.2%) used NTPs who were working within the participating clinics (Chibanda et al., 2011; Chibanda et al., 2016; Myers et al., 2019; Patel et al., 2010; Petersen et al., 2014; Rahman et al., 2016; Rahman et al., 2008), and in four studies (16.7%), NTPs were identified by the community (Edelblute et al., 2014; Fuhr et al., 2019; Sikander et al., 2019; Tripathy et al., 2010). Furthermore, one study (4.2%) recruited NTPs through advertisements and selected them on the basis of their performance in an interview which involved a questionnaire and a brief role-play (Patel et al., 2017). In five studies (20.8%), NTPs were selected on the basis of their communication skills and their ability to speak the local language (Ali et al., 2003; Ali et al., 2010; Fuhr et al., 2019; Patel et al., 2017; Sikander et al., 2019). Furthermore, in three studies (12.5%), NTPs who had shown a willingness to work voluntarily and a desire to help were selected (Fuhr et al., 2019; Joag et al., 2020; Sikander et al., 2019). Moreover, in some studies, NTPs were selected based on their available time and willingness to spare time for training (Edelblute et al., 2014; Joag et al., 2020), which in Patel et al. (2017) also included a two-year commitment to the pilot and future trial. Furthermore, in four studies (16.7%), the selection criteria included the ability to move freely within the community (Ali et al., 2003; Ali et al., 2010; Fuhr et al., 2019; Sikander et al., 2019).

Out of the sixteen studies describing the education of the NTPs, thirteen studies (81.3%) used NTPs who had minimal education ranging from nine to sixteen years, with many only completing secondary school education (Bolton et al., 2003; Jordans et al., 2019; Rahman et al., 2016; Rahman et al., 2008). Furthermore, NTPs who were working within healthcare had specific training to carry out their duties. In one study, this involved the use of lady health workers who had been trained to provide preventative maternal and child healthcare and education (Rahman et al., 2008), Similarly, another study used LHWs who had previous training in home-based care for people living with HIV, in community follow-up of persons on TB treatment and also in delivering community health education and promotion (Chibanda et al., 2011). Lastly, two studies (12.5%)

used NTPs who were university graduates but who had no experience in mental healthcare (Rahman, Khan, et al., 2019; Shidhaye et al., 2017).

Table 5.2 presents the characteristics of the NTPs as described in the study.

5.3.3. Delivery of training

The processes involved in the development of the training were poorly reported and only described in six studies (20%). In some studies, this involved simplifying the existing intervention materials to make it deliverable by non-clinicians (Bolton et al., 2003; Chibanda et al., 2011; Fuhr et al., 2019; Sikander et al., 2019). Furthermore, in Joag et al. (2020) the training manual was piloted among selected NTPs before training the remaining NTPs. Similarly, in Chibanda et al. (2011), the training and intervention were pre-tested with NTPs and patients to assess for acceptability.

The delivery of training was reported in twenty-nine out of the thirty studies. In the majority of studies (69%), training of the NTPs was delivered by a professional with expertise in the mental health field such as a psychiatrist or psychologist, which in five studies (17.2%) also involved them being a member of the research team (Bryant et al., 2017; Dawson et al., 2016; Murphy et al., 2020; Rahman et al., 2008). Training was delivered by members of the research team in a further two studies (6.9%); however, it was unclear who provided the training and what their level of expertise was (Hirani et al., 2010; Patel et al., 2010). A few studies (17.2%) provided training through collaboration of different specialists including family practitioners, psychologists, psychiatrists and therapists (Ali et al., 2003; Ali et al., 2010; Patel et al., 2017). Furthermore, two studies (6.9%) used trainers who had degrees in social sciences (Chibanda et al., 2016; Sikander et al., 2019). Lastly, four studies (13.8%) used staff from local organisations and programmes; however, their qualifications were unknown (Bass et al., 2012; Rotheram-Borus et al., 2015; Shidhaye et al., 2017).

The duration of training was reported in twenty-seven out of the thirty studies (90%). Training typically lasted between two to ten days (63%). However, some studies indicated that training lasted over several weeks or months (37%), with three studies (11.1%) providing additional training a few months later (Bass et al., 2012; Joag et al., 2020; Rahman et al., 2008). Furthermore, several studies (22.2%) allocated time for classroom and field training (Dawson et al., 2016; Fuhr et al., 2019; Jordans et al., 2019; Murphy et al., 2020; Sikander et al., 2019).

The format of the training was poorly described, with 14 studies (46.7%) not describing methods used in training. Out of the twenty-six studies that did, ten (38.5%) used a combination of didactic and experiential techniques which involved lectures (Jordans et al., 2019), role-play (Musyimi, Mutiso, Ndetei, et al., 2017), discussions (Fuhr et al., 2019; Sikander et al., 2019) and skills practice (Bryant et al., 2017).

Table 5.3 presents the characteristics of training including content and methods of delivery.

Table 5.2. Characteristics of NTPs delivering psychological interventions

Author (year)	NTP (No)	Selection	Job Role/Education and Experience
Ali et al., 2003	Counsellors (21)	Selected on the basis of their communication skills, motivation, attitude, ability to read and write Urdu and freedom to move in the community.	Not specified
Ali et al., 2010	CHWs (11)	Selected as counsellors based on their ability to maintain confidentiality, communicate empathically and to gain permission from family to move freely in the community.	Not specified
Bass et al., 2012	RATA counsellors (unknown)	Local lay individuals working for a local torture survivor and treatment organisation.	No formal degrees or education prior to training. Education not specified
Bolton et al., 2003	Group leader (9–10)	Local person of the same sex as the sex-segregated group; non-clinicians fluent in English and Luganda employed by World Vision.	Completed high school education
Bolton et al., 2014	Counsellors (20)	Staff at one of three local service organisations; qualifications were literacy in Burmese and demonstrated interest in mental health and counselling. All counsellors were Burmese refugees; were members of the Burmese community in Mae Sot and shared many cultural, religious, and political experiences with their clients.	Some had worked previously as teachers (n=7) or health workers (n=4), 2 had prior general counselling experience
Bryant et al., 2017	CHWs (23)	Not specified.	10 years' school education
Chibanda et al., 2011	LHWs (unknown)	Selected at random from participating clinics. All LHWs were female, literate, have at least primary school education and have lived locally for at least 15 years.	Average education of 8 years and previous training in home-based care for people living with HIV & AIDS, in community follow-up of persons on TB treatment and in delivering community health education and promotion
Chibanda et al., 2016	LHWs (11)	Attached to participating clinic. All LHWs in the study were female, able to use a mobile phone and resided near their respective clinic.	Mean of 10 years of education

Table 5.2. Characteristics of NTPs delivering psychological interventions

Author (year)	NTP (No)	Selection	Job Role/Education and Experience
Dawson et al., 2016	CHWs (23)	Women engaged in community health work with the government.	Varied levels of education (not specified) and did not have any training or experience in mental health care
Edelblute et al., 2014	Promotoras (7)	Based on community recommendations, church catechists were recruited through the local Catholic parish. Selected due to their community leadership roles and literacy level. Eligibility criteria for the promotoras included being a female over 18 years of age, the ability to read and write, availability for the 5-day training and few or no symptoms of depression.	Not specified
Fuhr et al., 2019 [a]	Sakhis (26)	Women who had shown an interest or desire to help and support other women within their community. Sakhis were recruited from the local community through word of mouth, particularly through key informants in women's self-help groups and CHWs. Selected based on similar socio-demographic background and life experiences to that of the target population, emotional maturity/range of life experience, motherhood experience, willingness to learn new skills, good interpersonal skills, ability to relate to mothers and their families, trustworthy, patient, non-judgmental, respectful and compassionate, energy/drive and enthusiasm, some understanding of maternal and child health issues, fluent in local language and able to move in the community freely including if the target population is slightly far off from her place of residence.	Minimum 7 years of schooling
Hirani et al., 2010	CHWs (unknown)	Not specified.	Not specified

Table 5.2. Characteristics of NTPs delivering psychological interventions

Author (year)	NTP (No)	Selection	Job Role/Education and Experience
Joag et al., 2020	Atmiyata Champions (59), Mitras (264)	The selection criteria for Champions were willingness to work voluntarily, leadership qualities or a leader of self-help group and farmer's club, understanding of geography and social dynamics of the village community, readiness to give time for the training and actual work, basic literacy skills, interest and enthusiasm for the work. Mitras were selected on the basis of their willingness to work voluntarily and give time for training and work.	Not specified
Jordans et al., 2019	Community-based counsellors (6)	Not specified.	Completed at least a high-school education
Khan et al., 2017	Lay helpers (2)	Not specified.	16 years of education
Lund et al., 2019 [b]	CHWs (6)	Recruited from a local non-government organisation. Selected after the training based on their understanding of the training material, their level of empathy and interpersonal style displayed during the role-plays.	Education levels ranging from grade 9–12 and had at least two and a half years of previous experience in the community doing health promotion
Murphy et al., 2020	Social collaborators (unknown)	Social collaborators were selected to deliver the intervention in consultation with staff at the Ministry of Labour, Invalids and Social Affairs.	Based in the community, support families and provide services; training and experience of social collaborators varied greatly (not specified)
Musiyimi et al., 2017 [c]	Traditional health practitioners (unknown)	Traditional health practitioners were selected from a list of healers provided by traditional and faith healers', Makueni County representatives in four regions of the county.	Not specified
Myers et al., 2019	CHWs (7)	CHWs selected from participating clinics.	Completion of high school and training as HIV adherence counsellors
Patel et al., 2010	LHCs (unknown)	LHCs selected from participating clinics.	Non-healthcare backgrounds. Education not specified

Table 5.2. Characteristics of NTPs delivering psychological interventions

Author (year)	NTP (No)	Selection	Job Role/Education and Experience
Patel et al., 2017 [d]	Lay counsellor (11)	Lay therapists were recruited through advertisements in newspapers and a local television channel. Candidates were selected by mental health experts to be interviewed. Essential criteria were the completion of 10th-grade education and fluency in local languages. Desirable criteria were having a higher education beyond 10th grade, lack of prior professional training in mental health, and a two-year commitment to the pilot and future trial. The interview entailed a structured questionnaire and a brief role-play in which candidates were asked to counsel a friend. Lay therapists were evaluated based on their willingness to be part of a team, communication and interpersonal skills.	Average of 15 years' education
Petersen et al., 2014	Lay HIV counsellors (2)	HIV counsellors selected from participating clinic.	Lay HIV counsellors provide health counselling and testing; education not specified
Pokhrel et al., 2018	CHW (1) HIV-positive person (1), social worker (1)	Not specified.	Not specified
Rahman et al., 2008	Lady health workers (4)	Lady health workers attached to participating clinics.	Completed secondary school and are trained to provide mainly preventive maternal and child health care and education in the community
Rahman et al., 2016	Lady health workers (9)	Lady health workers attached to participating clinics.	12 to 16 years of education with no previous clinical training or experience in counselling, social work, clinical psychology or psychiatry
Rahman et al., 2019	Facilitators (6)	Not specified.	Local graduates with bachelor's degrees without mental healthcare experience

Table 5.2. Characteristics of NTPs delivering psychological interventions

Author (year)	NTP (No)	Selection	Job Role/Education and Experience
Rotheram-Borus et al., 2015	CHWs (12)	Selected because of their good social and problem-solving skills and success in raising their own healthy children.	Not specified
Shidhaye et al., 2017	CHWs (39), counsellors (8)	CHWs were residents of the village.	None of them had any formal training or prior experience of working in the health sector except for 12 workers who were accredited social health activists; counsellors were university graduates but without formal training in psychology or counselling
Sikander et al., 2019 [a]	Razakaars (66)	Razakaars were identified by lady health workers and community elders. Selected based on similar socio-demographic background and life experiences to the target population, emotional maturity/range of life experience, motherhood experience, willingness to learn new skills, good interpersonal skills, ability to relate to mothers and their families, trustworthy, patient, non-judgmental, respectful and compassionate, energy/drive and enthusiasm, some understanding of maternal and child health issues, fluent in local language and able to move in the community freely including if the target population is slightly far off from her place of residence.	Average of 12 years of education
Tripathy et al., 2010	Local women (unknown)	Selected on the basis of criteria identified by the community which included being able to speak the local language and having the ability to travel to meetings.	Not specified

[a] Data extracted from (Atif et al., 2019); [b] Data extracted from (Munodawafa et al., 2017); [c] Data extracted from (Musyimi, Mutiso, Musau, et al., 2017); Data extracted from (Daisy R. Singla et al., 2014)

CHWs, Community Health Workers; RATA, A local torture survivor and treatment organisation; LHWs, Lay Health Workers, LHCs, Lay Health Counsellors; CES-D, Centre for Epidemiologic Studies Depression Scale

5.3.4. Content of training

5.3.4.1. Training for NTPs delivering interventions for CMDs

All but one study described the content of the training received by the NTPs. The majority of studies (75.9%) indicated that training covered basic knowledge on the target mental health condition. A few studies (13.8%) also trained NTPs on how to identify and assess these mental health conditions (Musyimi, Mutiso, Ndetei, et al., 2017; Myers et al., 2019; Shidhaye et al., 2017), which in one study included training in screening for depression using the Self-Reporting Questionnaire-20 (SRQ-20; Murphy et al., 2020). Furthermore, in some studies (10.3%), the NTPs were also trained to identify and address symptom worsening (Dawson et al., 2016; Fuhr et al., 2019; Joag et al., 2020). Training also incorporated the development of the NTPs' skills in communication (Ali et al., 2003; Ali et al., 2010), group management (Bass et al., 2012; Joag et al., 2020; Khan et al., 2017; Rahman et al., 2016) and relationship building (Fuhr et al., 2019). Most studies (13.8%) focused on training in the delivery of intervention strategies (Fuhr et al., 2019; Hirani et al., 2010; Lund et al., 2019; Rahman et al., 2016), which included the development of counselling skills (Bryant et al., 2017; Chibanda et al., 2016; Dawson et al., 2016; Patel et al., 2010; Patel et al., 2017; Petersen et al., 2014; Rahman et al., 2016) and its application (Jordans et al., 2019). Whilst in other training this involved problem management skills (Bass et al., 2012; Petersen et al., 2014), problem-solving techniques (Ali et al., 2003; Ali et al., 2010; Chibanda et al., 2011; Chibanda et al., 2016; Rotheram-Borus et al., 2015) and behaviour change strategies (Rotheram-Borus et al., 2015). The training in Bolton et al. (2003) involved the NTPs drawing on their own experiences with losses and ways of expressing grief in the culture. Furthermore, when training on the topic of the development of depression following a disagreement, a real-life disagreement was worked on within the group and how Interpersonal Therapy could be used to understand it. Some studies (24%) also included training in self-care strategies for the NTP themselves (Bryant et al., 2017; Chibanda et al., 2016; Dawson et al., 2016; Khan et al., 2017; Rahman et al., 2016; Rahman, Khan, et al., 2019). Lastly, four studies (13.8%) also included training in research protocol, ethical and confidentiality matters (Bass et al., 2012; Bryant et al., 2017; Edelblute et al., 2014; Hirani et al., 2010).

5.3.4.2. Training for NTPs delivering interventions for perinatal depression

Of the seven studies conducted on perinatal depression, one (14.3%) investigated comorbid depression and anxiety (Ali et al., 2010). Three of the studies (42.9%; Fuhr et al., 2019; Rahman et al., 2008; Sikander et al., 2019) delivered the Thinking Healthy Programme, a CBT-based intervention designed to reduce perinatal depression. In Rahman et al. (2008), the intervention was delivered by lady health workers and involved training on how to educate mothers about unhealthy thinking styles. Meanwhile, in Fuhr (2019) and Sikander (2019), training involved educating peer volunteers (PVs) on psychosocial factors affecting mother-and-child health during the perinatal period. In another study (Ali et al., 2010), as well as being trained in counselling skills, NTPs were

also trained in monitoring the growth and development of the baby and also in the use of the early child development tool. Furthermore, they were trained to provide information regarding child-rearing practices such as promoting breastfeeding and advice on weaning and immunisation. In another study, which also included pregnant women living with HIV, training also incorporated topics regarding HIV and the prevention of mother-to-child transmission of HIV (Rotheram-Borus et al., 2015). In this study, the CHWs also received training on how to document their contacts with mothers using a mobile phone and a paper log system.

5.3.5. Training evaluation

As described in section 4.3.5, the evaluation of training is essential in ensuring that the training program has been effective and has achieved its intended purposes (Ellington et al., 1993). Training evaluation may include the assessment of competencies and is important to ensure fidelity to the intervention (Mars et al., 2013). Despite its importance, no evaluation was reported in over half of the studies (60%); however, it is unclear whether this is due to no evaluation being conducted or due to lack of documentation. In the 12 studies that did report some form of evaluation, in the majority of them (58.3%) this was conducted through competency assessments after training and prior to intervention delivery (Bryant et al., 2017; Dawson et al., 2016; Fuhr et al., 2019; Khan et al., 2017; Patel et al., 2017; Rahman et al., 2016; Sikander et al., 2019), which involved assessing competency through role-plays (Fuhr et al., 2019; Khan et al., 2017; Patel et al., 2017), mock interviews (Bryant et al., 2017) and direct observations of the intervention (Sikander et al., 2019). Unsatisfactory competency levels were addressed in two studies (16.7%; Bryant et al., 2017; Khan et al., 2017). In Bryant et al. (2017), failure to pass competency assessments led to three CHWs not participating in the trial whereas in Khan et al. (2017), low competency scores resulted in lay helpers receiving additional training in areas where scores were low alongside additional practice sessions in the field under supervision. This was followed by reassessments of competency until the NTPs were deemed competent to deliver the intervention. One study evaluated the NTPs three months after training and found statistical improvement in their knowledge, skills and confidence in detecting mental health conditions. Alternatively, in another study, the NTPs completed a questionnaire every six weeks during implementation of the intervention, which included rating themselves on the ease with which they learnt the intervention, the ease with which they delivered it and the proportion of participants who seemed to benefit from the intervention (Chibanda et al., 2011). Lastly, in half of the studies, the acceptability of the training was examined through interviews, in which their experiences in training and delivering the intervention was explored (Fuhr et al., 2019; Jordans et al., 2019; Khan et al., 2017; Lund et al., 2019; Myers et al., 2019; Sikander et al., 2019).

Table 5.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Ali et al., 2003	Basic information regarding anxiety/depression, stress/anger management and communication/ counselling skills. Communication covered active listening, probing and feedback whereas counselling dealt with supportive, problem-solving and cognitive-behavioural techniques.	Not specified	Not specified	11 three-hour sessions over 4 weeks	Family practitioner, a sociologist, a psychiatrist or three clinical psychologists	None
Ali et al., 2010	Basic information regarding anxiety/depression, stress/anger management and communication/ counselling skills. Communication covered principles of active listening, probing and feedback whereas counselling dealt with supportive, problem-solving and basic cognitive behavioural techniques. Counsellors were trained to monitor the growth and development of the indexed baby by measuring weight, height and head circumference and use the early childhood development tool and provide information regarding healthy child-rearing practices including care of the cord, avoiding traditional harmful practices, promoting breastfeeding and advice on timely weaning and immunisation.	Not specified	Not specified	5 half-days per week, for 4 weeks, each session being of 3 hours	Two family practitioners, a psychiatrist and a clinical psychologist	None

Table 5.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Bass et al., 2012	Topics included qualities of an effective helper, confidentiality, empathy, listening and responding, questioning and problem management skills, stress and coping and information specifically on the consequences and needs of torture survivors. After a few months of providing individual services, the counsellors were provided with a second training on implementing the program in a group format, including skills for group management.	Not specified	Training manual	5-day training, followed by a second period of training 3 months after	International Catholic Migration Commission	None
Bolton et al., 2003 [a b]	During the training, trainers and trainees shared their own experiences with loss, ways of expressing grief in the culture and the rituals involved. Depression following disagreements. When training on this topic, the training group worked on a real-life disagreement regarding the schedule and the amount of payment for the training and subsequent work. The group discussed the IPT stages of defining a disagreement: define the problem, understand one's own as well as the other side's expectations and generate culturally appropriate options to express one's views and wishes and ask for what one would like to see happen.	Didactic teaching and experiential group processes with role-plays and group exercises	Not specified	2 weeks	Two faculty members of the New York State Psychiatric Institute (team led by the developer of IPT and group IPT) assisted by a psychologist and an experienced group therapist employed by World Vision	None
Bolton et al., 2014	Not specified.	Practice groups led by one of three local supervisors	Not specified	10 days	Doctoral-level psychologists	None

Table 5.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Bryant et al., 2017	Training covered knowledge of common mental health conditions, basic counselling delivery, PM+ and self-care strategies. Training also addressed issues related to GBV, as well as ethical and confidentiality matters.	Skills practice under supervision of local supervisor	Not specified	8 days (64 hours); 1-day training in psychological first aid	Member of research team (clinical psychologist)	CHWs were assessed for competency based on the supervisor's evaluation of mock interviews
Chibanda et al., 2011	Training covered didactic lectures on CMDs, including *kufungisisa* (thinking too much) and focused on skills to identify CMDs and to manage CMDs using simple psychoeducation and PST.	Didactic lectures and skills practice	A client referral manual, which included a list of NGO's, private and public institutions and church organisations	8-day training	Two clinical psychologists, a general nurse trained in systemic counselling and a psychiatrist	Lay workers evaluated the intervention once every six weeks using a questionnaire; one focus group with six workers was conducted, and they were asked to describe their experiences of delivering the intervention
Chibanda et al., 2016	Training topics included CMDs, counselling skills, PST and self-care.	Not specified	Manual written by the Friendship Bench team.	9 days	District health promotion officers (master's level in either the social sciences, public health or health promotion)	None
Dawson et al., 2016	Training included the provision of basic theoretical knowledge of CMDs, basic counselling skills, delivery of the PM+ intervention and self-care practices. Also received training in psychological first aid to know how to react in case people were exposed to new traumatic events during the study.	Not specified	Not specified	8 days classroom training, 4 weeks of practice cases	PI (clinical psychologist)	CHWs were required to pass competency assessments prior to intervention delivery

Table 5.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Edelblute et al., 2014	(1) Introduction and group norms, sharing migration stories; (2) stress: causes, symptoms and coping methods and active listening techniques; (3) presentation by local psychologist: definitions of depression, anxiety and addiction; (4) 'listen, advise, support' model and addressing automatic thoughts; (5) coping skills and role-plays, evaluation and celebration. Also, training to handle potential problems such as group dynamic or fidelity issues according to study protocol. They also received extensive training on human research ethics and confidentiality.	Role-plays	Flipcharts, notebooks outlining each of the MESA intervention session's activities and goals	5 days	Study personnel and a local psychologist	None
Fuhr et al., 2019 [c]	Training focused on intervention content and relationship-building skills and included sessions on dealing with difficult situations, recognition of symptom worsening and serious adverse events	Interactive, comprising of discussion and roleplays	Field guides and activity workbook	5 days, 8 sessions classroom training delivered in 2 phases (the antenatal phase and the postnatal phase) and field training of 2 months	Master trainer (mental health specialist)	Quality of the intervention was ensured through assessing peers' competencies after training through role-plays; qualitative interviews with peers on the feasibility of training and intervention [c]
Hirani et al., 2010	Training included skill-building on components of the intervention as well as research ethics of privacy and confidentiality.	Not specified	Not specified	21 hours	Research team	None

Table 5.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Joag et al., 2020 [d]	Training included BA activation including theory of behaviour and its connection to emotions, cycle of inactivity and activity, activity scheduling and motivating a person to take on small tasks and monitor and follow-up. The manual was extensive and included an introduction to common mental and physical health complaints, information and guidance on how to start a conversation for those who may be experiencing distress; tips on how to conduct a mental health support group in the community; training on how to do active listening, problem-solving and BA and guidance on when and how to refer those with more severe symptoms to additional services.	A mix of theory sessions and practical sessions, ranging from classroom-based lectures, films and interactive discussions to roleplays, how to use symptom cards and practicing dialogue and counselling sessions	Training manual in Mirathi and English, which also included cue cards and symptom cards	Champions: 7 days over 3 weeks; 1-day refresher training every 3 months Mitras: 1-day training	Champions: PI (psychiatrist), project members (psychiatrist and behaviour change specialists) and BAIF employees with experience in social care and rural development; additional sessions were provided either by clinicians or by field supervisors; mitras: community facilitators and champions	None
Jordans et al., 2019 [e]	Training includes topics such as understanding counselling concepts and process, the understanding of mental health problems and the application of counselling skills and specific intervention strategies. Training on skills specific for targeted beneficiaries as well as generic concepts such as working with coping strategies, symptom management techniques, psychoeducation and strengthening of existing resources.	Classroom training and practice; role-plays, lectures and experiential workshops	Manuals that have been translated and pre-tested in the Nepali language	400 hours of classroom learning, 150 hours of clinical supervision, 350 hours of practice, and 10 hours of personal therapy over 6 months; additional 10-day training in HAP	Nepali psychologists	Qualitative study assessing perspectives of counsellors[†]

Table 5.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Khan et al., 2017	Training covered knowledge of CMDs, basic counselling and group management skills, the group PM+ intervention and self-care strategies.	Classroom and practice	Not specified	6-day training, 4-week practice	Master trainer (clinical psychologist)	Before delivering the intervention, lay helpers completed competency assessments that involved role-plays that were scored on fidelity to the treatment, competency of intervention delivery and counselling skills; post-intervention qualitative interviews on experiences
Lund et al., 2019	Training on how to implement manual-based intervention (mundowafa)	Not specified	Training manual	5 days	Clinical social worker	Post-intervention qualitative interviews on experiences*
Murphy et al., 2020	The classroom session involved an introduction to depression symptoms, aetiology, screening and the principles and practice of the ASW. Training also included screening for depression using the SRQ-20.	Classroom and field training	Not specified	1-day classroom, 2-day field training	Study team, a psychiatrist from the provincial psychiatric hospital and district-level representatives of the health and social services sectors	None
Musiyimi et al., 2017	Training to identify and deliver evidence-based mhGAP-IG psychosocial interventions to patients screening positive for depression and also training on the causes of depression and mental illness.	Highly interactive experiential learning composed of small-group work and role-plays	Not specified	2 days	Mental health professional	Evaluated at the end of three months after training and showed 12.27% statistical improvement in the practice of confidence, knowledge and skills

Table 5.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Myers et al., 2019	Training on screening for hazardous/harmful alcohol use and depression, the counselling programme and referral pathways.	Not specified	Not specified	3 days	Psychologist	Post-intervention qualitative interviews on experiences in training and intervention delivery
Patel et al., 2010	Training included how to deliver the various treatments, including counselling skills, psychoeducation, yoga and IPT.	Not specified	Training manual	2 months	Research team	None
Patel et al., 2017 [f]	Training in general counselling skills and the HAP. Components included: (1) understanding depression, (2) HAP, (3) style of an HAP counsellor, (4) phase-wide guide, (5) useful strategies for specific problems, (6) telephone counselling, and (7) role of medication.	Lectures, demonstrations by trainers and practice of specific skills via role-plays	HAP manual	3 weeks	Two psychiatrists, two clinical psychologists and two senior therapists with experience in the intervention	Lay therapists' knowledge was assessed via a multiple-choice exam as well as their performance on role-plays using standardised vignettes
Petersen et al., 2014	The first two days involved training in micro-counselling skills as well as different ways of helping, psycho-education, problem management, healthy thinking and getting active. The next two days involved training in the group-based sessions and drew on the techniques learnt during the first two days.	Not specified	Not specified	4 days	Clinical psychologist and clinical psychology trainees	None
Pokhrel et al., 2018	Training to improve skills on home-based palliative care and psychosocial support.	Not specified	Not specified	5 days	Community home-based care network	None
Rahman et al., 2008 [g]	Training in educating mothers about unhealthy thinking styles and how to identify them.	Not specified	Training manual with step-by-step instructions for each session and health calendar	2-day workshop and a 1-day refresher 3 months after the first training	Psychiatrist (research team)	None

Table 5.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Rahman et al., 2016	Training comprised education about CMD, basic counselling skills, delivery of intervention strategies and self-care.	Classroom training and on-the-job training	Not specified	8 days	Local mental health specialists	Competency assessments conducted following training
Rahman et al., 2019	Training included education on adversity and its effects on mental health, basic helping skills, the delivery of intervention strategies, skills in group facilitation and facilitator self-care.	Classroom training and practice cases	Not specified	7 days	Master trainer (clinical psychologist)	None
Rotheram-Borus et al., 2015	CHWs were trained for one month on how to document their contacts with mothers using a mobile phone and a paper log system and on the educational knowledge regarding key health topics: HIV/TB, prevention of mother-to-child transmission of HIV, alcohol, mental health, breastfeeding and malnutrition. The second month of training focused on the theory of behaviour change and skills to facilitate behaviour change: goal setting, problem-solving, relaxation, assertiveness and shaping.	Didactics and role-plays	Videotapes	2 months	Philani Programme (unknown)	None
Shidhaye et al., 2017	CHW: training on identifying depression, mental health first aid and mental health awareness program. HCs: not specified.	Not specified	Not specified	Not specified	CHW: Sangath staff HC: Not specified	None

Table 5.3. Characteristics of training delivered to NTPs

Author (year)	Content	Methods	Materials	Duration	Trainer	Evaluation
Sikander et al., 2019 [c h]	The classroom training aimed to (1) educate the peer volunteers on psychosocial factors affecting mother-and-child health during the perinatal period, (2) learn and practice basic counselling skills and (3) understand the intervention principles, contents and delivery mechanisms.	Lectures, discussions and activities, use of case scenarios, sharing personal experiences and role-plays	Reference manual, job aids and health calendar consisting of health charts aimed towards BA of the mothers	5-day classroom training and 3-month field training	Local trainers (university graduates with at least a bachelor's degree in health or social sciences and no prior mental health work experience)	Competency assessment through direct observations; assessed with a checklist based on the ENACT rating scale, immediately after training; interviews on the experiences of trainers and peer volunteers of delivering and receiving training and supervision [c h]
Tripathy et al., 2010	Training involved reviewing the cycle's contents and practicing participatory communication techniques.	Not specified	Not specified	7-day training	Not specified	None

[a] Data extracted from (Bass et al., 2006); [b] Data extracted from (Verdeli et al., 2003); [c] Data extracted from (Atif et al., 2017); [d] Data extracted from (Shields-Zeeman et al., 2017); [e] Data extracted from (Jordans et al., 2007); [f] Data extracted from (Daisy R. Singla et al., 2014); [g] Data extracted from (Rahman, 2007); [h] Data extracted from (Atif et al., 2019)

[†] In (Jordans et al., 2007); * In (Munodawafa et al., 2017)

CMD, Common Mental Disorder; ENACT, ENhancing Assessment of Common Therapeutic factors; LHCs, Lay Health Counsellors; PM+, Problem Management Plus; PST, Problem-Solving Therapy; MESA; Mujeres en Solidaridad Apoyandose; HAP, Healthy Activity Programme; mhGAP-IG, Mental Health Gap Action Programme-Intervention Guide; IPT, Interpersonal Therapy; ASW, Antidepressant Skills Workbook; BA, Behavioural Activation; PI, Principal Investigator; GBV, Gender-Based Violence; NGO, Non-government Organisation; SRQ-20, Self-Reporting Questionnaire-20

5.3.6. Supervision of NTPs

Two studies (6.7%) did not report on any supervision; however, it is unclear as to whether supervision was provided and has not been documented or no supervision was provided at all (Hirani et al., 2010; Pokhrel et al., 2018).

Out of the twenty-eight studies in which supervision was described, two (7.1%) did not indicate who conducted the supervision. In a number of studies (28.6%), supervision was conducted by a mental health professional (Ali et al., 2010; Bolton et al., 2003; Bolton et al., 2014; Bryant et al., 2017; Dawson et al., 2016; Patel et al., 2010) or a member of the research team (7.1%; Edelblute et al., 2014; Rahman et al., 2008). Following the apprenticeship model (Murray et al., 2011), eight studies (28.6%) used local supervisors who were trained by an expert (Bolton et al., 2014; Bryant et al., 2017; Dawson et al., 2016; Khan et al., 2017; Petersen et al., 2014; Rahman et al., 2016; Rahman, Khan, et al., 2019; Sikander et al., 2019). This approach involves three groups of individuals: (1) a master trainer who is an expert in the intervention; (2) supervisors, locals who are trained by the master trainer and are in weekly contact with them to receive consultation and coaching and 3) NTPs, locals who provide the intervention. In this model of training, the supervisors and NTPs receive initial training from the expert; subsequently, further training and supervision for the NTPs are provided by the supervisors whilst they receive ongoing support from the expert. Supervision of the supervisors often consisted of building skills in the intervention (Dawson et al., 2016; Rahman, Khan, et al., 2019), discussing cases with the master trainer (Bolton et al., 2014) and training in research principles (Dawson et al., 2016). In some of these studies, the master trainer was residing in another country; therefore, supervision of the local supervisors occurred via Internet calls (Bolton et al., 2014; Bryant et al., 2017; Dawson et al., 2016; Rahman et al., 2016; Rahman, Khan, et al., 2019). A further two studies also described the training of the trainers (Chibanda et al., 2016; Jordans et al., 2019), which in one study involved the trainers receiving the first of the intensive training course from the original developers of the training programme (Jordans et al., 2019).

Out of the twenty-eight studies reporting on supervision, five of them did not indicate the frequency (17.9%). In most studies (56.5%), supervision occurred weekly, however, in some it occurred fortnightly (17.4%) or even monthly (26%). In one study, the frequency of supervision decreased as the NTPs became more confident in delivering the intervention (Ali et al., 2010). In Chibanda et al. (2011), the frequency of supervision depended on the expertise of the supervisor, with more frequent supervision being provided by a nurse, occurring weekly, and monthly supervision being provided by a psychiatrist. Furthermore, the frequency of supervision also varied with format with group supervision occurring more frequently in Lund et al. (2019). In contrast, individual meetings occurred more frequently, occurring twice monthly in Joag et al. (2020), with peer-led group meetings occurring monthly. Out of the twenty-eight studies reporting on supervision, only fifteen (53.6%) described the format of supervision. which occurred in a group setting in the majority of studies (80%).

Only sixteen out of the twenty-eight studies (57.1%) described the content of the supervision, which entailed reviewing and refreshing the intervention components delivered by the NTPs (Dawson et al., 2016; Sikander et al., 2019), case management (Bolton et al., 2014; Lund et al., 2019; Rahman, Khan, et al., 2019) and sharing successes and difficulties (Fuhr et al., 2019; Lund et al., 2019; Myers et al., 2019; Rahman et al., 2008; Sikander et al., 2019). In some studies, supervision consisted of listening to audio recordings (Fuhr et al., 2019; Patel et al., 2017) and reinforcing weak areas that were identified through assessments (Rahman et al., 2016; Rahman, Khan, et al., 2019; Sikander et al., 2019). Furthermore, studies which involved supervision in a group format allowed for opportunities for peer learning in which experiences were shared and collective problem-solving occurred (Joag et al., 2020; Khan et al., 2017).

Details of the supervision are presented in Table 5.4. Two studies did not report on supervision; however, it is unclear as to whether supervision was provided and has not been documented or whether no supervision was provided at all (Hirani et al., 2010; Pokhrel et al., 2018).

5.3.7. Ensuring fidelity of the intervention

Assessing the fidelity of an intervention can strengthen the validity of a study and ensures that it can be replicated in real-life settings (Breitenstein et al., 2010). The competence of the NTP and adherence to the intervention protocol are essential in ensuring fidelity to the intervention remains high. However, despite this, fidelity checks were only reported in fifteen studies (53.6%). In three of these studies (20%), fidelity was ensured through supervision (Bolton et al., 2014; Joag et al., 2020; Murphy et al., 2020). In a study by Dawson et al. (2016), attempts were made at audio recording sessions. However, almost all the participants refused to consent due to concerns surrounding confidentiality, which led to NTPs documenting the intervention components that they delivered which were then checked against the intervention manual. In a number of studies, the intervention sessions were audio-recorded (Chibanda et al., 2016; Fuhr et al., 2019; Lund et al., 2019; Myers et al., 2019; Patel et al., 2017) or directly observed (Bryant et al., 2017; Rahman et al., 2016; Rahman, Khan, et al., 2019; Sikander et al., 2019), and a small percentage was rated on a checklist to ensure intervention components were being delivered. Lastly, a multi-tier review approach was used in a study that adopted the apprenticeship model (Bolton et al., 2014). This consisted of NTPs monitoring their own fidelity by checking off their own steps on a step sheet as well as completing a monitoring form after each session. In the second layer, supervisors assessed fidelity by reviewing the monitoring forms during group supervision. Finally, fidelity checking was conducted through weekly Internet calls between the supervisor and experts, in which the supervisors provided an objective report of the sessions.

Table 5.4. Characteristics of supervision of NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check	Training of trainers/supervisors
Ali et al., 2003	Women had ready access to members of the training team throughout the study period	Not specified	Not specified	Not specified	Not specified	None
Ali et al., 2010	Clinical psychologist	Daily, then weekly as they became better trained and more confident	Not specified	The counsellors kept notes of their sessions and discussed these with the supervisor	Not specified	None
Bass et al., 2012	International Catholic Migration Commission staff	Not specified	Group and individual	Not specified	Not specified	None
Bolton et al., 2003	Local World Vision mental health professionals	Not specified	Not specified	Not specified	Not specified	None
Bolton et al., 2014	Three local supervisors (a doctor, a mental, health counsellor and a former political prisoner with no counselling experience or advanced degree)	2–4 hours, weekly	Group	Presentation of each and every case, review of client assessments and counsellors' treatment plans, review sessions, role-plays to practice components and planning upcoming sessions	Fidelity ensured through review of cases during supervision	Local supervisors received at least two hours/week of supervision from the U.S.-based trainers (doctoral-level psychologists) by phone call, Internet call and/or e-mail. All cases were then reported on and discussed with U.S.-based CETA trainers each week, who documented details of each case.

Table 5.4. Characteristics of supervision of NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check	Training of trainers/supervisors
Bryant et al., 2017	Two local supervisors (psychologists)	2 hours, weekly	Group	Not specified	To assess protocol adherence, 10% of randomly selected PM+ sessions were attended by a supervisor who used a checklist to ensure relevant treatment elements were provided.	The local supervisors received 1.5 hours of weekly training and mentoring in supervision via Skype. They were trained in ENACT to assess for key strategies required of CHWs.
Chibanda et al., 2011	A clinic staff nurse trained in counselling and clinical psychologist and psychiatrist	Weekly by nurse, fortnightly by psychologist (1 hour) and monthly by psychiatrist (45 minutes)	Group	Not specified	Not specified	None
Chibanda et al., 2016 [a]	Senior health promotion officers	Not specified	Not specified	Not specified	All sessions were audio-recorded and assessed using a checklist to ensure LHWs had covered all the critical components.	Two months' training on CMDs and the use of screening tools. Support from the clinical psychologists and psychiatrists.

Table 5.4. Characteristics of supervision of NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check	Training of trainers/supervisors
Dawson et al., 2016	Three local supervisors (clinical psychologists)	Weekly	Not specified	Intervention components delivered by the CHWs were reviewed	CHWs documented the treatment components they delivered for each session, which was checked against the specific components to be delivered according to the intervention manual. These forms were reviewed in supervision. Supervisors identified when fidelity was breached, and CHWs were required to deliver the treatment component in the subsequent session.	Participated in the same training as CHWs. The local supervisors were supervised weekly to fortnightly for one to two hours by the master trainer and a fourth local supervisor. Supervision comprised of building skills in the PM+ intervention as well as in training and supervision of CHWs with emphasis on research principles, such as standardisation and fidelity of treatment.
Edelblute et al., 2014	Study personnel	Weekly	Home visits and via phone	Discuss group dynamics, the effectiveness of different activities and any issues they may have experienced in leading the group the previous week	Not specified	None
Fuhr et al., 2019	THPP trainers	Fortnightly	Group, 2 individual supervisions	An audio-recorded session delivered by a Sakhi was played at each session, and successes and difficulties were discussed	Quality of the intervention was ensured through assessing peers' competencies after intervention delivery, through audio-recorded sessions. A random sample of 5% of audio-recorded sessions were rated on the Therapy Quality Scale.	None

Table 5.4. Characteristics of supervision of NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check	Training of trainers/supervisors
Hirani et al., 2010	None	None	None	None	None	None
Joag et al., 2020	Community facilitators	Bi-monthly individual, monthly peer	Individual, group	Community facilitators during their monitoring visits asked champions about counselling sessions. They provided hands-on support and coaching to champions within their own real-world working environment. Peer supervision involved champions sharing experiences or insights and provided a peer-to-peer platform for enhancing ways of working or skills used in the field.	Through supervision	Project lead and project manager supported and mentored community facilitators through monthly meetings.
Jordans et al., 2019 [b]	Nepali psychologist	Fortnightly	Not specified	Not specified	Competence in psychological treatments and other mental health services assessed through ENACT	Received the first of the intensive training course from the original developers of the training.

Table 5.4. Characteristics of supervision of NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check	Training of trainers/supervisors
Khan et al., 2017	Non-specialist supervisors	2–3 hours, weekly	Group supervision via Skype	Provided opportunities for peer learning and collective problem-solving	Before delivering the intervention, lay helpers completed competency assessments which involved role-plays that were scored on fidelity to the treatment, competency of intervention delivery and counselling skills.	The non-specialist supervisors received the same six-day training as the lay helpers by the master trainer.
Lund et al., 2019 [c]	Clinical social worker	2–3 hours, weekly group, 30 minutes, monthly individual	Group, Individual	Supervision focused on updates on participant progress, discussion of difficult cases, follow-ups on previous referrals and feedback on session notes. The counsellors reflected on their feelings whilst they were conducting the sessions and discussed these. The supervisor took field notes during supervision, and counsellors were offered mental health support by external counsellors if needed.	All counselling sessions were audio-recorded. The supervisor observed initial sessions and assessed fidelity on a checklist by listening to audio recordings of the sessions on a weekly basis depending on the issues raised by the counsellors. If counsellors felt uncertain about conducting a session or if the supervisor felt that most of the counsellors needed additional training based on fidelity checks, the supervisor provided training to revise key aspects of the intervention.	None
Murphy et al., 2020	Social worker	2 visits over 2 months	Not specified	Not specified	Through supervision	None

Table 5.4. Characteristics of supervision of NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check	Training of trainers/supervisors
Musiyimi et al., 2017	Not specified	Monthly	Not specified	Not specified	Not specified	None
Myers et al., 2019	Psychological counsellor	Weekly	Individual	Feedback on counselling sessions and how to improve fidelity and quality of counselling, retraining in aspects of the programme occurred if needed, and debriefing was provided for difficult or challenging cases.	All counselling sessions were audiotaped, and a random sample was reviewed for fidelity using a simple fidelity checklist.	None
Patel et al., 2010 [d]	Psychiatrist	Not specified	Not specified	Not specified	Not specified	Not specified
Patel et al., 2017	Expert	90 minutes, weekly	Group	Audio recordings were listened to, rated and discussed, and feedback was provided by all group members to the lay therapist whose tape was being rated.	Individual treatment sessions were audio-recorded and assessed using the Quality of the Healthy Activity Programme (Q-HAP) scale.	None
Petersen et al., 2014	Clinical psychology trainees	Weekly for 2 months, and then monthly	Not specified	Not specified	None	Trainees were supported by the clinical psychologist.
Pokhrel et al., 2018	None	None	None	None	None	None
Rahman et al., 2008	Experienced members of the research team	Half-day, monthly	Not specified	Involved brainstorming for solutions and discussing successes and failures in a supportive environment.	None	None

Table 5.4. Characteristics of supervision of NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check	Training of trainers/supervisors
Rahman et al., 2016	In-country supervisors	2 hours, weekly	Group	Weak areas that were identified through observations were reinforced during supervision.	During the intervention, a supervisor directly observed a randomly selected sample of 10% of sessions and used a checklist to systematically assess fidelity to the intervention, rating each session overall as satisfactory or unsatisfactory in terms of fidelity achieved.	Received 6-day training and supervised (1–2 hours per month via Skype) by the master trainer (clinical psychologists), building their skills in the intervention and in training and supervision of others.
Rahman et al., 2019	In-country supervisors	2 hours, weekly	Group via Skype	Supervision included review of participants' progress and individual case management, refresher training on strategies and rehearsing skills through role-play. Weak areas that were identified through observations were reinforced during supervision.	Intervention fidelity was monitored by independent observers in 15% of randomly selected sessions of each facilitator against a checklist consisting of items capturing key intervention strategies for each session. On the basis of this evaluation, the supervisor rated the overall fidelity of each session as satisfactory or unsatisfactory.	Supervisors received 1.5 hours of fortnightly supervision via Skype by the master trainer in Australia.
Rotheram-Borus et al., 2015	Not specified	Bi-monthly visits, monthly meetings	Site visits, in-service training meetings	Review of charts during visits and refresher training and role-plays of difficult cases during monthly meetings.	None	None

Table 5.4. Characteristics of supervision of NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check	Training of trainers/supervisors
Shidhaye et al., 2017	CHWs: HCs and Sangath clinical director HCs: Not specified	Monthly	Not specified	The CHWs submitted their weekly reports to the HCs who compiled these reports and also maintained case records of all the patients enrolled for HAP sessions. HCs also maintained the records of outpatient clinics. All the records were submitted to the monitoring and evaluation officer at the end of the month, and the progress was discussed in monthly meetings. The feedback was then given to the HCs and CHWs.	None	None

Table 5.4. Characteristics of supervision of NTPs

Author (year)	Who supervised?	Frequency	Format	Content	Fidelity check	Training of trainers/supervisors
Sikander et al., 2019 [e]	THPP trainers (university graduates)	Fortnightly	Group and individual field supervision	Supervision included (1) exploring the peer volunteers' experience of delivering the sessions, (2) discussing challenges and how best to deal with them, (3) revising the content of the THPP and practicing through role-plays and (4) sharing the success stories and ensuring peer volunteers' motivation and well-being. Any gaps in the knowledge and skills identified through assessments were addressed during supervisions.	Quality of the intervention was ensured through assessing peers' competencies, on the assessment forms, during direct observations. Trainers assessed competency with a checklist based on the ENACT rating scale, immediately after training and six months after training. Peers were assessed on their ability to engage with the mothers using basic counselling skills and on intervention specific skills.	THPP trainers received 20 hours of classroom and 6 months of field training and were supervised fortnightly via skype by the master trainer (mental health specialist).
Tripathy et al., 2010	District coordinators	Fortnightly	Not specified	Not specified	None	None

[a] Data extracted from (Chibanda et al., 2015); [b] Data extracted from (Jordans et al., 2016); [c] Data extracted from (Munodawafa et al., 2017); [d] Data extracted from (Pereira et al., 2011); [e] Data extracted from (Atif et al., 2019)

CETA, Common-Elements Treatment Approach; CHWs, Community Health Workers; PM+, Problem Management Plus; LHWs, Lay Health Workers; CMD, Common Mental Disorders; THPP, Thinking Healthy Programme-Peer Delivered; HAP, Healthy Activity Programme; HIC, Health Counsellor; ENACT, ENhancing Assessment of Common Therapeutic factors

5.4. Discussion

5.4.1. Summary of the findings

The objective of this review was to synthesise the evidence base for training and supervision of NTPs delivering psychological interventions for CMDs in LMICs. Based on our search criteria, we identified 30 studies. The majority of these studies targeted depression and delivered interventions in community-based settings. Almost half (47%) of the studies delivered interventions towards women with the majority of them focusing on perinatal depression. We intend for this review to help inform and promote the training of NTPs in HICs in the delivery of psychological interventions.

The most common NTPs were individuals working within community healthcare such as CHWs and lady health workers or peers with similar sociodemographic characteristics to the target population. The use of such NTPs reflects the attempts to disseminate effective psychological treatments globally by using local resources in poor resource settings (Fairburn & Patel, 2014) and also supports research that demonstrates community preference for local and similar providers (D. Singla et al., 2014). Education and selection criteria also reflected the nature of using this type of NTPs in poor income settings, with many studies requiring NTPs to have a secondary school education. Furthermore, studies using NTPs that were women required women to be able to move freely in their community, often a concern in LMIC where freedom of movement for women may often be restricted (Gailits et al., 2019).

On average, the NTPs received approximately 10 days of training, delivered by a mental health specialist, and employed mixed methods of didactic and experiential learning. However, training in most studies involved greater time spent on role-plays, practice and field training rather than classroom training. The importance of these forms of activities for these types of cadres has been highlighted in studies and emphasise that training should be responsive to the educational level of the NTPs, and didactic teaching should be kept minimal (Murray et al., 2011). This is also reflected by studies providing training to mental health professionals, where it has been found that training outcomes improve when there are opportunities to practice skills and receive feedback, rather than didactic lectures (Beidas & Kendall, 2010). Contents of training varied according to the intervention and target population; however, the five most common components incorporated within training included (a) basic education in mental health; (b) counselling skills; (c) communication skills; (d) self-care and (e) ethical, confidentiality and protocol matters. The latter component is of particular importance because NTPs will have overlapping roles with members of their own community, placing them at greater risk for breaking confidentiality (Barnett et al., 2018a).

Although an important initial step, training alone is insufficient in building confidence and competence of the NTP (Kemp et al., 2019). Supervision is necessary to provide feedback, correct negative and reinforce positive behaviours (Beidas et al., 2011). Within this review, a majority of studies provided supervision through a mental health specialist whose role involved supporting,

building competence, maintaining quality and evaluating the intervention. However, training and supervision provided by a mental health specialist is not scalable, particularly in a global context. In LMICs, where mental health professionals are scarce, there are few available to provide training, and not many are sufficiently experienced to provide supervision (Fairburn & Patel, 2014). However, a number of studies within this review used a task-shifting approach for supervision, using a 'cascade model' or 'apprenticeship model'. In this approach, local specialists are trained and supervised by a mental health specialist often residing in HICs, who will in turn provide support and supervision to the NTPs. This approach has been successfully adopted in a number of settings (Murray et al., 2013; Weiss et al., 2015) and is a more feasible and scalable approach to providing supervision in poor resource settings.

Research into task-shifting has predominantly been conducted in LMICs where it has been shown to be highly successful (Patel et al., 2010; Rahman et al., 2008). However, this method of delivering psychological treatments is still a fairly new concept in HICs, where a task-shifting approach will often involve educated individuals within the healthcare system expanding their roles to take further responsibilities to include mental health treatments (Quijano et al., 2007; Strong et al., 2004). However, using individuals already working within healthcare can lead to an overburdening as evident through trials that have trained CHWs to deliver psychological interventions (Haq et al., 2008) and can pose a problem for scaling up effective solutions (Jaskiewicz & Tulenko, 2012). A possible solution is to train members of the community to deliver psychological interventions, which may be more acceptable, feasible and cost-effective (D. Singla et al., 2014). However, a limited number of studies in HICs have trained community members to deliver these treatments (Pratt et al., 2017). Therefore, lessons learnt from task-shifting in LMICs should be used to successfully implement this approach within higher-income settings.

(1) Interventions can be diseased focused as well as use a transdiagnostic approach in which the intervention has a set of common practice components that can be delivered in varying ways to address a range of problems, allowing for flexibility in treatment (Chorpita & Daleiden, 2009). Within LMIC, a transdiagnostic intervention called Common Elements Treatment Approach for mood and/or anxiety disorders has been specifically developed for use in LMICs (Murray et al., 2014). This approach has been found to be effective in reducing intimate partner violence and hazardous alcohol use in Zambia (Murray et al., 2020) and in reducing depression among trauma survivors in Thailand (Bolton et al., 2014).

(2) NTPs can be successfully trained to deliver brief interventions such as counselling (Ali et al., 2010) or more complex interventions such as CBT (Rahman et al., 2008) or Interpersonal therapy (Petersen et al., 2014).

(3) Peers and community members who share similar characteristics, experiences and health conditions to the target population can be trained to effectively deliver psychological interventions

and may be preferred by community members due to being perceived as more approachable (D. Singla et al., 2014).

(4) Emphasis should be placed on the selection criteria of the NTPs and should consider personal characteristics, life experiences and the local cultural setting. For example, when recruiting laywomen from the community, it is important to consider the hierarchal family structure which in many cultures will involve families that are extended units with a strong patriarchal influence in all aspects of decision-making (Stein et al., 2019). Therefore, it may be necessary to select women who have been given permission by their family members to carry out such type of work and are able to move freely within their community.

(5) As evident from this review, training programs should be structured, incorporating both mental health education and therapeutic skills training. Furthermore, it should include both didactic and experiential learning.

(6) Supervision protocols should be implemented and delivered by specialists to ensure NTPs receive support and stay motivated and that the quality of the intervention remains high. In the context of limited specialists, local supervisors can be trained to support NTPs and in turn receive supervision themselves from a supervisor not residing in the country (Murray et al., 2011). Furthermore, technology such as the use of telephone and Skype can provide valuable opportunities for supervision at a distance and on demand in situations where face-to-face meetings may not be possible (Fairburn & Cooper, 2011). The use of models, tools and technology may improve the scalability and rigour of supervision, ensuring fidelity of the intervention (Kemp et al., 2019).

(7) Fidelity of the intervention should be measured and can be monitored through direct observations, audio recordings and self-reports (Breitenstein et al., 2010). Furthermore, standardised measures of non-specialist provider competence are available and should be used immediately after training and during intervention implementation to ensure high quality of the intervention (Kohrt et al., 2015).

(8) Involving community members who although may not be directly involved in intervention delivery, may be able to successfully support the implementation process and its acceptability within the community by helping to recruit participants, prevent stigma towards mental health and encourage intervention attendance (Singla & Kumbakumba, 2015).

5.4.2. Strengths and limitations

This review is the first to focus on the training and supervision of NTPs delivering psychological interventions in LMICs. This review offers in-depth information on the training that is provided to NTPs as well as insights into the lessons learnt from task-shifted interventions which could be adopted in high-income settings. It is important to be aware of the possibility of publication bias for all identified studies since we excluded unpublished studies and studies which were in languages other than English. This could limit the potential number of studies included in the review. Furthermore, the majority of these studies were conducted in South Asia and Africa, with no study being conducted within South America, Central Asia, Middle East and North Africa. Moreover, due to time constraints and a large number of studies included in the review, it was not possible to contact the authors of the included studies to request further information relating to the training of NTPs.

Although we have described the lessons learnt from task-shifted interventions in LMICs through NTPs, regulations from organisations that oversee the implementation of psychological treatments may limit the type of providers who can provide these services in HICs (Barnett et al., 2018a). For example, whilst local community members have been trained to provide CBT-based interventions (Rahman et al., 2008), providing such services in the UK requires accredited postgraduate training qualifications and experience working in mental health. Therefore, it still needs to be determined if and how NTPs with minimal training and experience can deliver effective psychological treatments in HICs.

5.5. Conclusion/Chapter Summary

- This review highlights the training and supervision provided to NTPs to deliver psychological interventions in LMICs and adds to the existing evidence base on the training involved in task-shifting.

- Although a number of studies have effectively implemented this approach in LMICs, there is limited evidence of the use of NTPs from the community to deliver evidence-based psychological treatments in HICs.

- Lessons should be learnt from LMICs and should be considered to successfully train individuals in HICs to deliver psychological interventions.

Chapter 6. Experiences of Lay Health Workers Trained in Task-Shifting Psychological Interventions: A Qualitative Systematic Review

The last two chapters summarised the evidence of training and supervision of NTPs that occurred in task-shifted psychological interventions in both HICs and LMICs. However, to fully identify and understand the important variables needed to train and support these individuals to deliver low-intensity psychological treatments, it is necessary to explore the experiences of the NTPs during training and intervention delivery. This chapter presents a qualitative review exploring the experiences of LHWs that have been trained to deliver psychological interventions. A version of this review has been published in the *International Journal of Mental Health Systems* on 14 October 2019 and can be seen in Appendix 9. An updated version of this review will be presented here.

6.1. Introduction

Studies that have adopted a task-shifting approach have used a range of LHWs, from paraprofessionals already working within health systems, such as nurses, to laywomen from within the community (Chowdhary et al., 2014). Furthermore, laypersons have been used in studies in LMICs to deliver psychological interventions (Ali et al., 2003; Cooper et al., 2009; Rahman et al., 2008) as a solution to the shortage of fully trained health workers. Qualitative data have shown that participants prefer LHWs from the same community who share common socio-demographic characteristics, as they are more accessible (D. R Singla et al., 2014) and less intimidating than a formal service (Mueller, 2010). Furthermore, it avoids a formal mental health label and diagnosis, a reason that often leads people to avoid mental health services due to the stigma attached (McClay et al., 2013).

In LMICs, laypersons often come from more deprived socioeconomic backgrounds and have minimal formal education. Therefore, in-depth training, supervision and support from mental health professionals are required for task-shifting to be successful and to ensure high-quality care (Agyapong et al., 2015). Systematic reviews of qualitative studies have previously been conducted on task-shifting of psychological therapies (Padmanathan & De Silva, 2013; Van Ginneken et al., 2013). However, to date, no review has been conducted on lay workers' experiences of training. Qualitative research methods such as in-depth interviews and focus groups are used to answer questions about experience and meaning to gain a deeper understanding of a participant's perspective in interventions such as task-shifting (Hammarberg et al., 2016). Therefore, the aim of this review is to systematically assess the qualitative literature on the impact of training and delivery of psychological therapies by LHWs. This systematic review is important to help us understand the existing knowledge in this area and to direct future training and delivery of task-shifting programmes.

6.1.1. Objectives

The aim of this review was to answer two primary questions:

1. How have studies explored the experiences of LHWs who have received training and delivered psychological therapies for CMD?
    a. What are the types of studies?
    b. What are the characteristics of the LHWs described in the papers?
    c. What are the characteristics of training?

2. What does the evidence say about the LHWs' experiences in training and delivering psychological therapies?
    a. What were the LHWs own experiences of receiving training?
    b. What were the barriers and facilitators to therapy delivery?
    c. What factors are required to effectively train LHWs to deliver psychological interventions?
    d. What was the impact of training and therapy delivery on the LHWs?

6.2. Methods

6.2.1. Eligibility Criteria

This review aimed to identify all papers that explored the experiences of LHWs delivering psychological interventions for CMDs. Therefore, we did not restrict the search to one type of qualitative methodology or articles published during a particular period. A 'lay health worker' was defined as any health worker carrying out functions related to healthcare delivery, trained in some way in the context of the intervention and having no formal professional or paraprofessional certified or degreed tertiary education (Lewin et al., 2005).

The inclusion criteria for studies were (a) available in English, (b) used qualitative data, (c) studies in which the LHW was a layperson with no mental health experience and (d) studies describing LHWs' experiences of training and therapy delivery.

The exclusion criteria were (a) studies evaluating the effectiveness of training LHWs that did not include any qualitative data, (b) studies focusing on the experiences of those receiving therapy and (c) studies involving participants with serious mental illnesses such as schizophrenia, bipolar disorder and other psychoses.

6.2.2. Literature search strategy

We searched databases (CINAHL, Medline, Embase, PsycINFO) from inception until 13 May 2020. All the searches were exported to EndNote, and duplicate references were reviewed and removed. Searches were conducted to specifically capture studies on task-shifting psychological interventions for CMDs. The search was adapted from another systematic review investigating non-specialist health worker interventions for the care of mental, neurological and substance abuse disorders (Van Ginneken et al., 2013). Key terms including 'lay', 'voluntary', 'untrained', 'non-professional' and 'task shift' were combined with terms for CMDs including 'common mental', 'anxiety' and 'depression'. The full search strategy can be seen in Appendix 1.

6.2.3. Data Extraction

Titles and abstracts were screened by one researcher (US), and full papers of potentially relevant abstracts were obtained. A second researcher cross-checked and agreed the included and excluded papers (WW), and a final decision was made. Data were independently extracted by two reviewers (US and MWW) onto a standardised Excel spreadsheet. Data was collected on study details including intervention and participants, design and methods, as well as the author's interpretations of their data. Data extraction followed the guidelines for meta-ethnography outlined by Noblit and Hare (Noblit & Hare, 1988), whereby first-order constructs defined as direct participant quotes were extracted. Therefore, where possible, we extracted data on LHWs' self-reported experiences of training, supervision and therapy delivery. However, in many cases, there was insufficient primary data; in this instance, we extracted second-order constructs, defined as the authors' interpretations of participants' quotes expressed as themes, extracted from both the results and discussion sections of papers to capture all constructs. Therefore, the second-order constructs referred to the authors' interpretations of the LHWs' experiences of training. Data extraction rigour was enhanced by continuous discussion within the review team, as US and MWW independently extracted the data, whilst WW reviewed both sets of extraction for consistency. The Critical Appraisal Skills Programme tool was used to assess the quality of included studies (Centre for Reviews and Dissemination, 2009). However, the quality of studies was not an inclusion criterion in this review. The decision to avoid quality as an inclusion criterion was in consideration of the different contexts in which qualitative studies are conducted (Pope et al., 2007).

6.2.4. Thematic analysis

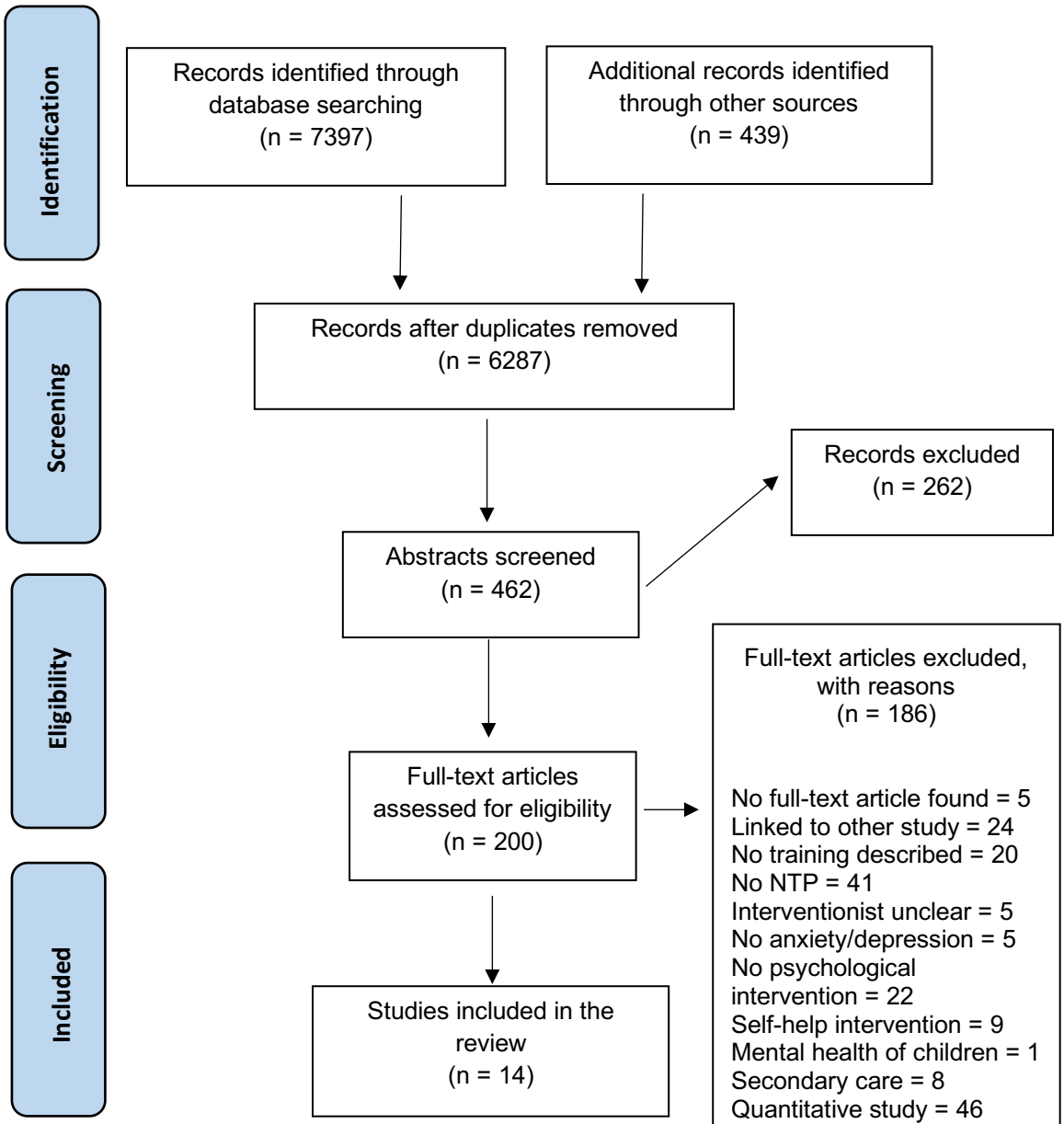
The thematic analysis approach to analysing qualitative data by Braun and Clarke (2006) was used to aid thematic identification and summarisation of data from included studies. The aim of this review was to descriptively summarise evidence from qualitative studies exploring the impact of training and delivery of therapy on LHWs; therefore, thematic analysis was appropriate.

In utilising the thematic analysis approach, we conducted all six phases described by Braun and Clarke (2006): (1) becoming familiar with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining themes and (6) the write-up process. All included studies were read multiple times to facilitate understanding of the key concepts published in the studies. The analysis was undertaken in a multidisciplinary team (PhD student (US), medical student (MWW) and a psychiatrist (WW)). Papers were read and re-read by two reviewers (US and MWW), and the extracted data was then grouped into broad themes by the reviewers (US, MWW and WW).

Broad themes and subthemes were then refined through a discussion among US, MWW and WW until consensus was reached. Once the themes had been broadly agreed, WW read through the data in each of the themes checking that the interpretation of the data was correct and suggesting changes based on the original context of the studies.

The results are reported in line with PRISMA guidelines for systematic reviews. The themes are presented in accordance with our review objectives as listed above.

Figure 6.1. PRISMA flowchart representing the process of identifying relevant papers (Moher et al., 2009)



6.3. Results

In summary, a total of 7397 papers were identified through the electronic search, and a further 439 papers were identified through hand searches. After duplicates were removed, 6287 were excluded after reading the title and a further 462 after reading the abstracts. Two hundred full-text articles were screened for inclusion: 262 were excluded, resulting in a total of 14 articles to be included in this review. The flow diagram for the included papers can be seen in Figure 6.1. Three articles that have been included in this review are a part of a large RCT that was conducted in Pakistan and therefore will be considered as one study (Atif et al., 2017; Atif et al., 2016; Atif et al., 2019). However, one of these studies was a qualitative study evaluating the feasibility and adaptability of the intervention in two separate RCTs, one of which was conducted in India and therefore will be considered as two separate studies for this review (Atif et al., 2017)

6.3.1. Characteristics of included studies

Out of the studies included in this review, only two were conducted in HICs which was the UK (n=2), and the remaining were conducted in LMICs, Pakistan (n=4), India (n=3), Nepal (n=1), Zimbabwe (n=1) and South Africa (n=1). Eight studies employed mixed methods, and five studies were qualitative. Over half of the studies used semi-structured interviews to collect data; two studies used focus groups whereas two used both interviews and focus groups, and another used open-ended questionnaires. A description of included studies is presented in Table 6.1.

Two studies investigated the experiences of the LHWs in delivering the intervention (Chibanda et al., 2017; Naeem et al., 2003) whereas one study examined the barriers and facilitators of delivering the intervention through PVs (Atif et al., 2016), their experiences in training and supervision (Atif et al., 2019) and the feasibility of an adapted intervention for delivery through peers (Atif et al., 2017). Another study examined the role of the voluntary sector in supporting women with perinatal mental health problems (Coe & Barlow, 2013). Two studies were conducted to investigate the perspective of stakeholders involved in the intervention (Jordans et al., 2007; Pereira et al., 2011), whilst three studies evaluated the feasibility and acceptability of the intervention (Joag et al., 2020; Khan et al., 2017; Myers et al., 2019). A study by Armstrong (2003) evaluated the impact of a common factors approach in training the LHWs. Rahman (2007) conducted a multi-method study to investigate the challenges and opportunities in developing an intervention for perinatal depression. Finally, Maulik, Tewari, Devarapalli, Kallakuri and Patel (2016) conducted a study to develop and test a tool for referral and treatment as well as gather research to understand perceptions about mental health in rural India.

As per inclusion criteria, studies only included participants with anxiety, depression or CMDs; however, one study included participants with mild to severe psychosocial problems, and in one study, the mental health condition was unknown.

In three studies, the intervention being delivered was counselling, three used the Thinking Healthy Programme based on CBT techniques, one study focused on psychoeducation and another used a form of social support. One study used PST, whilst another used the PM+ intervention. One study trained LHWs to deliver an integrated care approach called the Atmiyata intervention, which consisted of identifying members of the community with CMDs and providing counselling sessions. Similarly, counselling was also provided in a study by Myers et al. (2019). Lastly, another study trained LHWs in an intervention that utilised a mobile technology-based electronic decision support system to improve the identification and management of individuals.

Table 6.1. Characteristics of studies (n = 13)

Author/ Year	Country	Participant type (No.)	Study design	Psychological intervention	Mental health condition	Data collection method	Method of analysis
Armstrong, 2003	UK	Paraprofessional counsellors (12)	Mixed methods	Counselling	Unknown	Open-ended questionnaires	Content analysis
Atif et al., 2016, 2017, 2019	Pakistan	Peer volunteers (8)	Qualitative study	Thinking Healthy Programme (CBT)	Perinatal depression	Interviews and focus groups	Thematic framework analysis
Atif et al., 2017	India	Peer volunteers (9)	Qualitative study	Thinking Healthy Programme (CBT)	Perinatal depression	Interviews and focus groups	Thematic framework analysis
Chibanda et al., 2017	Zimbabwe	Lay health workers (7)	Qualitative study	Problem-solving therapy	CMD	Semi-structured interviews	Thematic content analysis
Coe, & Barlow, 2013	UK	Volunteer befrienders (14)	Mixed methods	Perinatal support	Maternal anxiety and depression	Qualitative interviews	Unknown
Joag et al., 2020	India	Atmiyata champions (16)	Mixed methods	Atmiyata intervention	CMD	In-depth interviews	Thematic analysis
Jordans et al., 2007	Nepal	Paraprofessional counsellors (26)	Qualitative study	Counselling	Mild to severe psychosocial problems	Semi-structured interviews	Content analysis
Khan et al., 2017	Pakistan	Lay helpers (2)	Mixed methods	Problem-solving and behavioural activation	Anxiety and depression	Semi-structured interviews	Thematic content analysis
Maulik et al., 2016	India	Accredited social health activists (4)	Mixed methods	Mobile technology–based electronic decision support system	CMD	Focus groups	Thematic analysis
Myers et al., 2019	South Africa	Community health workers (7)	Mixed methods	Counselling	Depression	Semi-structured interviews	Framework analysis
Naeem et al., 2003	Pakistan	Laywomen (11)	Mixed methods	Counselling	Anxiety and depression	Focus groups and open-ended feedback	Unknown
Pereira et al., 2011	India	Lay health counsellor (17)	Qualitative study	Psychoeducation	CMD	Qualitative semi-structured interviews	Thematic framework analysis

Table 6.1. Characteristics of studies (n = 13)

Author/ Year	Country	Participant type (No.)	Study design	Psychological intervention	Mental health condition	Data collection method	Method of analysis
Rahman, 2007	Pakistan	Lady health workers (24)	Mixed methods	Thinking Healthy Programme (CBT)	Perinatal depression	Focus groups	Systematic triangulation process

*CBT, Cognitive Behavioural Therapy; CMD, Common Mental Disorder

6.3.2. Characteristics of LHWs and the training received

A description of the characteristics of the LHWs is presented in Table 6.2. LHWs trained to deliver the interventions included two studies using paraprofessional counsellors, one study using lady health workers, one study using CHWs and the remaining four studies using laypersons. Four studies used volunteers, one in the form of volunteer befrienders, two in the form of PVs and another in which the volunteers were given the term 'champions'. Finally, one study used accredited social health activists (ASHAs) to deliver the psychological intervention.

Half of the studies did not report on the previous qualifications of the LHWs whereas the other half of the studies reported that LHWs had minimal education ranging from 8 to 16 years or had completed high school. Four studies used LHWs that were already working within the community. This included one study in which LHWs had been trained to provide preventative mother-and-child healthcare and education and similarly in another study where LHWs were responsible for providing basic maternal and child care through government-funded schemes. In one study, LHWs had previous training in home-based care for people living with HIV/AIDS, in community follow-up of persons on tuberculosis treatment and in delivering community health education and promotion. Similarly, another study also used CHWs who had training as HIV adherence counsellors. Another study used 12 paraprofessional counsellors where 5 had no counselling experience and 7 had previously attended some form of training. In four studies, LHWs had no previous training, whilst in two, previous training or role within the community was not documented.

In three studies, a member of the research team delivered the training to the LHWs whereas in one study, the training was delivered by a team of experienced mental health professionals including two clinical psychologists, a general nurse trained in systemic counselling and a psychiatrist. Two studies used a train-the-trainer approach in which the trainer received training and supervision themselves before training LHWs.

Training ranged from two days to months and consisted of a variation of lectures, role-play and fieldwork. The content of the training in almost all studies mostly focused on understanding the relevant mental health disorder, its management, counselling and communication skills. In three studies, supervision was conducted by a member of the research team, three studies used non-specialist supervisors whilst four studies used mental health professionals. However, supervision was poorly documented with two studies not detailing who conducted supervision and a number of studies not reporting on the format and content of the supervision. Of the studies that did, supervision involved LHWs sharing their experiences and receiving guidance and support in difficult cases.

Table 6.2. Characteristics of LHWs

Author/ Year	LHW	Previous qualifications of LHW	Previous training/role within the community
Armstrong, 2003	Paraprofessional counsellors	Not specified	Five people had no previous counselling training, whilst seven had some form of training experience.
Atif et al., 2016, 2017, 2019	Peer volunteers	Education of at least 10 years	No previous training
Atif et al., 2017	Peer volunteers	Minimum 7 years of schooling	No previous training
Chibanda et al., 2017	Lay health workers	Mean of 8 years of education	Previous training in home-based care for people living with HIV and AIDS, in community follow-up of persons on TB treatment and in delivering community health education and promotion.
Coe & Barlow, 2013	Volunteer befrienders	Not specified	No previous training
Joag et al., 2020	Atmiyata champions	Not specified	Not specified
Jordans et al., 2007	Paraprofessionals	Minimal educational background (i.e., mainly high school level, with a few college-level participants.	Not specified
Khan et al., 2017	Lay helpers	Lay helpers had 16 years of education	No previous training
Maulik et al., 2016	Accredited social health activist	Not specified	Responsible for providing basic maternal and child care through government-funded schemes.
Myers et al., 2019	Community health workers	Completed secondary school	Training as HIV adherence counsellors
Naeem et al., 2003	Laywomen	Not specified	No previous training
Pereira et al., 2011	Lay health counsellor	Not specified	Not specified
Rahman, 2007	Lady health workers	Completed secondary school	Trained to provide mainly preventative mother-and-child healthcare and education.

6.3.3. LHWs' own experiences of receiving training

6.3.3.1. LHWs' views on training

Generally, LHWs felt that there was insufficient information given during training and not enough time allowed for training regarding mental health issues (Armstrong, 2003) with one LHW also stating that training days were too long, making it difficult to take in all the information provided.

> *There was too much going on – I felt I wanted to go and sort it out before the next point.* (Paraprofessional counsellor) (Armstrong, 2003; p.275)

Similarly, LHWs in Myers et al. (2019) expressed their need for longer training to be able to practice the content of the intervention and build their confidence and competency. Furthermore, the need for regular refresher training sessions was voiced by an LHW so that they did not miss or forget anything related to the intervention (Atif et al., 2019).

> *The training should be about five days. Five days gives you enough time to role-play and ask questions and grasp everything . . . The role-play, there was not actually proper time for that.* (CHW) (Myers et al., 2019; p.4)

Others expressed a need for more advanced training, with authors commenting that LHWs voiced a need for more opportunities to share and network with other counsellors (Jordans et al., 2007). Similarly, Atif et al. (2016) found that LHWs expressed satisfaction with their training but believed that more detailed training would be required for dealing with a population with a range of health issues.

> *While most PVs [peer volunteer] found the training sufficient to prepare them for the volunteering role, some felt that a longer and comprehensive training would have equipped them better to deal with the diverse health issues of their target population.* (Atif et al., 2016; p.8)

Satisfaction in training and support was also reported in Maulik et al. (2016) and by Coe and Barlow (2013). Armstrong (2003) found that participation and engagement in training were facilitated by the LHWs' views of the learning environment as 'supportive' and 'encouraging'. Furthermore, Pereira et al. (2011) found that the LHWs cited 'a comprehensive training program focusing on skills-based learning' as critically important for successful delivery of the intervention (Pereira et al., 2011; p.8).

> *Training was good, we learnt a lot from this training, such as how to take care of one's self, how to overcome stress related problems and the importance of sharing one's problems. The training helped us to help others.* (PV, India) (Atif et al., 2017; p.11)

Views towards the trainers were only briefly explored in Atif et al. (2016, 2019), in which it was noted the friendly manner and approachability of the trainers encouraged the LHWs during training.

> *I liked the training . . . the trainers were friendly . . . the way they explained the content was very good. I didn't experience any problems in understanding it.* (PV) (Atif et al., 2016; p.6)

> *We never felt intimidated during the training. Whenever we asked any questions, whether relevant or not, trainers gave us answers very patiently and politely, which was encouraging for us.* (PV) (Atif et al., 2019; p.7)

6.3.3.2. LHWs' views on supervision

Most authors found that LHWs felt that supervision enhanced their skills and prepared them for any challenges and issues they faced in delivering the therapy (Atif et al., 2017; Atif et al., 2016; Pereira et al., 2011), which in one study also included managing their emotional well-being (Khan et al., 2017).

> *The majority of LHCs [lay health counsellor] reported that experience in the clinics, training before the program and monthly peer group supervision during the program . . . gave them confidence to overcome the challenges they faced.* (Pereira et al., 2011; p.5)

> *Group supervision is helpful to discuss and understand issues through listening to the audio recording. We share our experiences and challenges during supervision and get more idea from other colleagues and supervisors to help the mother. If we have missed something during the session, we learn about it when we listen to the audio recording. So, we can improve ourselves.* (PV, India) (Atif et al., 2017; p.11)

Atif et al. (2016) described how field supervision, in which supervisors accompanied the LHWs in therapy delivery, improved the LHWs' credibility within the community and their trustworthiness.

> *When xx (supervisor) accompanied me, mothers took me more seriously and shared their concerns more openly knowing that I have been properly trained and supervised.* (PV) (Atif et al., 2016; p.6)

Furthermore, in Chibanda et al.'s study (2017), an increase in skills and confidence led to a decrease in the rate of referral to the supervisor. Similarly, Maulik et al. (2016) described how with increasing confidence the LHWs required less support from the staff after becoming more comfortable using the screening tool.

> *They indicated that over the years the rate of referral to the supervisor had reduced significantly because they now felt confident with difficult clients.* (Chibanda et al., 2017; p.148)

Pereira et al. (2011) also commented on the LHWs' emphasis on supervision as a critically important element for successful delivery of the intervention, specifically on the use of a structured on-the-job supervision protocol involving both on-site supervision and once-a-month group supervision. This

emphasis on supervision was also highlighted in two other papers (Chibanda et al., 2017; Jordans et al., 2007). Finally, only Coe and Barlow (2013) reported on the satisfaction of the LHWs regarding supervision.

> *The training and guidance they received, coupled with ongoing support from the project coordinator, was valued and praised by the volunteer befrienders.* (Coe & Barlow, 2013; p.26)

6.3.4. Barriers and facilitators to therapy delivery

6.3.4.1. Barriers to therapy delivery

A few authors reported on barriers faced by the LHWs in delivering the intervention which affected them in their roles as therapists and hindered therapy delivery. In one study, in which LHWs were PVs often from the same village as the participants, the author commented on how the LHWs experienced difficulties, as the participants were hesitant to reveal personal information possibly fearing a breach of confidentiality or judgement from the LHW especially if they were from the same village (Atif et al., 2016). Confidentiality issues were also discussed by Khan et al. (2017), who observed that participants were reluctant to disclose their problems when the intervention sessions were made up of participants from the same household.

> *If in any session there were two or three participants from the same house that made it difficult to let the participants share their problems.* (Lay helper) (Khan et al., 2017; p.8)

> *One of the challenges that the PVs experienced was some mothers' reluctance to disclose personal information, especially when both the PV and the mother belonged to the same village.* (Atif et al., 2016; p.8)

Furthermore, barriers to therapy delivery also included a hesitance to seek help due to the stigma attached to mental illness and the lack of awareness, which influenced the LHW's level of acceptability.

> *She got upset when I told her that the assessment indicated that she has depression. She said that she is not mad and stopped me from coming in when I went for my next visit.* (PV) (Atif et al., 2016; p.6)

> *Some community members had low awareness about mental health problems or expressed scepticism regarding the Champions' work and their motives and resisted the intervention.* (Joag et al., 2020; p.10)

Jordans et al. (2007) noted that factors such as training, difficult clients and organisational difficulties limited the LHWs' abilities and affected their competency in delivering the interventions. Furthermore, the author addressed how for some LHWs the extra responsibilities were difficult to

carry out with their current duties due to a lack of time and conflicts of interest. Similar concerns were also reported in Myers et al. (2019). Other roles and responsibilities were also reported by Maulik et al. (2016), who discussed LHWs' concerns of the harvest season 'as both ASHAs [accredited social health activists] and many villagers work as season labourers in the fields during harvest' (Maulik et al., 2016; p.7).

> *For some multiple responsibilities were compatible with the counselling activities, but for others they were distracting or even incompatible . . . due to time restraints or confusing due to conflicts of interest, and generally reflective of a lack of management's prioritisation of psychosocial services.* (Jordans et al., 2007; p.63)

> *For designated CHWs, competing priorities and limited time were barriers to counselling delivery. These CHWs felt they were 'doing three jobs', with almost all mentioning that it would be easier to deliver the programme if all they did 'was concentrate on the intervention'.* (Myers et al., 2019; p.5)

6.3.4.2. Use of aids in facilitating therapy delivery

Physical aids. The use of materials to aid in the delivery of the intervention was briefly described in Armstrong (2003), in which the usefulness of handouts and video demonstrations of counselling sessions was emphasised by the LHW. Similarly, in Pereira et al.'s study (2011), as well as using a flip chart to aid in the delivery of the therapy, a patient card was also used to facilitate the LHWs in planning the intervention for the patient. Furthermore, the benefits of using pictures and stories were also noted in Atif et al. (2017) particularly for participants who could not read.

> *The flip chart was observed to facilitate the psychoeducation by helping the patients understand the content better and acting as a guide to the LHC.* (Pereira et al., 2011; p.4)

> *LHC's reported that the patient card with the screening results aided them in planning the intervention for the patient.* (Pereira et al., 2011; p.4)

In Joag et al. (2020), LHWs showed films to community members which depicted problems experienced by people within the village, aiding intervention delivery as they could identify and understand the content.

> *The films on mother-in-law and daughter-in-law (relationships) were liked by many women. Women liked the film on addiction. They (have) experienced it themselves.* (Atmiyata Champion) (Joag et al., 2020; p.8)

Abstract aids. Some studies also reported on the use of abstract aids such as being local to the community and current roles as health workers that facilitated the LHW in delivering the intervention. For example, Rahman (2007) commented on how the LHWs were already providing

preventative mother-and-child healthcare and education and therefore found it easier to understand the intervention. Furthermore, infant care was viewed as a 'mutually agreed agenda' and thus facilitated the therapists when they met challenges within the therapeutic process.

> *Infant care, on the other hand, was seen as a shared responsibility . . . It also helped [lady health workers] negotiate difficult situations within the therapeutic process by referring back to this common mutually agreed agenda.* (Rahman, 2007; p.7)

Chibanda et al. (2017) and Joag et al. (2020) noted how being local to the community was also found to facilitate therapy delivery, as this increased the LHWs' level of trustworthiness.

> *So, because we are known as Ambuya Utano (lady health workers) there is a certain level of trust we get from PLWH [people living with HIV]. We have lived here for more than 20 years so we are known because with most of them we see each other at the market, we have helped them in the past.* (LHW) (Chibanda et al., 2017; p.147)

The LHWs' own experiences were also seen as a facilitator due to a mutual understanding between the therapist and client, which aided in therapy delivery.

> *Because I (LHW) also live with HIV when I show understanding (empathy), they are grateful and when I share my own experience this helps to further open up their mind.* (LHW) (Chibanda et al., 2017; p.147)

6.3.4.3. Motivations for training to become a therapist

The motivation of the LHWs was also important in facilitating successful delivery of the intervention. Atif et al. (2016) noted how the LHWs' perceived personal gains, which were described as being altruistic, opportunistic or linked to their well-being, were factors contributing to their motivation. Furthermore, for others, the work was seen as an opportunity to develop new skills and increase their chances of employment.

> *Several factors were identified which contributed to their motivation such as their own families endorsement to their role and approval from mothers' families.* (Atif et al., 2016; p.8-9)

> *In our village there are limited opportunities for women to gain knowledge and learn new skills. My experience of working as a peer will hopefully improve my chance to gain a job as a LHW*. (PV, Pakistan) (Atif et al., 2017; p.10)

Furthermore, enjoyment in working and the altruistic benefits motivated LHWs to work voluntarily, without receiving any remuneration in Joag et al. (2020). In contrast, in a study involving experiences of PVs in both Pakistan and India, it was found that PVs in Pakistan were happy to work on a voluntary basis whereas the PVs in India expressed the need for monetary incentive to hold their interest (Atif et al., 2017).

> *People used to ask us 'Are you doing this job because of payment? 'I explained to them that we don't get any payment. We have to do social work, volunteer ourselves for good work. The aim is how people can live happily, healthier mentally and physically as well. One person asked, 'If you don't have any profit why do you work here?' I told (that person) 'I like it, that is why I do (it)'.* (Atmiyata champion) (Joag et al., 2020; p.9)

> *People ask us why we are going for this job if it does not pay us. If we got monthly salary, then, it would be good. We will also be interested in working.* (PV, India) (Atif et al., 2017; p.11)

Furthermore, family and community endorsement also motivated LHWs to receive training and deliver the intervention.

> *My family is supportive, without their encouragement, I would not have done this work. It would have been really difficult to leave housework and children.* (PV) (Atif et al., 2016; p.6)

6.3.5. Factors required to effectively train LHWs to deliver psychological interventions

6.3.5.1. Acceptability

Confidentiality. A common theme found by authors was that the level of acceptability and successful delivery of the intervention was dependent on the LHWs' ability to maintain confidentiality. Naeem et al. (2003) commented on how initial reluctance from the clients disappeared as trust in the LHW developed. Similarly, Pereira et al. (2011) reported how the LHWs learnt to emphasise confidentiality over time which helped the patients become more comfortable in disclosing personal information.

> *In time the LHCs were accepted by the patients and appreciated by the primary care staff due to their polite and friendly nature and also for maintaining confidentiality.* (Pereira et al., 2011; p.8)

> *I stressed to every patient that whatever they would confide in me would remain confidential. I felt these would make the patient feel more comfortable with me and they would ventilate their feelings more easily.* (LHC) (Pereira et al., 2011; p.9)

Local and trustworthy. Khan et al. (2017) found that level of acceptability was also closely linked with the trustworthiness of the LHW, further suggesting that being local and known in the community might be one factor which contributed to the LHWs being trusted compared to a health professional who would be an outsider and unfamiliar to the participants. Atif et al. (2016) observed how being local and trustworthy was an advantage to the LHWs, benefitting them in delivering the intervention, which was also found by Chibanda et al. (2017).

> *The PVs level of acceptability was dependent upon a number of key factors, including their personal characteristics (e.g., empathy and trustworthiness), being local and linked to the health system, and the intervention perceived as beneficial.* (Atif et al., 2016; p.7)

> *LHWs successfully facilitated the introduction of lay-helpers to the community and invited participants to the sessions. They were ideal hosts for Group PM+ as they are trusted and respected in the communities, overcoming a barrier to accessing women in need.* (Khan et al., 2017; p.9)

Furthermore, as a relationship was built between the LHWs and clients over time, the LHWs became more trusted and accepted, leading to the clients disclosing personal information (Atif et al., 2016; Naeem et al., 2003).

6.3.5.2. Developing a therapeutic relationship

Chibanda et al. (2017) observed that the LHWs used their own life experiences to help build a relationship with the clients, as well as using physical gestures to connect with them.

> *Because I (LHW) also live with HIV when I show understanding (empathy), they are grateful and when I share my own experience this helps to further open up their mind.* (LHW) (Chibanda et al., 2017; p.147)

> *Connecting with clients came in several forms from touching the hand and other culturally appropriate parts of the body, offering a tissue paper to a crying client, and praying. It was not unusual for the LHWs to use their own life experiences to help create rapport.* (Chibanda et al., 2017; p.146)

Empathy was also described by two authors as an important factor in building a relationship between the LHWs and the client and was also linked to their level of acceptability (Atif et al., 2016; Naeem et al., 2003). Similarly, in Joag et al. (2020), LHWs initially built trust and a relationship with participants before presenting the intervention components.

> *Initial resistance from the clients that gradually disappeared as empathy, trust and confidentiality developed.* (Naeem et al., 2003; p.2)

> *In the beginning I did not show the films directly. I first won their heart and made a place in their heart. I made them understand what qualities I have and only then I showed them the film.* (Atmiyata champion) (Joag et al., 2020; p.9)

6.3.5.3. Collaborative work with other healthcare professionals

Collaborative work can also be regarded as an important component to becoming a successful therapist, as it can provide the therapist with more guidance and support from more experienced

professionals. Only three authors discussed this collaborative work with Atif et al. describing the LHWs 'good links with the local health system' (Atif et al., 2016; p.5) and Jordans et al. observing that the counsellors expressed a desire for more 'opportunities to share and network with other counsellors' (Jordans et al., 2007; p.3).

> *Nobody knows about us whereas, LHWs (lay health workers) are working for the last 18–19 years. It would be really difficult for the PVs to work without their involvement.* (PV) (Atif et al., 2016; p.6)

Myers et al. (2019) also noted how support from the primary healthcare clinic was essential for facilitating the intervention delivery and in facilities where the staff was interested the 'counselling proceeded smoothly' whereas in facilities where the staff was less interested, 'CHWs were often interrupted during counselling' (Myers et al., 2019, p. 5). Furthermore, LHWs suggested that involving employers and supervisors within training may lead to better implementation of the intervention.

> *There was some miscommunication because they [NGO] (non-government organisation) didn't have a lot of understanding as to what was expected from us. So, for future, it would be nice if the managers could be in one of the training sessions just to know what it is all about . . . to avoid confusion as to the time spent with patients.* (CHW) (Myers et al., 2019, p. 5)

Moreover, collaborating with healthcare professionals who are already trusted within the community may lead to a greater level of acceptability and aid in intervention delivery.

> *Everyone (in the community) knows that LHWs are government employees and give useful information. When we tell them about our trainings at BHU (basic health unit) and about our linkage with LHW, people show more respect to us, they know that we will also give them useful information. Without this linkage it would be difficult.* (PV) (Atif et al., 2019; p.7)

6.3.5.4. LHWs' expected skills

Through analysis of the papers, it was found that specific skills are required for the intervention to be successful. Chibanda et al. (2017) commented on how the LHWs found it difficult to only deal with one problem at a time and that they often felt pressured by the clients to provide solutions. Therefore, it is important for LHWs to be able to learn the skills to manage more than one issue and have the ability to prioritise more serious concerns.

> *[B]ecause we are LHWs they think we have answers and we should tell them which problem to start with, so it can take going forward and backward before they identify one problem on their own.* (LHW) (Chibanda et al., 2017; p.147)

Furthermore, it is necessary for the therapists to have the ability to adapt the intervention to the patient's needs. Chibanda et al. (2017) discussed how the therapists felt that the first session of the intervention required greater emphasis, and the subsequent sessions could be shorter. Furthermore, the author noted that as the LHWs realised that clients were not able to attend sessions regularly, adjustments were made to the intervention to ensure that the clients took home a solution that was 'specific, measurable and achievable after the first visit' (Chibanda et al., 2017; p.149).

> *Ensuring that the bulk of the work was done in the first session was critical because sometimes clients were unable to come back for subsequent sessions. Furthermore, LHWs felt that waiting a week before a problem was reviewed was discouraging for clients.* (Chibanda et al., 2017; p.146)

Pereira et al. (2011) also found that the LHWs were able to find solutions to involve those who were reluctant about the intervention. Similarly, in Joag et al. (2020), LHWs employed alternative tactics to work around the stigma and sensitivity surrounding mental health.

> *The LHCs observed that providing explanations about the importance of treatment and explaining the mind-body link also helped engage patients who were sceptical about the program's effectiveness.* (Pereira et al., 2011; p.5)

> *We used normal words and explained things while chatting. We did not make them (people) feel like they were mental, and we were treating them . . . If anyone from the patient's family asked me why I had come, I used to tell them that I had come just to chat. While chatting, we used to get to the topic, and I would make them talk about the problem and try to explain to them.* (Atmiyata champion) (Joag et al., 2020, p. 9)

In contrast, Khan et al. (2017) observed that LHWs had difficulties motivating the participants to attend the intervention due to a lack of monetary incentive; therefore, it is necessary to provide training to the LHWs to be able to encourage the participants to attend intervention sessions.

> *Participants wanted some monetary incentives and when it was not provided, they lost interest and they were not punctual.* (Lay helper) (Khan et al., 2017; p.8)

It is also important for the therapists to be able to deal with social issues that may arise during the intervention, as often task-shifting approaches are used in LMICs where factors such as financial problems may be a major concern of the patients. Chibanda et al. (2017) commented on how problems related to finance were difficult for the LHWs; however, over the years and with experience, they were able to find solutions by focusing on the reason for needing the money.

> *Some (patients faced) social difficulties like financial problem which is mainly due to seasonal work, daily wages and alcoholism. Another problem was patients not having proper documentation to apply for social schemes e.g., unregistered marriage . . . But I tried to give*

them information about various available schemes and how to follow the procedure and some even applied for it. (LHC) (Pereira et al., 2011; p.5)

One woman needed $30 for school fees. After we talked about ways of making $30 she came up with several solutions. (LHW) (Chibanda et al., 2017; p.148)

6.3.6. The impact of training and therapy delivery on the LHW

6.3.6.1. LHWs' gains

Impact of training. Some authors commented on the positive benefits that the training had on the LHW. Armstrong (2003) noted that the LHW valued the training, emphasising that the stimulating learning environment and working within a group allowed them to share their personal thoughts and feelings and gave them the opportunity to meet new people. Furthermore, the author noted that training led to personal development and a way of enhancing their skills (Armstrong, 2003); this was a common theme which was also observed by Naeem et al. (2003) and Jordans et al. (2007).

> *Participants used the training experience as an opportunity to facilitate their development as counsellors, to learn more about themselves, and to increase their personal effectiveness in their day-to-day lives.* (Armstrong, 2003; p. 275)

The training and supervision were also found to have a positive impact on the confidence of the LHW (Armstrong, 2003; Jordans et al., 2007; Naeem et al., 2003), with Naeem et al. (2003) noting that the training led to a positive approach towards life for the LHWs.

> *I am more self-confident in my ability, more self-aware and . . . more open to others views.* (Paraprofessional counsellor) (Armstrong, 2003; p. 274)

> *I have always thought I am not good enough. During supervisions through sharing my experiences and receiving praise and encouraged, I started gaining confidence which is now spilling over to other parts of my life.* (PV) (Atif et al., 2019; p.8)

Impact of therapy delivery. Most of the authors described the positive impact of delivering the therapy on the LHWs themselves. A common theme that emerged from most papers was that the LHWs developed new skills, which included enhanced listening skills and empathy in Armstrong (2003) and learning tolerance and maintaining confidentiality in Naeem et al. (2003). In Maulik et al.'s (2016) study, the new skills led to the LHWs feeling empowered to talk to the community about mental health whereas Rahman (2007) noted how the skills made them more effective health workers. A similar benefit was also described by LHWs in Myers et al. (2019), who incorporated their newly learnt counselling skills into their interactions with other patients. This

benefit to existing duties of the LHWs was also mentioned by Armstrong (2003), who suggested that the development of interpersonal skills appeared to be 'helpful in relation to existing human service work' (Armstrong, 2003; p. 274-275).

> *It's just really . . . I just found it really rewarding. I wanted to give something back to the community really and I feel that I have done that. Um. It's kind of made me feel accepted in a way.* (Volunteer befriender) (Coe & Barlow, 2013; p.26)

> *I wasn't able to communicate with people easily, but now speaking in front of hundreds of people is not a problem for me. Who would have thought that one day I would become the lady counsellor for my area.* (PV) (Atif et al., 2019; p.8)

Furthermore, LHWs also gained personal benefits from therapy delivery (Joag et al., 2020). This also involved an improvement in their relationship with others, with Pereira et al. (2011) stating that the LHWs used intervention components in handling interpersonal problems. Similarly, LHWs in Myers et al. (2019) described how they now applied the intervention components on themselves to stop negative thoughts.

> *I used to worry a lot. when I was doing the intervention then I realised that there are things we worry about that are not important… so, it seems like I am helping someone else, and I am also helping myself.* (CHW) (Myers et al., 2019, p. 5)

Coe and Barlow (2013) also found that LHWs reported an increasing sense of acceptance from therapy delivery, and Naeem et al. (2003) found that the LHWs described having an increase in sensitivity and becoming more accepting towards others, as well as understanding the importance of working together and helping each other solve problems.

> *[T]his training taught us to live our life in a new and different way.* (Laywoman) (Naeem et al., 2003; p.2)

> *I have gained insight and knowledge on how to approach people sensitively, allow them time . . . remembering that it is their experience, making no assumptions . . . that your solution is necessarily theirs.* (Paraprofessional counsellor) (Armstrong, 2003; p. 273)

6.4. Discussion

6.4.1. Summary of the findings

This is the first review of LHWs' experiences of receiving training to deliver low-intensity psychological interventions. The findings of this review provide support for the feasibility of training non-professionals to deliver psychological interventions as well as highlight a number of areas that have not been adequately addressed in the published literature, such as how to successfully train and support non-professionals in delivering psychological interventions.

Fourteen studies were included and ten themes emerged under four overarching areas, which were the LHWs' own experiences of receiving training, barriers and facilitators to therapy delivery, factors required to become a successful therapist and the impact of training and therapy delivery on the LHWs.

There are limitations to drawing conclusions about LHWs' views on training. Limited data about views on the content of training exist and even less on whether the delivery of the training was acceptable. Our findings demonstrate that whilst training is positively received by LHWs, generally it is felt that there is a lack of focus on mental health problems, with more comprehensive training required to support a population with mental health issues. Mental healthcare professionals, in all probability, will have existing knowledge about mental illnesses and therapy delivery. In contrast, lay therapists will have little to no knowledge in this area, making delivery of therapy difficult. Despite this, emphasis is placed on training the therapists in delivering the intervention which, although an important element, would be more successful if the therapist had a greater knowledge and broader understanding of the nature and context of mental health issues.

A number of barriers and facilitators to therapy delivery were identified in this review, which researchers should be aware of when planning their own training. A critical barrier highlighted in this review is participants' hesitance to reveal personal information, fearing a breach of confidentiality. Whilst this barrier is more likely to arise in LMICs where the patient and LHW will often come from the same village (Rahman et al., 2008), and where there is a greater stigma attached to mental health (Saraceno et al., 2007), it is also important to be aware of this when task-shifting interventions in HICs. Given that interventions will often be delivered by a volunteer from within the local area, there is a probability that the therapist and patient may know each other or when the intervention is delivered in a group that knows fellow group members. Within the wider literature, confidentiality and disclosure concerns are a known barrier to accessing mental health services (Gulliver et al., 2010; Salaheddin & Mason, 2016). Loss of confidentiality is closely related to the stigma often surrounding mental health problems within the communities; for example, fear of a breach in confidentiality can stem from the fear of stigma and embarrassment of others finding out (Clement et al., 2015). The basis of any therapeutic relationship is confidentiality (MacMurray, 1986), and building trust between individuals, communities and mental health services is important

when ensuring access to mental health services (Memon et al., 2016). Therefore, those developing and delivering mental health training should carefully consider how best to create a confidential environment which allows patients to safely make personal disclosures. Training should focus on the importance of boundaries and confidentiality, as well as incorporate solutions for when a patient is reluctant to disclose information, or for when disclosure is necessary, for example, due to risk of harm to self or others.

Numerous facilitators were also described in this review, with aids such as training materials guiding the LHWs during intervention delivery. Physical materials such as flip charts and handouts not only support the training but can also act as guides or points of information for the therapist to refer back to when faced with a challenge. Moreover, abstract factors such as the previous life experiences of LHWs can aid in delivering interventions, as by having similar experiences to the patients they may be more able to empathise with them as well as understand the intervention better (Fuhr et al., 2014). This is a crucial element when selecting LHWs to train; for example, past service users can use their own experiences and offer guidance through experiential knowledge of mental illness (Oborn et al., 2019), acting as role models and restoring hope for the patient (Davidson et al., 2012). Therapist self-disclosure in which the therapist discloses personal information regarding the therapist's life outside the therapeutic encounter can have facilitating effects on the therapeutic relationship, by building rapport and adding to client comfort (Audet & Everall, 2010). This experience may also serve as motivation for helping others, with the review identifying motivation as a facilitating factor for successful delivery of the intervention. However, qualitative data by Atif et al. (2016) shows that despite having well-trained and motivated therapists, it is possible an intervention may not be accepted by the community if the therapists selected are not desirable or non-matched to the community they are serving. Therefore, in addition to similar experiences of mental health problems, it may be useful to recruit LHWs who are peers from the same socio-demographic area as those that they will work with to ensure they are not perceived as 'foreign' by the community. Peers who are persons who share socio-demographic characteristics with the target population have been used to perform a variety of tasks including counselling, coaching and advocacy (Pitt et al., 2013), with evidence suggesting that peers may have a small additional impact on patient outcomes compared to standard psychiatric care (Fuhr et al., 2014).

Training and therapy delivery can lead to multiple gains for LHWs as outlined by this review, which can be used as an incentive by researchers when recruiting people to deliver the intervention. Training can lead to a positive impact in terms of confidence and development of new skills and provides the opportunity to meet new people. Furthermore, delivery of the intervention can develop the LHWs' communication skills and lead to an improvement in their relationship with others. In addition, the skills learnt can benefit the individuals in their existing work, especially if they are involved in healthcare and human services. The benefits of delivering therapy are supported by McLeod (2013), who suggests that this type of work is greatly satisfying, and individuals feel a

privilege to be a part of a process in which someone turns their life around. Moreover, evidence has supported the benefits of incorporating self-practice into training, in which trainees practice therapy techniques on themselves and reflect on their experiences (Gale & Schröder, 2014). Therefore, training should include aspects of self-reflection, as this can lead to increased empathy for the client and enhance therapeutic understanding and therapist skills (Bennett-Levy et al., 2001; Gale & Schröder, 2014).

This review also identified losses which may be experienced by the LHWs. For example, the stigmatising nature of mental health can lead to reluctance in accepting help and disclosing information by the participants (Rahman, 2008), but may also lead to stigmatising and negative attitudes towards those who are delivering the psychological interventions (Barnett et al., 2018a). Another loss or barrier that was noted in this review was the LHWs' difficulty in balancing the extra responsibilities of delivering their respective interventions with their current roles and duties. This should be considered when selecting LHWs, particularly in HICs where LHWs will most likely be volunteers who have other work commitments, leading to a lack of time and conflicts of interest and hence affecting their competency in delivering the intervention. Moreover, numerous roles and responsibilities may lead to burnout, a phenomenon that is common among the mental health service workforce due to higher workloads, and can impact the quality of care provided to mental health consumers (Morse et al., 2012; O'Connor et al., 2018). Therefore, preventing burnout through management of workloads and increasing supervision is essential to maintain therapists' satisfaction and a high quality of care (Westwood et al., 2017).

Supervision data is relatively absent from the literature. However, the data available highlights the importance of supervision for successful task-shifting. Supervision is an essential factor for increasing the confidence of the LHW, which in turn can lead to less support required as skills are developed. Furthermore, supervision can improve the trustworthiness of the therapist within the community, which is of particular importance in LMICs where there is a greater reluctance to seek help for mental health issues and disclose personal information. Clinical supervision is an integral part of psychotherapy training and continuous development, and its importance is supported through empirical evidence suggesting that supervision has positive effects on the trainees' therapeutic development and competencies (Bambling, 2014). Furthermore, specific supervision formats such as video monitoring and feedback may be effective in improving both therapist competence and treatment outcomes (Gonsalvez et al., 2016).

A number of key messages have been derived out of this review which can help in further improving the quality of training programmes and highlighting the benefits that are available for the therapists. First, duration and skill development should be reconsidered in training programmes to include sufficient time for learning about the nature and context of CMDs. Second, it should be explained to LHWs that as this is a new role, expectations of their performance are realistic, and it is with supervision and time that they would be able to improve their skills. A reassuring

supervisory role by a senior member of the team can help in building therapists' confidence and trust within the community, thereby facilitating the learning and therapy-delivering process. Moreover, LHWs should be given the opportunity to collaborate with other healthcare professionals, as they can offer further guidance and support through their own experiences. Lastly, it is necessary to ensure that LHWs understand the nature and boundaries of therapeutic relationships and that they have the practical knowledge of how to develop them.

6.4.2. Strengths and limitations

To our knowledge, this review is the first of its kind to focus on the experiences of LHWs trained in delivering psychological interventions. Our literature searches were systematic and transparent, but searching for qualitative studies is challenging, complex and requires further investigation (Booth, 2016).

Whilst the main objective of this review was to explore the experiences of LHWs on training and therapy delivery, the papers included in this review were mostly focused on the intervention itself with training only encompassing a small aspect of the papers. Therefore, it was not possible to gain in-depth information on each element of training such as format, content and delivery methods. Furthermore, direct quotes of patient experience were limited for extraction, and therefore, much of our findings were based on authors' interpretations of LHWs experiences. Whilst this has provided interesting data which adds considerably to the literature on the training of LHWs, a greater depth of data direct from LHWs would have been desirable.

To maximise data available, a range of psychological interventions and mental health conditions were included. Whilst this facilitated increased data for inclusion, it also created limitations for transferability of the findings. First, the content of training for various types of interventions will differ. Interventions such as CBT and PST are more likely to focus on the delivery components of structured interventions whereas counselling interventions will focus on the development of therapeutic relationships, engagement of the patient and person-centred approaches. Second, studies investigating CMDs would have to include training on a range of mental health conditions compared with those only investigating a single condition such as perinatal depression, leading to information on the mental illnesses being condensed, which could likely influence experiences.

It should be noted that 11 out of the 13 studies meeting the inclusion criteria were from LMICs, where LHWs are commonly used as a solution to the health worker shortage. Although differences can be seen between HICs and LMICs in terms of barriers faced by the LHWs in therapy delivery, there are also factors such as confidentiality that were common across all studies, and the themes that arose are universal themes that would be applicable elsewhere.

6.4.3. Implications for future research

Key lessons learnt from this review should be incorporated into a training framework so that future developers of LHW training interventions are aware of the important factors that need to be incorporated into the training plan. Future research should focus on identifying barriers and facilitators to training LHWs. We should seek to identify in-depth accounts of LHWs' experience of training, supervision, and therapy delivery. A further review should also be conducted to explore the experiences of trainers and supervisors. Synthesis of the experience of LHWs, trainers and supervisors can then inform the future development and delivery of training programmes for lay workers. Furthermore, whilst a review investigating the effectiveness of LHWs delivering psychological interventions has been conducted, the authors have noted that the quality of the studies used was low (van Ginneken et al., 2021). Therefore, further high-quality research needs to be conducted to better estimate the effect of LHW delivered interventions for the treatment of depression and anxiety.

6.5. Conclusion/chapter summary

- Task-shifting psychological interventions to LHWs have been found to be an effective solution to address the health worker shortage and is often seen as less intimidating and stigmatising than a formal service.
- Training is an essential component for successful task-shifting, and therefore, to be able to develop effective training programmes for these LHWs, their experiences in training and therapy delivery should be considered.
- This review highlights the important elements that researchers should be aware of when developing their own training programmes.
- The findings of this review have added to the evidence base of existing knowledge which should assist researchers to develop high-quality training based on clinical and research experience.

Chapter 7. Overview of study methodology

This chapter aims to present the research questions and the aims and objectives of the qualitative study. It will also discuss the different approaches to qualitative research, the rationale behind the qualitative approach employed and the methods that were used for selecting the task-shifting exemplars that were investigated. This research is reported in line with the COnsolidated criteria for REporting Qualitative research checklist (Tong et al., 2007), which can be seen in Appendix 10.

7.1. Study aim, objectives and research questions

The central aim of this study was to explore the perspectives of key persons who participated in the training of NTPs to deliver psychological interventions, to add to the literature on what constitutes essential training components required to successfully train NTPs to deliver psychological interventions. However, the reviews identified a lack of information and clarity in documentation of training; therefore, the author also decided to explore the opinions of experts on explanations for this.

Specific research objectives are:

- To explore the experiences of NTPs in training and intervention delivery.
- To explore the essential components for training NTPs as perceived by experts.
- To identify factors that influence the reporting of training by researchers within studies.
- To develop a reporting checklist that can aid researchers in reporting training during the writing process.

The research question has a vital role in guiding decisions about the study design and methodology (Bryman, 2007). A good research question should allow for the exploration of the phenomena of interest and be relevant and useful to the policy, practice or the development of the theory. Furthermore, it should be informed by existing literature and theory and have the potential to make a useful contribution or to fill current gaps. The research questions for this study are:

I) What are the essential components for training NTPs as perceived by experts?
II) What factors influence documentation of training as perceived by experts?
III) What are the barriers and facilitators experienced by NTPs during training to deliver psychological interventions?
IV) What are the barriers and facilitators experienced by NTPs in the delivery of psychological interventions?

7.2. Research designs

Research designs refer to the overall strategy that the researcher chooses to use to integrate the different elements of the study in a coherent and logical way to effectively address the research

question (De Vaus, 2001). There are two approaches to collecting and analysing data: quantitative or qualitative. Each approach has a different set of assumptions and underlying principles.

7.2.1. Quantitative research

Quantitative research relies on positivist principles, with the aim of measuring variables and testing hypotheses (Neuman, 2014). Quantitative methods emphasise objectivity, and scientific inquiry relies on data that are observed or measured to answer questions about a population. Researchers will often try to measure aspects of a problem to understand the relation to other variables by gathering data that is quantifiable. Data will often be collected through surveys, experiments, field research, and public data (Allen, 2017). Therefore, quantitative studies are either observational, in which variables are observed without intervening such as in case studies or longitudinal studies, or experimental, in which the variable is controlled to try and determine causality. For example, in before–after studies or RCTs, an experimental condition will be introduced and variables will be measured before and after to test the hypotheses. Quantitative research allows for generalisation to a larger population through the use of statistics, allowing the researcher to make generalisations of how a larger population may have a similar reaction to the sample population being tested. However, a degree of error may always be present with making generalisations due to differences in sizes between the actual population and the sample; therefore, it is necessary to be cautious when making generalisations (Allen, 2017).

7.2.2. Qualitative research

Qualitative research is a broad term that includes a wide range of approaches and methods found in different research disciplines. A naturalistic and interpretative approach, this type of research aims to provide ‘an in-depth and interpreted understanding of the social world through an individual’s social and material circumstance, their experiences, perspectives and histories’ (Ritchie et al., 2014, p.23). A feature of this type of research is the volume and richness of the data collected through different qualitative methods such as participant observation, interviews and focus groups and analysed and interpreted through a variety of distinctive approaches, leading to different kinds of output. Qualitative research differs from qualitative, as it is concerned with answering ‘what’, ‘why’ and ‘how’ questions using specific data involving words or images rather than answering ‘how many’ questions which seek to quantify or measure.

Until the 1960s, quantitative methods involving the testing of hypotheses through controlled experimentation were the dominant approach to research in the natural, physical and social sciences. However, advocates of qualitative research in the social sciences argued that methods involving observation and interviewing would be more suited for studying people and would provide a better understanding of human behaviours in their social and material contexts, eventually leading to the introduction of qualitative research methods in the healthcare field.

Mental health research is complex due to the multifactorial nature of mental disorders in terms of both aetiology and treatment. Management of the disorder often includes the involvement of a multidisciplinary team as well as a range of approaches to treatment such as pharmacological and psychological. Furthermore, mental health research is often considered challenging due to the sensitive nature of topics, which can raise ethical concerns. However, qualitative methods are useful, as they provide a voice to participants, exploring their experiences and opinions, which can allow for the development and testing of theories and interventions, the development of tools and measures, and for understanding the issues around translation and implementation into clinical practice (Peters, 2010). According to Padgett (2016), qualitative research is most appropriate when:

- Relatively little is known about the topic being explored.
- The topic involves sensitivity and emotional depth.
- The goal is to capture the 'lived experience' from the perspective of those who live it and create meaning from it.
- The goal is to explore and understand the processes of practice, programs and interventions.
- The goal is to resolve unanswered questions left by quantitative research.
- Conducting action-orientated participatory research aimed at merging advocacy with research.
- The goal is to study complex social processes.

Although qualitative research methods are increasingly used in clinical settings, it has been criticised for lacking scientific rigour. Most criticisms include the notion that qualitative research is strongly subject to researcher bias and lacks reproducibility and generalisability (Mays & Pope, 1995). To address this, qualitative researchers stress the importance of rigour in data collection and analysis (Mays & Pope, 1995), and guidelines for assessing qualitative research have been developed (Kitto et al., 2008). Research integrity and robustness are important aspects of qualitative studies, and it is widely accepted that qualitative research should be ethical, important, clearly and coherently described and use appropriate and rigorous methods (Cohen & Crabtree, 2008). Whilst quality criteria used in quantitative research such as internal validity, generalisability, reliability and objectivity are not suitable to assess the quality of qualitative research, qualitative researchers often defend the integrity of their work through the concept of trustworthiness (Korstjens & Moser, 2018). The best-known criteria for determining trustworthiness has been defined by Lincoln and Guba (1985) and can be seen in Box 7.1.

Box 7.1. Quality criteria for trustworthiness

Credibility	The confidence that can be placed in the truth of the research findings. Credibility establishes whether the research findings represent plausible information derived from the participant's original data and a correct interpretation of the participant's views. This is determined through strategies such as prolonged engagement, persistent observation and member checks.
Transferability	The degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents. This is ensured by providing a thick description of behaviour, experiences as well as their context to ensure it is meaningful to an outsider.
Dependability	The stability of findings over time. Transparently describing the research steps through a well-documented audit trail.
Confirmability	The degree to which the findings of the research study could be confirmed by other researchers. Confirmability is concerned with establishing that data and interpretations of the findings are not figments of the researcher's imagination but are clearly derived from the data
Reflexivity	The process of critical self-reflection about oneself as a researcher (own biases, preferences, preconceptions) and the research relationship (relationship to the respondent and how the relationship affects participant's answers to questions).

Source: Lincoln & Guba (1985, as cited in Korstjens & Moser, 2018)

Although often a complex process involving rigorous analysis, qualitative methods are receiving increasing recognition in healthcare, as they enable researchers to answer questions that may not be easily answered by quantitative methods. Furthermore, the knowledge gained from qualitative research can allow for the development of new research instruments and interventions and inform social policy and theory. However, it needs to be conducted with explicit methodology, and researchers must demonstrate the validity of their analysis and conclusions to ensure the robustness of the research.

7.2.3. Mixed methods

Mixed methods is a research approach where researchers collect and analyse both quantitative and qualitative data within the same study (Bowers et al., 2013). The integration of data allows researchers to seek a wider view of their research, viewing phenomena from different perspectives. This form of research is useful for answering research questions which neither quantitative or qualitative methods would be able to answer alone (Shorten & Smith, 2017). Furthermore, it allows the researcher to gain a better understanding of any connections or

contradictions between qualitative and quantitative data as well as provides an opportunity to gain perspectives and experiences of stakeholders throughout the research process (Wisdom & Creswell, 2013). However, using a mixed-methods approach can increase the complexity of conducting the research, as it often requires more resources, additional training and a multidisciplinary team to be able to analyse and interpret the data (Wisdom & Creswell, 2013). A summary of all three research designs can be seen in Box 7.2.

Box 7.2. Differences between research designs

Quantitative Methods	Qualitative Methods	Mixed Methods
Pre-determined	Emerging methods	Both pre-determined and emerging methods
Instrument-based questions	Open-ended questions	Open- and close-ended questions
Performance data, attitude data, observational data and census data	Interview data, observation data, document data and audio-visual data	Multiple forms of data
Statistical analysis	Text and image analysis	Statistical and text analysis
Statistical interpretation	Themes, patterns, interpretation	Interpretation across the database

Source: Creswell (2014)

7.2.4. Rationale for the research design employed

Qualitative methods are well suited to examining complex issues and often address research questions that involve exploration and the development of emerging concepts and theories. In this context, a qualitative methods approach is considered appropriate to answer the research questions, as it requires the exploration of the essential training components for NTPs task-shifting psychological interventions and can help identify the reasons as to why they are perceived to be essential.

7.3. Theoretical and applied research

Research methodology distinguishes between theoretical and applied research. The purpose of theoretical research is to increase understanding with the aim of testing, generating and enhancing thinking by developing theories or testing existing theories (Ritchie et al., 2014). Meanwhile, applied research is concerned with using the knowledge that is gained through research to solve concrete real-world problems and bring about social change (Babbie, 2013). However, within the field of social sciences, there is a disagreement about whether there should be a distinction between theoretical and applied research due to the important interaction between social theory

and social research, a concept which is integral within the social sciences. Therefore, it has been suggested that all research be based on theoretical assumptions, concepts or hypotheses, and similarly, research can also contribute to theory by enhancing knowledge and providing a deeper understanding of the social world (Ritchie et al., 2014). Although social research is considered most useful when theoretical and applied research are mutually enhancing, and often most research lies in the middle of the continuum, it is important to distinguish between the two, as they have implications for the design and evaluation of the research. For example, research aimed at increasing knowledge and understanding will have a different set of decisions informing the research design compared to research aimed at developing policies (Gooyert & Größler, 2018).

Although the distinction between theoretical and applied research may be blurred, the term 'applied social policy research' is often used with regard to studies which aim to contribute towards the development, monitoring and evaluation of policies (Ritchie et al., 2014). Research into policies is necessary to ensure optimum efficiency and utilisation, and therefore, applied policy research is essential and often multifaceted and extensive. Framework analysis is a qualitative method that is suited for applied social research policy, as it has the ability to answer specific questions within a limited time frame, with a focus on a pre-designed sample and a priori issues (Ritchie & Spencer, 2002). This method of analysis will be described in detail further on in the chapter.

7.3.1. Qualitative data analysis approaches

Data analysis in qualitative research is the process of reducing large amounts of data and making sense of it by searching for patterns, developing ideas and linking those findings with existing research (Bernard, 2013). There are many different approaches to qualitative data analysis which will vary based on the nature of the research question and the aims and objectives that the analytical process sets out to achieve (Ritchie et al., 2014). Furthermore, the decision as to which method of analysis to use will also depend on whether the focus is substantive, where emphasis is placed on what the text 'says', and is concerned with capturing and interpreting meanings in the data such as in thematic analysis and grounded theory, or whether the focus is structural, emphasising language and what the text 'does' such as in discourse and conversational analysis. Analyses may range from detailed examinations of texts (narrative and discourse analysis) to general syntheses of data (case study and ethnography) to interview-intensive methods (phenomenological analysis and grounded theory) (Padgett, 2016). A brief description of some of the main qualitative data analysis approaches is provided below:

- *Ethnographic research* involves the researcher describing and interpreting the shared and learnt patterns of values, behaviours, beliefs and languages of a cultural group (Creswell, 2007).

- *Narrative research* captures personal and human dimensions of experience over time, taking into account the relationship between individual experience and cultural context (Clandinin & Connelly, 2000). Compared with other qualitative approaches that segment data into categories, narrative approaches are concerned with preserving the integrity of a particular event, actions, language and genres within an individual's conversation (Riessman, 2011).
- A *phenomenological study* describes the meaning for several individuals of their lived experiences of a concept or a phenomenon. Researchers focus on capturing the features that all the participants may have in common as they experience a certain phenomenon (Creswell, 2007).
- *Grounded theory* involves the development of an explanatory theory of basic social processes, studied in the environments in which they take place through the generation of analytic categories, their dimensions and the relationships between them (Ritchie et al., 2014).
- *Case study research* involves the researcher exploring single or multiple cases over time, through detailed, in-depth data collection, which will involve using multiple sources of information such as interviews, reports and observations (Creswell, 2007). Case study research, through reports of existing programs, allows for the exploration and understanding of complex issues (Zainal, 2007) and when applied correctly can be a useful method in research to develop a theory, evaluate programs and develop interventions.
- *Content analysis* examines the content and context of documents.
- *Conversation analysis* focuses on the structure of conversation and interaction between individuals (Ritchie et al., 2014)
- *Discourse analysis* focuses on the use of language within a social context (Salkind, 2010).
- *Thematic analysis* involves discovering, interpreting and reporting patterns of meaning within the data. Topics are identified and clustered into higher-order themes by working through the text (Ritchie et al., 2014). This process of 'coding' is used in many analytical approaches (grounded theory and framework analysis) and will be described in greater detail in the next section.

7.3.2. Framework analysis

Analysis of qualitative data is based on principles which involve transcribing the data; immersing oneself within the data to gain insight into the phenomena being explored, developing a data coding system and linking codes to form overarching themes which can lead to the development of a theory (Morse & Richards, 2002). Generating themes from data is a common analytical method used in approaches such as thematic analysis or the framework approach. Although thematic analysis can provide rich and insightful findings of complex phenomena (Braun & Clarke, 2006), it has been critiqued for lacking depth, fragmenting the phenomena being studied, being subjective

and often lacking transparency concerning the development of themes, which can lead to difficulties when judging the rigour of the findings (Attride-Stirling, 2001).

Framework analysis is a method that has been used since the 1980s and is becoming an increasingly popular approach in medical and health research (Gale et al., 2013). A more structured approach than other qualitative methods, the framework analytical process is more transparent and is drawn from questions derived from the aims and objectives of the study as well as the participants' views and experiences (Pope et al., 2000). This analysis enables the use of both a deductive approach in which themes are pre-selected based on specific research questions, as well as an inductive approach which allows for the discovery of other unexpected aspects of the participant's experience (Gale et al., 2013). Furthermore, the approach has a greater emphasis on showing the linkage between the stages of analysis, with distinct interconnected stages allowing the researcher to move back and forth across the data until a coherent account arises (Ritchie & Lewis, 2003). The key features of the framework analysis can be seen in Box 7.3.

Framework analysis is not aligned with a particular epistemological, philosophical, or theoretical approach (Gale et al., 2013). Having both a deductive and inductive nature, it is a flexible tool that can be adapted for use with many qualitative approaches with the goal to generate themes. However, for this research the epistemological stance is interpretivism in which the researcher and the social world impact on each other, therefore the social researcher will explore and understand the social world using both the participant's and the researcher's understanding (Ritchie & Lewis, 2003). This approach states that facts and values derived from the data are not distinct and findings are influenced by the researcher's views and values, consequently making it difficult to conduct objective free research as the researcher is part of the research, interprets data and can never be fully removed from the research. For example, within this study the author's past experience as a trainee may influence the interpretation of the data due to her own perceptions on effective and ineffective training strategies. However, this can be addressed by the researcher being transparent about their assumptions (Ritchie & Lewis, 2003). Therefore, interpretive research needs to be reflexive, whereby the researcher needs to take account of how their assumptions and views have impacted on the research process (Charmaz, 2006). Reflexivity practices carried out by the author for this study are discussed in section 7.4.9.

Box 7.3. Key features of framework analysis

Grounded or generative	It is heavily based in, and driven by, the original accounts and observations of the people it is about.
Dynamic	It is open to change, addition and amendment throughout the analytical process
Systematic	It allows methodological treatment of all similar units of analysis.
Enables easy retrieval	It allows access to, and retrieval of, the original material.
Allows for between- and within-case analysis	It enables comparisons between and associations within cases to be made.
Accessible to others	The analytical process, and the interpretations derived from it, can be viewed and judged by people other than the primary analyst.

Source: Richie & Spencer (2002)

Due to the nature of the analytical process being accessible and well documented, it allows for the reconsideration and reworking of ideas. The framework approach involves a systematic process of sifting, charting and sorting material according to key issues and themes. The five key stages in the framework analysis approach are (i) familiarisation, (ii) identifying a thematic framework, (iii) indexing, (iv) charting, and (v) mapping and interpretation (Ritchie & Spencer, 2002).

7.3.2.1. Familiarisation

This is the first step in the analytical process, in which the researcher will immerse themselves in the data, gaining an overview of the content and becoming aware of key ideas and recurrent themes that may be emerging and taking note of them (Ritchie & Spencer, 2002).

7.3.2.2. Identifying a thematic framework

In the second stage, the researcher will return to the notes made during familiarisation and attempt to identify key themes, issues and concepts corresponding to the data. These themes and sub-themes will be refined, sorted and grouped to construct an initial thematic framework. Grouping and sorting of themes and sub-themes may occur according to different levels of generality, in a hierarchical arrangement, allowing the researcher to hold an overall structure in their head (Ritchie et al., 2014). At this stage, themes and sub-themes should be descriptive rather than abstract and remain grounded in the data. The construction of this framework will be based on a priori issues derived from the research question, emerging issues mentioned by the participants and themes developing from recurring views or experiences of participants (Ritchie & Spencer, 2002). According to Ritchie and Spencer (2002, p. 180), the development of the thematic framework

involves both analytical and intuitive thinking and does not occur automatically. The process involves having a deeper understanding of the context and requires the ability to make judgements about meaning, recognising the relevance of certain issues that are arising and making connections between ideas. The framework also ensures that the research questions are fully addressed. If the study involves more than one sample of participants, individual frameworks may need to be developed for each sample, or a common framework with additional categories could be used which would help identify commonalities between the samples.

7.3.2.3. Indexing

The thematic framework is used to annotate and label the data. In this stage, the framework is applied to the textual data, and indexing references are recorded in the margin of the transcripts using a numerical number that was assigned to each theme (Ritchie et al., 2014).

7.3.2.4. Charting

Data that was indexed will be arranged into charts with headings and subheadings that may be drawn from a priori research questions or during the development of the thematic framework (Ritchie & Spencer, 2002). The indexed data will be summarised and referenced to allow the ability to locate them in the original transcript.

7.3.2.5. Mapping and interpretation

In the final stage, the key characteristics within the chart will be mapped out and interpreted. This process will provide a diagram of the phenomenon under investigation, facilitating the researcher in their interpretation of the data. At this stage, the researcher will review the charts and research notes, compare and contrast the different views and experiences, search for patterns and connections and find explanations for these within the data (Ritchie & Spencer, 2002).

The framework analysis approach provides clear steps to follow and provides highly structured outputs of summarised data; therefore, it is particularly convenient for managing large data sets where there is a need to produce a descriptive overview of the data (Gale et al., 2013). Furthermore, this approach is useful for generating recommendations on outcomes within a limited time frame to address policies with specific research questions (Srivastava & Thomson, 2009). If implemented properly, it can shed light on important issues and can be a useful tool for contributing to the improvement of health services and the development of new policies (Gale et al., 2013).

7.3.3. Rationale for using framework analysis

Framework analysis was considered the most appropriate method to analyse data from this study, as it is transparent, systematic and emphasises rigour. Ritchie and Spencer (2002) outline four types of research questions that they suggest framework analysis can address:

I) **Contextual** - identifying the form and nature of what exists
II) **Diagnostic** - examining the reasons for, or causes of, what exists
III) **Evaluative** - appraising the effectiveness of what exists
IV) **Strategic** - identifying new theories, policies, plans or actions

Therefore, framework analysis is deemed appropriate to use as it can help address the research questions which fit both within the 'contextual' and 'strategic' categories – in so far as this research is interested in finding out about the nature of NTPs' and experts' experiences of receiving or delivering training (contextual) but also in developing a checklist for reporting training in the future (strategic). Furthermore, the large scope of data gathered through interviews will help appraise the effectiveness of the training programs that exist (evaluative).

The structure of framework analysis allows for analysing data both across cases as well as within individual cases which is vital to be able to compare and contrast interviews with participants from the HIC and LMIC. Furthermore, the framework method is best suited for this study as it can use a combination of deductive and inductive approaches, where the study has some specific questions to explore through the research aims and objectives, but also aims to leave space to discover other unexpected aspects of the participants' experiences.

It is essential that the analysis be conducted by a researcher skilled in qualitative research, as the framework method involves reflexivity, rigour and quality analysis. Furthermore, qualitative research skills are essential to appropriately interpret the matrix and facilitate the development of descriptions, categories, explanations and typologies (Gale et al., 2013). Therefore, the author attended the NatCen Social Research course 'Analysis of Qualitative Data' to ensure that analysis was conducted systematically and with rigour.

7.4. Research procedures

Research procedures describe the precise steps conducted when carrying out research.
These include methods of sampling, data collection and analysis and are described in further detail within this section.

7.4.1. Sampling strategies for qualitative research

As the central aim of qualitative research is to explore a phenomenon and meanings and generate new ideas and concepts, the samples chosen need to ensure the inclusion of relevant characteristics to allow for understanding. Ritchie et al. (2014) have termed this principle of sampling as 'symbolic representation', as a sample is chosen to 'symbolise' and 'represent' relevant characteristics to the study. Furthermore, it is necessary to ensure the sample is as diverse as possible within the set limits of the chosen population. This increases the chances of identifying the full range of characteristics that may be associated with the phenomenon being investigated. Additionally, greater diversity allows for interdependency between characteristics so that those features that are more important can be studied separately from those that may be deemed less important (Ritchie et al., 2014). Therefore, to ensure that the requirements of 'symbolic representation' and 'diversity' are met, it is necessary for samples to meet a prescribed selection criterion to be chosen.

A key characteristic of qualitative samples is that they are relatively small in size, which allows for an in-depth investigation of the phenomena being studied (Ritchie et al., 2014). Within social research, a distinction is made between probability sampling and non-probability sampling.

7.4.1.1. Probability sampling

In probability sampling, each member of the population has an equal chance of being selected. Although this method of sampling is inappropriate for qualitative research, it is generally held to be the most useful approach in quantitative sampling, as it produces a sample that is statistically representative of the whole population.

7.4.1.2. Non-probability sampling

In contrast, qualitative research uses non-probability sampling, in which samples are deliberately chosen to reflect particular characteristics within a group under investigation (Ritchie et al., 2014). In this method of sampling, the probability of selecting each member of the population is unknown and therefore not representative of the whole population. However, the overall aim of non-probability sampling is to gain in-depth information into the processes being investigated. This can be achieved through a number of sampling strategies including purposive, theoretical, convenience and snowball sampling, which have been described in further detail ahead.

7.4.1.3. Purposive sampling

In this method of sampling, the sample selected by the researcher is based on a certain criterion, which will allow for a deeper understanding of the phenomena under investigation. Decisions about the selection criteria will often be made at the early stages of the research and will be influenced by

several factors, such as existing knowledge in the area of study and gaps in knowledge about the study population, or it may be guided by the aims, objectives and hypotheses that the study is exploring (Ritchie et al., 2014). Furthermore, qualitative samples are often purposive, in that they are selected due to their capacity to provide rich information (Vasileiou et al., 2018), with research demonstrating the greater efficiency of purposive sampling compared to random sampling in qualitative studies (van Rijnsoever, 2017).

7.4.1.4. Theoretical sampling

Theoretical sampling is a process of data collection where the researcher simultaneously collects data, codes and analyses it to develop a theory (Glaser & Strauss, 2017). The process is iterative in that the researcher will analyse an initial sample of data and then select a further sample to refine the emerging categories and theories. The process will continue until the researcher reaches data saturation, and there is no new insight from the further samples (Ritchie et al., 2014). According to Glaser and Straus (2017), theoretical sampling for saturation can be a multifaceted investigation, where there are no limits to the techniques used for data collection or the types of data acquired. Theoretical sampling is a rigorous way of ensuring thorough data collection and allows for exploration of studies in unfamiliar areas; however, it is more time-consuming and less predictable due to its iterative process.

7.4.1.5. Convenience sampling

In convenience sampling, selection of the sample is made based on who is available. Although this method of sampling can help obtain information about a study relatively quickly and cheaply, it carries with it some limitations. The sample selected will often be an underrepresentation of the target population and is often subject to bias beyond the control of the researcher.

7.4.1.6. Snowball sampling

Within snowball sampling, researchers will often identify a small number of initial participants who fit the research criteria, who will then be asked to recommend other individuals with similar characteristics. In this way, researchers use their social networks to establish links, with the increasing chain of participants acquired through the developing sampling momentum. Sampling will often end when the target sample size has been reached (Parker et al., 2019).

7.4.1.7. Sample size

In qualitative research, the decision of how many samples to select can be difficult to consider and, according to Merriam and Tisdell (2015), may haunt a novice researcher. In applied research, often there is a demand for guidelines for recommended sample sizes that studies should adopt, as often the practicalities of planning a study and costs require having a fairly good idea of how many

interviews will need to be conducted or how many sites will be visited (Green & Thorogood, 2018). Ritchie et al. (2014) suggest that for qualitative research, the sample size for a study involving interviews with individuals will usually be under 50 people. In contrast, Green and Thorogood (2018) state that the experience of most qualitative researchers is that when conducting interviews addressing a specific research question, little 'new' comes out after analysing 15 transcripts. Sandelowski (1995, p.183) suggests that qualitative sample sizes should be large enough to allow the development of a 'new and richly textured understanding', but small enough so that the 'deep, case-orientated analysis' of qualitative data is not hindered. Generally, a larger sample size can become difficult to manage in terms of the quality of the data and the analysis that would be conducted whereas if appropriate sampling is used, a smaller sample size can allow for rich data and enable the relevant characteristics to be studied.

7.4.2. Procedures for sampling in this study

A complex sampling strategy was employed throughout this study. Initially, exemplars using a task-shifting approach were identified through snowball sampling. By using snowball sampling, researchers that were involved in task-shifting studies were able to provide a point of contact to further researchers who had conducted a comparable study involving a task-shifting approach. The four task-shifting exemplars described in Chapter 8 were then selected through a combination of purposive and convenience sampling. The selection criteria for the exemplars are outlined in section 7.4.2.1. Studies were selected from both HICs and LMICs to allow us the ability to compare and contrast the different training strategies and how these may differ in a poor-resource setting compared to a rich-resource setting. Convenience sampling was then used to select the final programs based on limited resources and the author's ability to travel to the recruitment sites. Participants for the interviews were selected through purposive sampling for the reasons outlined in section 7.4.1.3. Further details about the selection criteria of the programs and participants are provided below.

7.4.2.1. Selected task-shifting exemplars

When selecting exemplars to investigate, access was a central consideration as the programs needed to allow the researchers to access the key personnel, the organisation and information needed for analysis within this study. Therefore, inclusion criteria included (a) ongoing studies or studies that had ended within the last year, (b) studies using a task-shifting approach that trained NTPs in delivering psychological interventions, (c) studies in which substantial information is available or can be made available on the training of the NTPs and (d) studies in which participants have CMDs.

7.4.2.2. Experts involved in training NTPs in psychological therapies

The criteria for selecting experts to interview included: (a) Individuals who were involved in the training and/or supervision of the NTPs, (b) individuals involved in the development of the training and (c) master trainers who had been involved in the initial training of the trainers who had then proceeded to train NTPs.

7.4.2.3. NTPs trained in delivering psychological therapies

NTPs who had taken part in the training within the studies to deliver psychological therapies were selected via purposive sampling and identified through principal investigators/study organisers of the program. Although the initial selection criteria of the NTPs involved selecting individuals who had no training or education in mental health, this was found to be difficult in the HIC setting. Therefore, the selection criteria were modified to include individuals who may have had a social science degree but did not have any training or experience in delivering the psychological intervention.

7.4.3. Recruitment

Considerations and planning for recruitment occur during the early stages of the study development and are vital to the success of a research study (McDonald et al., 2006). It is a process that usually involves approaching participants, informing them about the study and obtaining written or verbal consent.

7.4.4. Procedures for recruitment

Studies that fit the study's inclusion criteria were first approached via email and were given information regarding the study and made aware of what would be required from them, i.e., access to their training materials and the ability to interview experts and NTPs involved in training. Studies that confirmed their participation provided approval letters to show their acknowledgement in participation (Appendix 11, THPP, Appendix 12: Big Life, Appendix 13: LTPP). A formal letter of approval was not needed from the PERSUADE study, as the research was carried out within the Centre for Primary Care. Following approval, the principal investigators/study organisers gave the author access to the contact information of the NTPs and experts involved in training. The aim was to recruit a total of 36 participants (12 experts, 24 NTPs) from both the UK and Pakistan. The author e-mailed information sheets (Appendix 14: NTP version, Appendix 15: Expert version) and consent forms (Appendix 16: NTP version, Appendix 17: expert version) to all the participants at least 24 hours prior to the interview. As NTPs in Pakistan did not have an e-mail, information sheets and consent forms in Urdu (Appendix 18: Information sheet, Appendix 19: Consent form) were sent to the principal investigators/study organisers, who then gave them to the Pakistani NTPs. Prior to the start of the interview, the author briefly gave the participant an overview about

the study, as well as providing the information sheet and consent form. Written consent was taken from all participants prior to the interview. Furthermore, all the participants were informed about their right to withdraw from the study at any time and were also made aware that all their information will be kept strictly confidential. Following the consent, the author arranged a time to interview the participant at a location of their convenience or over the phone.

7.4.5. Data collection

Data collection is a process of collecting information from all the relevant sources to address the research question. Data collection can be divided into two categories: secondary data, where analysis of existing data is conducted, and primary data, where new data is generated for the study. Although secondary data can be a valuable approach to bringing a new perspective to the already existing data, it requires a level of scrutiny for the data to reach the same level of quality and relevance that will often come from primary data (Ritchie et al., 2014). Furthermore, data collection for qualitative studies can either be 'naturally occurring' data, in which the data is not directly elicited by the researcher but is rather obtained through observation (Potter, 2002), or it can be 'generated', in which the data is obtained directly through interaction between the researcher and participant (Ritchie et al., 2014). The main data collection methods within qualitative research include interviews, focus groups and observations and are described in detail below.

7.4.5.1. Interviews

Interviews are an important qualitative research method and allow the researcher to generate descriptions and interpretations of an individual's social world. Webb and Webb (1932, as cited in Ritchie et al., 2014) described the interview method as a 'conversation with a purpose'. Interviews allow for participants to freely express their ideas and opinions and shape the interview according to their answer and allows the interview to probe and expound the participants' response (Rubin & Rubin, 2011). Whilst there are a number of different perspectives on interviewing and the types of interviews that exist (Brinkmann & Kvale, 2015; Rubin & Rubin, 2011), the key features that are widely agreed upon are the flexible and interactive nature of the interview, its ability to achieve depth and the generative nature of the data (Ritchie et al., 2014). Qualitative interviews can be described as either being semi-structured or in depth. Semi-structured interviews are based on a series of open-ended questions about a number of issues that are relevant to a particular topic whereas in-depth interviews will cover a fewer number of topics but usually will be in greater detail.

7.4.5.2. Focus groups

Within focus groups, data is generated by the interaction between the group of participants. In this type of qualitative method, the participants will express their views and experiences whilst also

listening to the other people in the room. This allows them to reflect on what is being said and present their opinions in the context of the other people's views, generating additional information. The principle behind this method of data collection is that group processes can allow people to explore and clarify their views in a way that may not be as easy in an individual interview. Furthermore, focus groups allow the researcher to observe the different forms of communication that individuals would use in interactions such as jokes, anecdotes, teasing and arguing (Kitzinger, 1995).

7.4.5.3. Observations

Observational methods are useful for when the researcher seeks to understand a phenomenon in its natural setting (Ritchie et al., 2014). This form of data collection offers the researcher the ability to analyse non-verbal communication by observing behaviours, actions as well as social interactions. The data generated through observations will be subjective and influenced by the experiences of the researcher. Observational methods are often rarely used alone and will commonly be used in combination with another form of data collection in a mixed-methods design. This allows further insights that are unlikely to have been gained from one method alone.

7.4.6. Procedure for collecting data in this study

Data for this study was collected through semi-structured interviews conducted by the author (US) who interviewed NTPs who delivered the intervention as well as through interviews with experts involved in training. This aimed to address the research questions to explore the essential components within training as perceived by experts in task-shifting and by NTPs who have received training in delivering psychological interventions. A topic guide developed by Perryman (2014), who interviewed Primary Care Practitioners and experts on their perceptions of effective healthcare professional training, has been used as a foundation to create a topic guide for interviewing experts and NTPs from the chosen exemplars. The topic guide was also developed based on the findings from the systematic reviews which were conducted prior to this study and were used to ensure consistency across the interviews. The topic guide consisted of a series of open-ended questions that related to a number of topic areas including content and delivery of training, facilitator and supervision. NTPs who were trained to deliver psychological interventions were interviewed to explore their experiences in receiving training (see Appendix 20). Furthermore, their experiences with delivering the intervention were also discussed along with any barriers and facilitators they encountered and how they feel that the training could address this. The experts were also further questioned on areas that the NTPs were not, including their views on theoretical frameworks for training. Furthermore, although the main objective of this qualitative study was to explore the experiences of delivering training in practice, the reviews identified a lack of information in the reporting of training in papers. Therefore, interviews with experts also included questions regarding the lack of reporting on training in research papers and how this could be improved (see

Appendix 21). As interviews with NTPs in Pakistan were conducted in Urdu, the topic guide was translated into Roman Urdu for ease of the author conducting the interviews (see Appendix 22).

Conducting interviews is a high-skill activity (Gale et al., 2013); consequently, to obtain the most detailed and richest data, the researcher must be appropriately trained in interviewing techniques (Boyce & Neale, 2006). Therefore, the author attended the Social Research Association course 'Interviewing (Qualitative Data Collection)' to be able to conduct high-quality interviews.

All interviews took place between October 2019 and January 2020 and were audio-recorded using an encrypted recording device. Ethical approval for this study was obtained from the University of Manchester Research Ethics Committee (Appendix 23), and local ethics approval was also obtained from Pakistan (Appendix 24).

7.4.6.1. Procedures for collecting data in Pakistan

Data collection for NTPs and experts in Pakistan involved the researcher travelling to the cities of Rawalpindi and Karachi, where the studies were based (see section 8.4). Interviews with experts were conducted face-to-face at the main research centres of the programs (n=11), with the exception of one interview, which took place over the telephone, and another in which the master trainer was residing in the UK. Therefore, the interview was conducted face-to-face at the experts' place of work in Manchester. Procedures for conducting interviews with the NTPs involved in the THPP consisted of the author visiting the homes of the NTPs in the rural subdistrict of Kallar Seydan, Rawalpindi. To ensure safety, the author was accompanied by two field coordinators from the Human Development Research Foundation, who also introduced the NTPs to the author and acted as translators when there were any language barriers.

When arranging interviews with the NTPs involved in LTPP, the author had been advised against travelling to Gadap town in Karachi to conduct interviews due to safety concerns. Subsequently, the Pakistan Institute for Living and Learning organised transport for the NTPs to travel to the research centre, where the interviews were conducted in a private office.

7.4.6.2. Procedures for collecting data in the UK

Within the UK, both NTPs and experts were given the option of having a telephone or face-to-face interview. Face-to-face interviews (n=4) took place at the participants' place of work. All telephone interviews (n=7) were conducted at the University of Manchester in a private office.

7.4.7. Data analysis

The data was analysed using framework analysis as described in section 7.3.2. All interviews that were conducted in Urdu were transcribed in Roman Urdu by a trained transcriber from Pakistan and were analysed by the author in the same language. This was done so that any phrases of expression that were specific to the Urdu language were not lost in translation. Interviews that were conducted in English were transcribed by the author. To ensure accuracy of the transcription and translation, all transcribed interviews were checked for errors by the author against the original recordings and corrected prior to analysis. Whilst returning transcripts to participants for comments and correction would have ensured accuracy of the transcription, this was not possible to do due to lower levels of literacy of the NTPs.

The analysis was conducted by the main author (US) and reviewed by the supervisory team. All five steps of the framework analysis were conducted and described as follows:

Familiarisation: Familiarisation of the data took place during the transcription of the interviews when checking the quality of the interviews and through reading the transcripts multiple times. This allowed the author to become familiar with the data and identify emerging themes and subthemes. Emerging themes were noted in Excel for each participant alongside sections of the transcript. For transcripts in Urdu, relevant sections were translated and referenced back to the original data.

Identifying a thematic framework: The construction of a thematic framework was initiated as themes continued to emerge. A separate framework was developed for NTPs and experts. Similar themes were grouped and organised in the framework. The different sub-themes within Excel were colour-coded to distinguish between sub-themes. Summary data for each participant was recorded in the framework matrix in an Excel document with reference back to the original transcript, allowing them to be located and ensuring this process was transparent.

Indexing: After the development of the framework, the process of indexing began in a separate Word document for NTPs and experts, in which themes within the thematic framework were refined even further to create sub-themes with overarching themes. Data was split according to HIC and LMIC to allow the ability to compare and contrast emerging similarities and differences between the two settings.

Charting: After indexing, a final charted framework was developed in Excel, which was separated into NTPs and experts. A summary of data for each participant according to themes and sub-themes was charted with a reference back to the original transcript.

Mapping and interpretation: In the last stage, the thematic charts of the NTPs and experts were analysed to examine key links and associations. The data within each theme was explored, and responses were compared and contrasted to interpret the data. A narrative account of the data which describes the themes and subthemes was produced separately for NTPs and experts and is presented in Chapter 9.

7.4.8. Rigour and trustworthiness

To ensure that all the steps followed in the analysis were transparent, systematic and accurate, the summary of data was checked against the original transcripts to ensure that the summaries were true to the participants' accounts. Furthermore, each summary had a reference back to the original location in the data.

Trustworthiness was determined against the criteria highlighted in Box 7.1. During the development of the thematic framework, themes and subthemes were reviewed by the supervisory team. Furthermore, to check that the data fit within its relevant theme, a portion of themes with charted data was presented and reviewed by the supervisory team, and any discrepancies were reviewed and resolved by moving the data into a more appropriate theme. The method of framework makes it easy to illustrate themes with data extracts, to check whether there is sufficient evidence for a proposed theme and allows for a well-documented audit trail describing the steps of the research was kept to ensure the stability of the findings over time.

Another method of ensuring trustworthiness may have been by showing participants results of the data analysis to confirm that interpretations of the findings are credible and not a figment of the researcher's imagination. However, this was not possible due to the start of the COVID-19 pandemic, making it difficult to contact participants. Furthermore, it was believed that checking the findings might not be possible for study participants in the LMIC due to low literacy levels.

7.4.9. Reflexivity

This section aims to reflect on how the author's position as a health psychology researcher may have impacted on the qualitative analysis and describes strategies that were put in place to increase trustworthiness in the research undertaken in this thesis. According to Berger (2015) the position of the researcher may impact the research in three major ways. Firstly, participants may be more willing to share their experiences with a researcher whom they perceive as sympathetic to their situation. Secondly, the position may shape the researcher-participant relationship, which consequently affects the information that participants are willing to share. Lastly, the worldview and background of the researcher affects the way in which they construct the world, uses language, poses questions and processes and interprets information gathered from participants. However, the goal of reflexivity is to monitor these effects and enhance the credibility of the findings.

The author was a female, PhD student with an undergraduate degree in Psychology with previous experience of being a trainee on various postgraduate and researcher training programmes and training that the author attended during previous employment will have influenced personal perceptions about training. Particularly, training sessions that were perceived as useful in gaining knowledge will have led to self-reflections about what influenced the effectiveness of the training. Similarly, the author's experiences with receiving supervision or lack of supervision during this

postgraduate study may have influenced perceptions on the importance of supervision and the consequences of not receiving continuous supervision. Furthermore, the author's previous experiences may have led to biases in the interpretation of the data. However, reflexivity was ensured by keeping a diary during the interviews in which all thought processes and observations were recorded, this was then referred to during the data analysis phase to ensure correct interpretation of the data. Incorporating reflexivity and rigour into the data collection process meant that whilst the potential influence of the author's experiences were acknowledged, the author was mindful to return to the data and check to ensure the interpretation of the data was not influenced.

7.4.10. Ethical considerations

Good ethical practice is a key component of high-quality research and should be considered throughout the research from the initial stages of designing to the end stages of reporting and dissemination. Various guidelines, codes and frameworks exist on good ethical practice (British Psychological Society, 2009), which set out the following key principles:

- Research should not make unreasonable demands on participants.
- Participation should be based on informed consent.
- Participation should be voluntary.
- Risks of harm should be known to the participants, and adverse consequences should be avoided.
- Confidentiality and anonymity should be ensured.

Source: Ritchie et al. (2014)

The main ethical issues that were anticipated during different phases of the study have been outlined in Table 7.1, along with plans on how this issue would be addressed.

7.4.11. Data storage

The audio files were deleted immediately after transcription. The transcribed data has been stored on secure electronic files on the University of Manchester servers, and consent forms have been stored in a locked filing cabinet at the University of Manchester, both of which are only accessible by the research team. Consent forms will be retained as essential documents, but items such as contact details were deleted as soon as they were no longer needed. Transcriptions of anonymised interviews will be kept for up to five years in accordance with American Psychological Association (APA) guidelines (APA, 2016).

Table 7.1. Ethical issues which may arise during the study

Which phase of the study the ethical issue occurs	Ethical issue	How the issue would be addressed
Prior to conducting the study	• Seek university approval on campus through an institutional review board. • Gain permission from programs and participants. • Select a site without a vested interest in the outcome of study. • Negotiate authorship for publication.	• Submit ethics application to University Research Ethics Committee. • Identify and send letters to programs; find key personnel to help. • Select sites that will not raise power issues with researchers. • Give credit for work done on the project; decide on author order in future publications.
Beginning the study	• Disclose the purpose of the study. • Do not pressure participants into signing consent forms. • Participants who give consent to contact but are not invited to interview. • Respect cultural norms and values. • Be sensitive to the needs of vulnerable populations	• Contact participants and inform them of the general purpose of the study. • Tell participants that they do not have to sign the form; give them time to process information. • Participants will be sent a letter to thank them in considering participation in the study. • Find out about cultural, religious, gender and other differences that need to be respected. • Obtain appropriate consent.

Table 7.1. Ethical issues which may arise during the study

Which phase of the study the ethical issue occurs	Ethical issue	How the issue would be addressed
Collecting the data	• Respect the site, and disrupt as little as possible. • Avoid deceiving participants. • Avoid collecting harmful information • Participants becoming distressed. • Unethical practice or risk to participants revealed.	• Build trust and convey the extent of anticipated disruption gaining access. • Discuss the purpose of the study and how the data will be used. • Adhere to questions stated in the topic guide. • The supervisor will be contacted on who will direct them towards further support. • Participants will be informed that any risk to themselves or others disclosed during the interview will be reported to their managing body and supervisor.
Analysing the data	• Respect the privacy and anonymity of participants.	• A unique reference number will be assigned to each participant.

Table 7.1. Ethical issues which may arise during the study

Which phase of the study the ethical issue occurs	Ethical issue	How the issue would be addressed
Reporting, sharing and storing data	• Avoid falsifying authorship, evidence, data, findings, and conclusions. • Avoid disclosing information that would harm participants. • Communicate in a clear, straightforward, appropriate language. • Share data with others. • Keep raw data and other materials (e.g., details of procedures, instruments). • Provide complete proof of compliance with ethical issues and lack of conflict of interest, if requested. • State who owns the data from a study.	• Report honestly. • Use unique reference numbers so that individuals cannot be identified. • Use unbiased language appropriate for audiences of the research. • Provide copies of the report to participants and stakeholders. Share results with other researchers. • Store data and materials for five years (APA, 2016). • Disclose funders for research (if any). Disclose who will profit from the research (if any). • Give credit of ownership to researchers, participants and advisers.

Source: Creswell (2014)

7.5. Chapter Summary

- This chapter outlines the research questions and aims and objectives of this study as well as a detailed overview of the research methods used in this thesis.

- Qualitative methods and framework analysis were deemed appropriate due to their transparent and systematic nature.

- The next chapter will present the qualitative study that was conducted for this thesis.

Chapter 8. A qualitative study exploring the experiences of experts and NTPs involved in training for a task-shifted psychological intervention: Task-shifting exemplars summary

This chapter provides an overview of the four task-shifting exemplars that were central to this thesis. Two of the exemplars used as a basis for this study are concerned with delivering interventions to women with perinatal depression in Pakistan. Therefore, an overview of mental healthcare in Pakistan will also be provided before proceeding to describe the exemplars.

8.1. Study background

As little is known about the essential training components required to train NTPs to deliver psychological therapies, qualitative research, which allows for in-depth exploration of a topic or phenomena, was deemed a suitable methodology for this study. In-depth interviews with both experts and NTPs will enable the exploration of the views of both sets of individuals, allowing both perspectives to be taken into account when investigating the essential training components, as well as the barriers and facilitators experienced by the NTPs in both training and intervention delivery. Furthermore, as the systematic reviews in the previous chapters showed that documentation of training is often poor, the perspectives of experts will also be explored to examine potential factors behind this and how this may be improved.

Four task-shifting exemplars were selected in which NTPs were trained to deliver psychological interventions. As previously mentioned in section 2.1.2, a task-shifting approach is commonly used in LMICs to address health worker shortage, where psychological therapies are delivered by NTPs with minimal education and no experience in mental health. However, although this approach is also used in HICs, tasks are often shifted to individuals who will often have a degree in health or the social sciences and will have some background knowledge in mental health (Strong et al., 2004). Therefore, exemplars were chosen from the UK and Pakistan to allow the ability to gain perspectives from both resource-rich and resource-limited settings.

Participants recruited for this qualitative study were key stakeholders involved in the training processes within the exemplars. Procedures for sampling and recruitment of the exemplars and participants are described in sections 7.4.2 and 7.4.4. The task-shifting exemplars and the training will be described below.

8.2. UK exemplars

8.2.1. The Big Life Group: Multi-Modality Practitioners

8.2.1.1. Exemplar background

The Big Life Group is a social enterprise in Manchester that offers services and support aimed at people who cannot access public services due to long waiting lists or due to being turned away from traditional services because they are deemed too difficult or had tried to change but were unsuccessful. They offer a wide range of services from self-help services to NHS-commissioned mental health services; drug and alcohol recovery and services that provide advice, skills, training, employment and homelessness support. Furthermore, through their experience of working with people experiencing multiple needs, they acknowledge that this group of individuals are less likely to achieve positive outcomes than people with fewer needs and would benefit from a different type of intervention to those currently available. To address this issue, they have suggested implementing a new type of multi-skilled worker known as a multi-modality practitioner who can use several interventions that take into account a full range of factors that their client may experience and directly deliver evidence-based interventions in a more personalised and timely manner. In this way, they suggest that onward referrals to traditional services will be reduced, as they will be able to provide interventions at the first point of contact, and any referrals that do occur will be of high quality, as the multi-modality practitioners will have the skill to triage with accuracy. Furthermore, Big Life suggests that training multi-modality practitioners can help address public sector workforce issues such as retention and career development as outlined in the mental health workforce plan for England (Health Education England, 2017).

Therefore, The Big Life Group has conducted a pilot study in which they have trained coaches from an already existing service that offers advice on employment, housing, family and money issues to take on a role as a multi-modality practitioner. Coaches have a variety of different educational backgrounds and experiences from social science degrees to their own experiences with mental health services. The role of a multi-modality practitioner has three elements:

1) *Key-worker support*: A behaviour change intervention that assists clients in resolving crises and developing a personalised action plan that is specific to their needs. Also, through the use of motivational interviewing and person-centred techniques, the multi-modality practitioners can increase the client's resilience and their ability to set and achieve goals.
2) *Assessments*: Clients are assessed using a range of evidence-based assessment tools that establish a baseline against which progress can be measured.
3) *Multi-modality support*: A toolbox of multi-modality interventions that provide immediate specialist support to clients. The multi-modality practitioner will have expertise across the modalities of mental health, employment and skills, health and long-term conditions, and children and families.

8.2.1.2. Training

For this study, the company collaborated with the University of Salford, which identified existing interventions and approaches that were suitable for use and designed and delivered training to the multi-modality practitioners. The training consisted of 10 seven-hour sessions which were spread out across the year in 2018. The training was delivered in the Limelight Centre in Manchester and was delivered by a range of lecturers from the University of Salford who had expertise in different areas. It was not compulsory for the multi-modality practitioners to attend every session of training, and attendance was down to the availability of the multi-modality practitioner. Furthermore, service managers were also provided with the same training so that they had the same level of knowledge of the interventions that their staff deliver and were able to provide monthly supervision. Training consisted of six modules:

1) *Core skills and knowledge*: Training in essential skills, tools and theories based on the social sciences and therapeutic disciplines that highlight the multi-modality practitioner approach. This module enables the multi-modality practitioners to have person-centred conversations with clients and their families.
2) *Mental health assessment and interventions*: Provides an introduction to CMDs and family mental health as well as trains multi-modality practitioners in their role and how they should respond.
3) *Health and well-being*: The module explores the social factors that affect health and well-being as well as the applications of motivational interviewing and CBT to support clients to make positive lifestyle changes. Furthermore, the module teaches multi-modality practitioner about the role of social prescribing in terms of promoting and maintaining health and well-being, especially amongst individuals with long-term health conditions.
4) *Think family*: This module is concerned with the importance of family on health and well-being, and theory is provided through learning ecological systems theory and family systems theory.
5) *Employment, skills and welfare*: This module teaches the multi-modality practitioners how to support their clients to seek work or training or to remain in work or training. The module includes training on money and debt and the use of better-off calculators that inform clients of benefits they may be entitled to.
6) *Multi-modality practice*: The last module allows the multi-modality practitioner to draw on all aspects of training to prepare and present a casework plan in relation to hypothetical case studies. The module is a method of allowing multi-modality practitioners to demonstrate their knowledge and ability that they have learnt through training and apply it to real-life scenarios.

The content of the multi-modality practitioner training program is outlined in Box 8.1.

As this was a pilot study, training was constantly refined through feedback from clients and practitioners and has led to the development of a new accreditation. Training for new multi-

modality practitioner cohorts will now involve a Level 7 Postgraduate Certificate in Multi-Modal Practice at the University of Salford. The qualification will consist of two modules lasting around half a year each and consist of 300 hours of learning, a 4000-word assignment and a portfolio and presentation assessment. Furthermore, multi-modality practitioners will carry out a six-month work placement, which will be assessed by managers.

For this study, interviews on their experiences with the training programme were conducted with four multi-modality practitioners from the first cohort of trainees and also three lecturers at the University of Salford.

Box 8.1. Content of Multi-modality practitioner training programme

Module 1: Core Skills and People Work
Multi-modality practice
1.1.1 Concepts of multi-modality practice
1.1.2 Introduction to critical practice
Multi-modality practice and practitioner resilience
1.2.1 Reflective practice, Gibbs' model for reflection, resilience and self-care
Compassionate communication and self-compassion
1.2.2 Compassionate mind training, compassion-focussed therapy and changing self-critical internal dialogue
Developing orientation to change
1.3.1. Role induction, problem-solving protocol, goal setting and contracting
1.3.2. Motivational interviewing and the stages of change
Empowering communication
1.4.1 Concepts from transactional analysis
Strengths-based and solution-focused work
1.5.1 Principles of strengths-based work and solution-focused therapy
Module 2: Mental Health Assessment and Interventions
Common mental health problems
2.6.1 Understanding and responding to common mental health problems
Mental health across the life course
2.7.1 Children and adolescent mental health and adverse childhood experiences (ACEs)
Mental health and working with risk
2.8.1 Risk assessment and management
2.8.2 Consolidation (revisit Motivational Interviewing)
Module 3: Physical Health and Long-term Conditions
3.9.1 Promoting health and well-being
Module 4: Think Family: Interventions and Assessment
An ecological system approach
4.10.1 Ecological systems theory

Box 8.1. Content of Multi-modality practitioner training programme

4.10.2 Family systems theory
Adult-oriented issues: Domestic abuse
4.11.1 Domestic abuse
Adult-oriented issues: Substance misuse
4.12.1 Substance misuse
Adult-oriented issues and safeguarding
4.13.1 Safeguarding and interagency collaboration
Safeguarding: Children
4.14.1 Safeguarding and child protection
Module 4: Think Family: Interventions and Assessment (continued)
Positive parenting
4.15.1 Parenting and early help
Child development and neglect
4.16.1 Neglect
Module 5: Employment and Welfare
Employability and skills toolkit
5.17.1 Preparing for work or training, assessments and planning
Employability toolkit
5.18.1 Finding and staying in work
Debt and money toolkit
5.19.1 Assessments, advice and financial planning
Module 6: Multi-modality Practice
6.20.1 Consolidation

8.2.2. PERSUADE: Preventing Depression in the Community by Voluntary Sector Providers

8.2.2.1. Exemplar background

PERSUADE is a feasibility trial that was developed and conducted in 2018 at the Centre for Primary Care and Health Services Research at the University of Manchester (Kenning et al., 2019). The research centre recognised that the current burden of depression cannot be reduced by more than 35% through current existing treatments (Andrews et al., 2004) and suggested that the burden of depression may be reduced even further through knowledge and prevention. Therefore, they identified that there is a need to develop better treatments that can be delivered at the early stage of treatments to prevent progression into full-blown symptoms of depression. Consequently, the aim of their trial was to deliver a one-day, manual-based psychoeducational workshop in the community for individuals with subthreshold depression (score between 5 and 9 on the Patient

Health Questionnaire) (Kenning et al., 2019). The intervention was adapted from the 'Depression Prevention Course' developed by Munoz and Ying (2002), which includes evidence-based CBT techniques. The intervention was designed to be accessible and easy to understand, and therefore a one-day psychoeducational group was offered to participants, as the researchers believed that asking participants who do not have a diagnosable condition to commit to an eight-week intervention requires time, effort and resources (Kenning et al., 2019). Furthermore, the intervention was facilitated by voluntary sector workers working in pairs, as this can potentially increase access to treatments for hard-to-reach groups (Horrell et al., 2014). These voluntary sector workers already had some experience of working or volunteering in the community, working in groups, and already had some knowledge in mental health.

8.2.2.2. Training

When using voluntary sector workers to deliver patient-centred interventions, it is necessary that they be trained and supervised appropriately. Therefore, the four facilitators who delivered the workshops were provided with training over two days at the University of Manchester. The training was delivered by a psychiatrist and a mental health lecturer and consisted of teaching them the basics of group-based CBT interventions, which included elements of behavioural activation and cognitive restructuring. In addition, the facilitators were trained on how to deliver the intervention manual since the role of the facilitators was to teach the participants about techniques through the use of a manual rather than directly deliver the therapy themselves. The structure of the training program is outlined in Box 8.2. The two-day training included both didactic learning in the form of a presentation and experiential learning through group discussions and role-play. As the training was delivered for the first time, it was kept flexible, where the facilitators were able to give their suggestions and opinions on the training and also in ways in which they could facilitate the workshops. Furthermore, due to the nature of the feasibility trial, the facilitators did not receive formal supervision and instead were supported through the presence of a researcher at the workshops.

For the present study, interviews on experiences with the PERSUADE training were conducted with three facilitators and the mental health lecturer who delivered the training.

Box 8.2. Contents of the PERSUADE training programme

Day 1
• Welcome and introductions • Introduction to the PERSUADE study and manual • What is depression? *- Talking about depression in a workshop format* *- The vicious cycle of low mood* • Planning for goal settings in a workshop • Thinking about negative thoughts
Day 2
• Recap of day 1 • Introducing changes in behaviour • Thinking about social contacts and low mood • Ending and planning for the future • Time for questions • Time to practice techniques and delivery of content

8.3. Pakistan exemplars

8.3.1. Mental health in Pakistan

The Republic of Pakistan is a South Asian country with a population of over 212 million, making it the world's fifth most populous country (World Bank, 2018b). The country is considered a lower-middle-income country with a GDP per capita of $1,482 in 2018, which ranks Pakistan 157th in the world (World Bank, 2018a). Additionally, it has been recognised as one of the next 11 countries that have the potential to become one of the world's largest economies in the 21st century (Grant, 2011). Furthermore, the United Nations Development Programme ranks Pakistan 152nd out of 189 countries on its Human Development Index, which measures well-being according to life expectancy, years of schooling and gross national income per capita (United Nations Development Programme, 2019). Pakistan is facing challenges with poverty, illiteracy and a continuously rising population, which has led to the lowest Human Development Index amongst all the comparable regional countries in South Asia, a concern which has been exacerbated by its poorly performing health system (United Nations Development Programme, 2019).

Within Pakistan, the healthcare delivery system is mixed, consisting of both public and private sectors and modern and traditional medicine. The public sector aims to deliver care through a three-level healthcare system where the first level includes government healthcare facilities such as basic health units and rural health centres, which form the basis of primary care. Secondary care involves first and second referral facilities that provide acute and inpatient care through Tehsil

headquarter hospitals and district headquarter hospitals. Lastly, tertiary care is covered by teaching hospitals (WHO, n.d.). However, like many developing countries, the healthcare system in Pakistan is suffering from many issues such as a growing population, poor distribution of health professionals, an insufficient workforce, a lack of funding and limited access to these health services. Furthermore, whilst the underperformance of these public healthcare services has led to the growth of the private sector, which includes a diverse range of professionals such as doctors, nurses and traditional healers, this is largely unregulated and functions predominantly for profit (Shaikh, 2015).

Mental health is the most neglected field in Pakistan where the prevalence of CMDs ranges from 29% to 66% for females and 10% to 33% for males (Mirza & Jenkins, 2004). The field is severely underfunded and under-researched, and it is believed that only 0.1% of the government health budget is spent on mental health (Bashir, 2018). Human resources within mental health services are alarmingly low with WHO (2009) reporting only 342 psychiatrists (0.20 per 100,000 population) and 478 psychologists (0.28 per 100,000 population) for the whole country. Furthermore, these psychiatrists are mostly located in large urban centres, whilst the majority of the Pakistani population live in rural areas where mental health services are virtually non-existent (Karim et al., 2004). Additionally, there are a total of 3729 outpatient mental health facilities available in the country as well as only five mental health hospitals (WHO, 2009). All these factors have contributed to the increasing prevalence of mental disorders in the country. Whilst the Mental Health Act was passed in 2011 to protect the rights of psychiatric patients and ensure that they get the best possible treatment, there have been limited attempts at implementation due to lack of political will and insufficient resources (Bashir, 2018).

The limited access to services for illness has led many people to seek traditional care through faith healers (Shaikh & Hatcher, 2005). Faith healing is commonly used amongst people who believe that mental illness is a result of supernatural illnesses, particularly in rural areas where resources are scarce and health literacy is low (Javed et al., 2020). Furthermore, the taboo nature of mental illness in the country often prevents individuals from seeking formal mental healthcare (Stuart, 2016). This stigma is even greater for women who suffer from mental illnesses, who are often reluctant to discuss their problems with others due to the fear of being judged or considered insane (Niaz, 2004). Generally, in Pakistan, psychiatric illnesses are greater in women than men with factors such as societal norms, attitudes and cultural practices contributing to the high prevalence (Mirza & Jenkins, 2004; Niaz, 2004). Women are often the target of gender-based violence as a result of marital conflicts, feuds and marriage practices such as dowry, all of which can have adverse psychological impacts (Niaz, 2004). Furthermore, the stress of extended family systems, the role of in-laws in daily lives and relationship problems with the husband have been associated with increased suicide attempts (Khan, 1998).

In recent years, mental health during pregnancy, childbirth and in the postpartum period has become a public health priority due to its high prevalence and the negative impact it can have on not only the mother but also on the child's health and development (Parsons et al., 2012).

Evidence suggests that children of depressed mothers are at a greater risk of stunting, child malnutrition and increased rates of diarrhoea compared with children of non-depressed mothers (Saeed & Saeed, 2017). Furthermore, the adverse effects on the child as a result of poor maternal mental health may persist up to the age of eight years (Bennett et al., 2016). The rate of maternal depression in Pakistan is amongst the highest in the world with a prevalence of 25% during pregnancy and ranging from 28% to 63% postnatally (Gulamani et al., 2013). The increasing prevalence of perinatal depression has led to the development of a psychosocial intervention delivered through CHWs called the Thinking Healthy Programme (THP), which has shown to have positive effects on both maternal depression and child outcomes (Rahman et al., 2008). Furthermore, the success of the programme has led to WHO promoting the intervention for global dissemination for use in a variety of settings with an established CHW healthcare delivery system (WHO, 2015). The program will be described in further detail in the section below.

8.3.2. Thinking Healthy Program Peer Delivered (THPP)

8.3.2.1. Exemplar background

THPP is an RCT that was conducted in the rural sub-district of Kallar Syedan, Rawalpindi, Pakistan, between 2014 and 2016. The program is part of the Human Development Research Foundation's focus on research on maternal and child health. The THP is an evidence-based psychosocial intervention which uses CBT techniques, behavioural activation and problem-solving, consisting of 16 sessions that are delivered to the mother during the last month of pregnancy and then 6 to 8 months after birth (Rahman et al., 2008). In the initial THP study, the intervention was successfully delivered by trained lady health workers who incorporated the intervention into their routine community work, with results showing that the rate of prenatally depressed women more than halved in the intervention group. Furthermore, the mothers had less disability and better social functioning with effects lasting even after one year (Rahman et al., 2008). The success of the intervention has led to its integration into existing health systems in a rural sub-district of Pakistan and was recommended by WHO as the first-line treatment for perinatal depression in primary and secondary care settings. However, as the lady health workers were carrying out their existing duties, they were overburdened by competing demands, which has limited efforts towards scaling up the THP. Therefore, the THP was adapted to be delivered by PVs with an RCT conducted to evaluate its effectiveness, showing a reduction in symptom severity, remission and disability within the first three months after birth (Sikander et al., 2019). As the intervention was delivered by peers, it was adapted to be made simpler and more deliverable by placing greater emphasis on behaviour and less on cognition (Atif et al., 2017). THPP consisted of 10 individual sessions and 4 group sessions lasting between 30 and 45 minutes from the third trimester of pregnancy to 6 months post birth (Sikander et al., 2019). This project is still ongoing with a trial being conducted to evaluate the effects of the intervention delivered through 36 postnatal months (Turner et al., 2016).

8.3.2.2. Training

The PVs were local volunteers, around the ages of 30–35 years, were married with children and had similar socio-economic backgrounds as the depressed mothers. The women had at least 10 years of education but had no experience in delivering healthcare (Sikander et al., 2019). The training of the PVs involved 5-day training (30 hours) at the government health facility and involved didactic learning in the form of lectures and experiential learning through role-plays, discussions and activities. The content of the training is outlined in Box 8.3. To assist them in delivering the intervention, all the PVs were given a THP reference manual and job aid, which were also used during training. Following the classroom training, the PVs were assigned a mother to deliver the intervention to for three months, which provided an opportunity for the PVs to practice their skills and ensure their competency for intervention delivery. Assessments of the quality of the intervention and the PVs' competency were measured through observation of sessions and scoring them on a Quality and Competency Checklist (Atif et al., 2019). However, to progress to field training, PVs had to score at least 70% on a competency checklist that was based on the ENhancing Assessment of Common Therapeutic Factors rating scale, which was conducted immediately after training and six months after training (Sikander et al., 2019). Furthermore, the PVs received both group and individual supervision from the trainers, which involved discussing challenges faced by the PVs, revising the content of the intervention and sharing stories and experiences.

This project followed a cascade model of training (see section 2.4.1), in which the trainers who conducted training and supervision were local trainers consisting of female university graduates with at least a bachelor's degree in health or social science and no mental health experience. The trainers received 20 hours of classroom training followed by 6 months of field training which was supervised by the master trainer. Furthermore, the local trainers received fortnightly supervision via Skype with the master trainer, in which they discussed challenges and strategies to address them. The master trainer, based in the UK, had training in CBT and over 10 years of clinical experience in mental healthcare (Atif et al., 2019).

For this study, interviews were conducted with six PVs, three local trainers and the master trainer.

Box 8.3. Contents of training for PVs (adapted from Human Development Research Foundation, 2017)

Day 1
• Introductions and establishing ground rules • Introducing peer volunteering concept • Introducing the PVs' training and supervision guidelines • Understanding depression, its risk factors and impact • Introducing THPP *- The three steps of the Thinking Healthy approach* *- The five skills required for delivering the THPP*

Day 2
• Revising content from day 1 • Practicing the five key skills essential to the delivery of THPP
Day 3
• Revising content from previous days • Understanding and practising delivery of THPP individual sessions
Day 4
• Revising content from previous sessions • Understanding and practising the delivery of THPP group sessions • Severe and adverse events and the recommended procedures to follow
Day 5
• Revising content from previous sessions • PVs' competency assessment through role-play observations

8.3.3. Learning through Play Plus (LTPP)

8.3.3.1. Exemplar background

LTPP is a cluster-RCT that was conducted in Gadap town, one of the 18 towns in Karachi, Pakistan. The intervention was carried out by researchers at the Pakistan centre in Karachi. The research centre aims to improve the health and well-being of people with a particular emphasis on mental health by increasing awareness, reducing stigma, promoting training in research methods and developing innovative, culturally appropriate solutions for mental healthcare through research. The research centre recognised that poor maternal mental health can have a negative impact on child attachment and child care during the first three years of life, which is a critical period in child development (Shah & Lonergan, 2017). Therefore, they conducted a cluster-RCT to test the efficacy of delivering LTPP on the mother's mental health as well as on child development. LTPP is a 10-session group psychosocial intervention that combines parenting information with CBT (Husain et al., 2017). The LTP part of LTPP is a program that is aimed at stimulating child development with the use of a pictorial calendar for parents. The calendar depicts eight stages of child development from birth up to three years of life, with pictures and activities that promote parental involvement, learning and attachment. The 'plus' element of the intervention is a CBT component derived from THP outlined in section 8.3.2.1 and was adapted for use in a group setting. The intervention spanned across three months, consisting of weekly 60- to 90-minute sessions that were delivered for 8 weeks and then fortnightly during the last 4 weeks. The intervention was delivered by local CHWs and was co-facilitated by master's-level LTPP-trained psychologists.

The CHWs were lady health workers. In Pakistan, lady health workers are trained women who are responsible for visiting households each month and providing services that include health education and promotion of healthy behaviour, family planning services, maternal and child

healthcare and immunisation. Each lady health worker is attached to a government health facility from which they receive training, medical supplies, a small allowance of approximately $343 per year and supervision. Lady health workers are required to have at least eight years of education, which includes passing middle school. To become a lady health worker, women must attend a 15-month training course, which consists of three months of classroom training including practical learning and twelve months of on-the-job training, which includes one day per month in the classroom working on problem-based activities (WHO, 2006).

8.3.3.2. Training

For the LTPP intervention, lady health workers were given three-day training (18 hours), at the local government health facility. Training included presentations, discussions and role-play using the intervention calendar, which aided them in intervention delivery. Furthermore, as the lady health workers were involved in recruiting and screening participants, they were trained on how to use the Edinburgh Postnatal Depression Scale and screening checklist. The training was delivered by experienced psychologists. Following the completion of the training, a competency assessment was carried out, and the lady health workers were assessed on their knowledge, attitude and practices. As intervention delivery was co-facilitated by a master's level psychologist, no supervision was provided. However, all the lady health workers were provided with monthly training refreshers. Furthermore, fortnightly supervision was in place for all the researchers who were co-facilitating the intervention.

For this study, interviews were conducted with six lady health workers and four research staff who were involved in the LTPP intervention.

8.4. Chapter summary

- There is a lack of evidence about the essential training components required to train NTPs to deliver psychological therapies, with existing literature minimally contributing due to poor documentation. Therefore, it is necessary to explore the experiences of stakeholders involved in the training process.

- An in-depth exploration of this study forms the basis of the research question, aims and objectives of this study.

- This chapter describes the four task-shifting exemplars that were involved in this study, a summary of which is outlined in Table 8.1.

- The following chapters will present the research conducted for this thesis.

Table 8.1. Summary of training of the four exemplars

	Big Life: MMP	PERSUADE	THPP	LTPP
NTP	Multimodality practitioners	Voluntary sector workers	Peer volunteers	Lady health workers
Mental health condition	Low-level mental health problems	Subthreshold depression	Perinatal depression	Perinatal depression
Intervention	Assessments, evidence-based interventions, life skills and support	CBT-based psychoeducational group	CBT intervention	Parenting intervention + CBT
No. of days (hours)	10 (70)	2 (12)	5 (30)	3 (18)
Format	Lectures, group discussions	Lectures, group discussions, role-plays	Lectures, group discussions, role-plays	Lectures, group discussions, role-plays
Location	Limelight centre	University of Manchester	BHUs	BHUs
Trainer	Mental health lecturers	Mental health lecturers + psychiatrist	Local trainers with social science or health degree	Master's-level psychologists
Supervision	Monthly	None	Monthly	None
Competency assessment	None	None	ENACT Quality and Competency Checklist	KAP questionnaire
Remuneration	The role is part of their new job description	None	Sustenance allowance	Regular salary

*CBT, Cognitive Behavioural Therapy; BHU, Basic Health Unit; ENACT, ENhancing Assessment of Common Therapeutic factors; KAP, Knowledge, Attitudes and Practice; NTP, Non-traditional provider; MMP, Multi-modality Practitioner; THPP, Thinking Healthy Programme-Peer Delivered; LTPP, Learning Through Play Plus

Chapter 9. Results

This chapter presents the results from the analysis of data collected. The first section will present the results from the semi-structured interviews with the NTPs, which will be followed by the findings from the experts' semi-structured interviews. Findings from interviews in both the HIC and LMIC will be presented together, where any comparisons and similarities will be drawn.

9.1. Results: Non-traditional Providers

Recruitment of NTPs took place between October 2019 and January 2020. In total, 20 participants were approached to participate in the study (see sections 7.4.2 and 7.4.4 for sampling and recruitment procedures). One participant declined to participate due to personal circumstances; therefore, a total of 19 in-depth interviews were conducted, 7 of which were in the UK and 12 in Pakistan. The majority of the participants were female, with only 3 male participants. Meanwhile, in the UK, all the NTPs were working within a health and well-being service and had university-level qualification; in Pakistan, the majority of the participants had a role within their community, and almost all had minimum-level education (see Table 9.1).

The interviews lasted between 45 and 60 minutes, and all were recorded using an encrypted recorder after receiving consent from the participants.

Table 9.1. Characteristics of NTPs

Participant ID	Gender	Job Role	Education*
NTP01HIC	Female	Team leader of health service	BSc Exercise, Physical Activity and Health
NTP02HIC	Female	Team leader of health service	BA Marketing and Communications
NTP03HIC	Male	Well-being coach	BA Photography
NTP04HIC	Female	Well-being coach	MSc Applied Psychology and Therapy
NTP05HIC	Male	Well-being coach	BA English Literature
NTP06HIC	Male	Trainee counsellor	BSc Psychology
NTP07HIC	Female	Counsellor, trauma-focused therapist and supervisor	BA Education Management
NTP08LMIC	Female	Stitching, works at the beauty salon, volunteer	Eighth Class (8 years)
NTP09LMIC	Female	Gives polio vaccinations	Matric (10 years)
NTP10LMIC	Female	Community counsellor	Matric (10 years)
NTP11LMIC	Female	Midwife, polio vaccinations	Intermediate (12 years)
NTP12LMIC	Female	Housewife	MA Islamic Studies
NTP13LMIC	Female	Housewife	Matric (10 years)
NTP14LMIC	Female	Lady health worker	Eighth Class (8 years)
NTP15LMIC	Female	Lady health worker	BA (unknown)
NTP16LMIC	Female	Lady health worker	Eighth Class (8 years)
NTP17LMIC	Female	Lady health worker	Intermediate (12 years)
NTP18LMIC	Female	Lady health worker	Intermediate (12 years)
NTP19LMIC	Female	Lady health worker	Intermediate (12 years)

*BSc, Bachelor of Science; BA, Bachelor of Arts; MSc, Master of Science; MA, Master of Arts; Matric, equivalent to GCSE; Intermediate, equivalent to A Level

Data were analysed using framework analysis (see section 7.3.2). In the final stage of data analysis, data were organised into five themes and seventeen sub-themes (Table 9.2) representing the important factors to consider when developing training for NTPs as perceived by NTPs themselves. Quotes that captured the essence of the themes and supported any interpretation were selected for presentation. Further quotes can be found in Appendix 25.

To avoid confusion with participants who took part in this qualitative study, the participants who received the intervention within the programs will be referred to as ‘clients’ with regard to interviews conducted in the UK and ‘mothers’ concerning the interviews conducted in Pakistan.

Table 9.2. Thematic framework of NTP interviews

Index no.	Thematic framework - NTPs
1.0	**Who are the NTPs?**
1.1	Shared characteristics
1.2	Knowledge in mental health
1.3	Capacity to deliver the intervention
2.0	**Elements of training**
2.1	Accessible training venue
2.2	Tailored training
2.3	Experiential learning
2.4	Training materials
2.5	Solution-focused training
2.6	Supervision as time for review, reflection and revision
3.0	**Trainer attributes**
3.1	Experience vs expertise
3.2	Personal traits
4.0	**Facilitators for NTPs**
4.1	Altruistic gains
4.2	Personal gains
4.3	Support from others
5.0	**Barriers for NTPs**
5.1	Other commitments
5.2	Reluctance from clients and their families
5.3	Working within limitations of the role

9.1.1. Who are the NTPs?

This theme presents the key qualities to consider within an NTP which may aid in the delivery of psychological interventions. The analysis revealed three sub-themes: (a) shared characteristics, (b) knowledge in mental health and (c) capacity to deliver the intervention.

9.1.1.1. Shared characteristics

All NTPs interviewed in the LMIC were local women who had similar sociodemographic characteristics to the individuals to whom they delivered the psychological interventions. Having a similar background, sharing the same culture and therefore being considered as a peer are perceived to be an important factor in the delivery of psychological interventions. Many NTPs in the LMIC stated how being from the same village made it easier to deliver the intervention.

> *We knew the mothers because they were from our village so it was easy to deliver it to them.* (NTP09LMIC)

A local NTP would have familiarity with the cultural norms and the family dynamics within each household and therefore was perceived to have a better understanding of the issues surrounding the individuals.

> *The benefit of being from the same village, is that they know what the atmosphere is like in the home. Like how I know my area, if someone dies, I go for condolences, if someone is ill, I will go or if there is a wedding at someone's house then I will go . . . I know what the people in my area are like and what the situation is in their homes.* (NTP10LMIC)

Furthermore, being from the same area aids in building trust between the NTP and the individual, allowing for the initial reluctance in sharing their feelings to disappear. In contrast, an NTP who is considered an outsider may cause hesitation from the individuals in revealing their problems due to a fear of breach of confidentiality.

> *If she's [the NTP] from the village it's better because she knows about the home, she knows about the mother, the husband, the children. It should be someone she [the mother] trusts, because she's telling her about everything . . . If it was someone from outside then she [the mother] might not be able to share fully because she would be thinking, 'Who is this person, what are they thinking, they might share my problems with the village'.* (NTP09LMIC)

Being local may also facilitate understanding of the intervention, as it would allow the NTP to explain concepts in their own language and in simple terms, a factor which is necessary, as individuals from LMICs may have lower literacy levels, similar to the NTPs themselves.

> *If it's someone from their own village then she can use her own language and words to explain things.* (NTP13LMIC)

In contrast, interviews conducted in the HIC were with NTPs who were working within health sector organisations and may not be considered as a peer, as they may not necessarily have shared similar sociodemographic characteristics to their clients. Compared to Pakistan where the NTP will most likely have some familiarity with the individual that they were delivering the intervention to, in the UK the relationship will differ, where the NTP and the client would be meeting for the first time on the day of the intervention. However, the benefit of being a peer was still mentioned by one participant who, similar to the NTPs in Pakistan, stated how being a peer can aid in simplifying concepts of the intervention, making it easier to understand.

> *I think that benefits also from its delivery being uh from kind of a peer or lay because it does normalise or level out what the content is in that sense, that somebody can go, 'Yeh well he's given me a real-world context about that, he's a guy like me or she's a woman like I am, she's come from this background, I understand, they live their lives in a way that I would understand and like being lived and they've had the same pressures and stresses'*. (NTP05HIC)

9.1.1.2. Knowledge in mental health

When comparing the interviews in the HIC and LMIC, there was a significant difference in the understanding and experience in mental health between both countries. Within the UK, knowledge in mental health was acquired through experience and education. Whilst some participants recruited from the HIC did have a degree in psychology, all of them were already working with health organisations and with individuals suffering from mental health issues, and therefore, they had some form of experience in mental health even if it was not a formal qualification.

> *I didn't do any qualifications but in terms of working with people on the front line with poor mental health, I guess that gave me a bit of experience. And I'd work quite closely with self-help services.* (NTP01HIC)

Furthermore, one participant described how a background in mental health was part of the job specification.

> *I remember being interviewed for my job and part of the criteria was an understanding for mental health and the ability to prove that and that was also in the application form. We were also asked about if we had personal experience with mental health issues. So, I feel that the staff have been hand-picked on the premise that we already have this knowledge.* (NTP04HIC)

In comparison, the majority of the NTPs in LMICs had low literacy levels (Table 9.1) and had no concept of mental health prior to receiving training, with many stating that the training helped in learning about mental illness and its identification. The quote below is in line with the misconception that often surrounds mental health, particularly in LMICs where mental health is still considered taboo.

> *I didn't know anything about mental illness. I used to think that those people were crazy and they don't understand anything so there's not point speaking to them, but from this project I learnt how to identify those who are mentally ill.* (NTP17LMIC)

Furthermore, whilst some NTPs were working as lady health workers (Table 9.1) and had some knowledge surrounding health, this did not extend to mental health.

> *We have knowledge around the child and mother, we give vaccinations, we measure weights, we give women advice about food and rest but we were learning about why someone can become mentally ill for the first time.* (NTP14LMIC)

Whilst participants in the UK did have some mental health knowledge, the studies in Pakistan suggest that a formal qualification or experience in mental health is not necessarily required to be

able to deliver psychological interventions, and basic concepts surrounding mental health can be learnt through effective training.

9.1.1.3. Capacity to deliver the intervention

It is necessary for NTPs to have the capacity to deliver the intervention, which can be seen through their confidence in their ability to deliver the intervention and through assessments of knowledge and in their intervention delivery.

Confidence: A key factor which emerged in both countries was having confidence in the ability to deliver the intervention. One NTP in the UK described how having confidence could lead to learning enough during training to be able to deliver the intervention effectively.

> *I genuinely believe that if you can empathise and you have the capacity, the confidence perhaps or find that confidence in yourself to deliver you can, if the training is right, you can learn as much as you need and no more, and you can still be full and high quality and effective.* (NTP05HIC)

This confidence may be gained through preparation and revision, which is essential in delivering a high-quality intervention and is perceived by one participant as a way of showing respect to the individual who is seeking help.

> *I always think preparation is important because you need to know it, not inside out necessarily. . . . We need to respect the fact that somebody has walked in, to a room of people they've never met before and the action of opening that door is saying something about them or something they believe about them or some help that they want. So, we need to respect that and I think that is one of the ways we need to do it, by being prepared. We should never be unprepared.* (NTP05HIC)

> *I would read the book the night before and I revise everything.* (NTP15LMIC)

Furthermore, in the LMIC where a majority of the NTPs expressed initial reluctance when delivering the intervention for the first time, confidence may increase over time after gaining experience in intervention delivery.

> *Now it's been one year, I'm not scared of anyone, I will go on my own.* (NTP14LMIC)

Assessments: A method of measuring an NTP's capacity to deliver the psychological intervention is through formal assessments which were conducted in both studies in Pakistan. Participants

described how assessments were carried out through observations of the intervention and through written assessments carried out pre and post training.

> *After the training we did role-plays which was our test to see how we are delivering the intervention*. (NTP09LMIC)

In contrast, no formal assessments were carried out post training in the studies in the UK. One participant acknowledged the importance of assessment, going on to describe how the decision to conduct an assessment may depend on the type of psychological intervention being delivered, with more complex interventions requiring a formal assessment of skill and knowledge.

> *I personally think it [assessment] is important but I understand why in some contexts people don't do it, or maybe why some people don't think it's necessary. Because obviously for something like PERSUADE it's kind of psychoeducation rather than therapy and that being quite a big difference because obviously with things like therapy like counselling and CBT, like literally you're not allowed to do it until you've got a competency-based assessment that you've passed and you've got a diploma. But I think for psychoeducation because it's not therapy, it's not really done, it's not really assessed.* (NTP06HIC)

9.1.2. Elements of training

This theme presents the essential factors to consider within training. The findings are divided into six sub-themes: (a) accessible training venue, (b) tailored training, (c) experiential learning, (d) training materials, (e) solution-focused training and (f) supervision as time for review, reflection and revision.

9.1.2.1. Accessible training venue

A common theme which emerged in both countries was the need for the training venue to be accessible. For participants in the LMIC, this accessibility to training was ensured through transportation. Both programs in Pakistan provided travel arrangements for the NTPs to attend training, with the majority of participants expressing how this was a great benefit to them, and in some cases facilitated the NTP in gaining permission from their family members.

> *A car would come to pick us up and drop us off and that's why my family agreed to this . . . if I had to walk there or get the bus then my family wouldn't have allowed me to go.* (NTP14LMIC)

Furthermore, when asked about any difficulties during training, transport and accessibility were highlighted as key issues for some. NTPs in Pakistan delivered interventions in rural settings, and therefore, a number of them expressed their concerns over the uncertainty of not having transportation.

> *The only problem I had with training was that I was worried whether the car would come to pick me up or not.* (NTP14LMIC)

Although transportation is not often a major barrier in the UK, due to the majority of the population owning a car and the availability of public transport, accessibility was also mentioned by participants who stated how they would prefer to have training at their place of work, with one participant suggesting how this may encourage more people to attend training.

> *If you are recruiting specifically from . . . the Big Life; clearly, it's going to work better if you go there because you can have somebody who's going to have time to come down from the office, you are widening a pool from that group and you will likely get a better sort of take up I would have thought. It would be hard to convince, wouldn't it? If you've got a community room in a building or the people going to the training are from that building and you bring them here [University of Manchester]. It would be hard to do that; it wouldn't make any sense.* (NTP05HIC)

9.1.2.2. Tailored training

Analysis revealed the necessity of tailoring training to the learning preference and past experience of the NTPs.

Learning style: Through questioning participants on their preferred training format, a common theme of diverse learning styles emerged. The majority of participants in the HIC described their learning style as practical where they would learn more effectively through seeing the psychological intervention techniques performed in front of them or through practicing it themselves. In contrast, others preferred learning through didactic lectures and engaging with the trainer, where they have the opportunities to ask questions and gain feedback.

> *I'm a practical person you see, so seeing the interventions and knowing how the interventions work and then seeing the role-plays and stuff like that, that would probably work for me. Whereas, you might get someone who is more theory based and be more around the stats and think, 'Well actually, the stats are telling me this and I can work off that'.* (NTP01HIC)

In contrast, the theme of learning styles was not prominent amongst the interviews with participants in the LMIC, as the majority of them had minimal education, and therefore, it is unlikely that they would know about their preferred learning styles due to their limited time spent in learning. However, a number of participants commented on the size of the group during training, expressing their preference for a smaller group size, which would allow for discussions.

> *If there are three or four people then I can learn through discussions . . . if I can sit with three or four people then I can focus on what is being said.* (NTP18LMIC)

Experience: It may be important to consider recruiting individuals for training who all come from a similar background so as to not waste time on topics which may be irrelevant. One participant expressed how diversity in the *professional background* in the room meant that some of the training was not relevant for some due to the types of clients they were working with. Moreover, trainers should also gauge the previous training that the NTPs may have so as to use training time efficiently and not spend a great amount of time on topics that the NTPs may already have received training in.

> *There was a little too much focus on children because, we never worked with children. Umm, so at times we'd be talking quite a lot, and I'm aware at the time there were nursery and school practitioners in the session as well so it's relevant to them umm but I was sitting there thinking, you know, there's stuff on families and children here and I don't work with families and I don't work with children.* (NTP03HIC)

Furthermore, it is also important to gauge the *NTP's experience in mental health and their previous education*, with another participant in the UK expressing how training needed to be simplified, and trainers needed to consider individuals who did not have higher qualifications or an academic background.

> *[W]ith the lecturers it's fine, it's good because they're obviously in their roles because they've got experience of doing the job; but then they've gone on to teaching or writing papers . . . But then, sometimes they lose the fact that we are just lay people and some of us haven't done university training or been to university and some of us aren't academic.* (NTP02HIC)

Similarly, this lack of education was also mentioned by NTPs in Pakistan, who stated how their lack of education meant that more time was needed in understanding concepts. However, in contrast to the training in the HIC, where participants had different levels of qualification and understanding in mental health, in Pakistan, almost all the participants did not have any education or experience in this area. Therefore, time in training was spent on simplifying concepts to ensure better understanding.

There was nothing difficult during training. I don't have a lot of education which I told them, but if there were any difficult words then we would ask them and they would explain it in simple language. (NTP09LMIC)

9.1.2.3. Experiential learning

A common theme that emerged in both the HIC and LMIC is training incorporating experiential learning, in which knowledge is gained through experience (Kolb & Kolb, 2005). NTPs from both countries mentioned how interactive parts of training in the form of role-play and discussions facilitated learning and understanding of difficult concepts.

[W]e did a lot of role-plays, they used to do it first and then they would get us to do them and we learnt a lot from them, even more than the studying we learnt more from the role-plays. (NTP11LMIC)

We did a . . . solution-focused based session and one of the team leaders did a bit of role-play with the guy that was taking it and it sort of makes sense when they were doing it, and I was like, it makes more sense now, now that I've seen it put into action, I understand it a bit better. (NTP01HIC)

In Pakistan, role-plays and discussions in which NTPs shared their stories were also used as a way of problem-solving, in which solutions could be gained through the experiences and advice from others.

In the role-plays one person would be the mother and I would ask how they're doing, if they're having any problems with their children . . . if the child has a problem and I can't find a solution then everyone in the group would give their opinion so we could find the best way to solve the problem. (NTP12LMIC)

Similarly, in the UK, the diverse professional background of the NTPs in the training room was seen as an advantage, allowing experiences to be shared from different perspectives.

We did, the MMP (multi-modality practitioner) training with self-help and it was quite interesting to see the different approaches and even across our team really, we all come from different backgrounds and it was quite interesting to see how we all tackle the same issues but we all take a different stance on it and look at it in a different way. (NTP04HIC)

However, some participants in the UK acknowledged the notion of role-plays having a sense of artificialness attached to them, often not representing what an individual may experience in a real-world setting, with one NTP suggesting that using real-life issues during training, which the NTP

may be experiencing themselves, may allow for the role-play to feel more genuine as well as enable them to evaluate through their own experience which intervention techniques were more effective and which were not.

> *I understand that with a lot of the training you couldn't do role-play, it just wouldn't be real and it wouldn't sort of mirror what people go through when they are speaking with their clients.* (NTP02HIC)

9.1.2.4. Training materials

A common factor in training in both the HIC and LMIC was the use of training materials. Training materials commonly used included training manuals, presentation slides, flipcharts and handbooks. In both countries, the materials were considered beneficial to use as a point of reference which the NTP could look at prior to delivering the intervention or as a form of revision.

> *All that information is in the handbook that we received so it's always good to have stuff to go back to that you can look at, just to give you that bit of a refresh.* (NTP01HIC)

However, in one of the programs conducted in the UK, whilst mentioning the usefulness of the materials, the NTPs also expressed dissatisfaction, revealing how they still had not received materials that were shown to them during training.

> *We did get some handouts but my expectation was that we were going to get all of the handouts sent to us and it was all going to be in a book so that we could sort of go through them as we went through the training but that didn't happen… I still haven't got that book with all of the course in.* (NTP02HIC)

In the LMIC, the majority of the NTPs stated how the materials facilitated learning and also aided in delivering the intervention to the mothers.

> *The whiteboard was really good, they would write down each individual thing and if we didn't understand anything, we were told to write it down in the diary.* (NTP13LMIC)

9.1.2.5. Solution-focused training

A key factor which emerged through the interviews in the HIC was the need for training to provide tools and solutions to problems that the NTP may encounter when they are delivering the intervention.

> *I think maybe there's an element missing in training generally of what it feels like to actually deliver it and what plans you can put in place if you have a problem with it rather than just, 'Okay here's the techniques, off you go'. It's not as simple as that.* (NTP06HIC)

A number of participants expressed how whilst training taught them multiple intervention techniques, not enough time was spent on how to use them in practice, with NTPs feeling that training time could have been allocated more efficiently to incorporate extra time on skills consolidation.

> *It's funny because I was being shadowed by a colleague this morning who asked me about the MMP training and I said, 'It's really good and it's really informative but there wasn't much time for kind of skills consolidation'.* (NTP04HIC)

In contrast, whilst this was a common theme that emerged from interviews in the HIC, participants in Pakistan expressed general satisfaction with the training that they received.

> *The information that we learnt was enough, because this is the first time there has been a project like this in our village . . . it was enough for us to be able to help them (mothers) understand.* (NTP12LMIC)

However, although there was overall satisfaction in training, one NTP in the LMIC mentioned how they would have liked more information surrounding mental health. This view was also voiced by NTPs in the UK, who suggested that it is important for training to incorporate a background on the mental health condition prior to teaching about intervention techniques.

> *I think you need the background in order to be able to deliver the intervention. So rather than just being able to deliver the intervention I do think you definitely need some, you need some knowledge around the condition before you can just say, 'Well here's an intervention'.* (NTP01HIC)

9.1.2.6. Supervision as time for review, reflection and revision

Supervision is an important element in training NTPs to deliver psychological interventions. Whilst in both programs in the LMIC, the NTPs received supervision in the form of direct observations or through feedback of audio recordings of their intervention sessions, the programs conducted in the HIC did not have a form of supervision incorporated within them. However, as the NTPs were working within healthcare services, where they were most likely receiving supervision or had experienced the process of supervision, their views on this important element were still explored. From analysis of the data, three important factors within supervision emerged: (a) reviewing, (b) reflection and (c) revision.

Reviewing: In both the UK and Pakistan, supervision was a chance for the supervisor to review the work of the NTP and provide feedback. This form of supervision may also be known as 'case management supervision' in clinical settings within the UK. In particular, one participant in the UK emphasised the importance of receiving feedback, suggesting how it may allow the NTP to identify areas of improvement, allowing for the supervisor to make suggestions as to where further training may be required.

> *They listen to the recordings and see what was good and bad and then they will tell us which helps a lot, it tells us where we did things wrong. it improves our knowledge so that we can deliver the next session even better.* (NTP09LMIC)

> *I think it's [supervision] important for a number of reasons. That you've got that one to one with your line manager, that you can discuss any issues obviously that you are having with the job, that you can talk about your training needs and you know that you can receive praise if you're doing a good job; and I'm not saying I'm the type of person that needs a pat on the back every time I've done something well but I think good feedback is important you know when it's deserved.* (NTP02HIC)

Reflection: In both the HIC and LMIC, supervision was also seen as an opportunity for the NTP to reflect on their work and share their successes and failures.

> *I think having a forum like supervision to discuss, 'Well actually I found that this bit feels really frustrating to deliver or this bit doesn't feel like it's really working'. (NTP06HIC)*

Furthermore, as the NTPs will often be dealing with sensitive issues, supervision allows the NTPs to gain emotional support from their supervisors by reflecting on anything that their work may have triggered or brought up for them.

> *I'm a big believer in that [supervision] because I think for staff especially um, they need sort of that safe space to talk about things, especially if they are really struggling.* (NTP01HIC)

Revision: A number of NTPs highlighted how supervision was a learning opportunity and a time for revision, particularly in Pakistan, where supervision often involved role-plays to practice any areas that the NTPs may be struggling with.

> *If I was ever worried about how to approach a topic in the groups then I would practice it in the role-plays [during supervision] and I would write it down, so I knew what to do at the time of the groups.* (NTP12LMIC)

9.1.3. Trainer attributes

A common theme that emerged from interviews in both the HIC and LMIC was the personal qualities of the trainer and how it facilitated learning for the NTPs. This theme has been divided into two sub-themes: (a) experience vs. expertise and (b) personal traits.

9.1.3.1. Experience vs expertise

When questioned about their views on the trainer, the majority of the NTPs highlighted that the experience and academic knowledge of the trainer were important factors in ensuring that the training was credible. In both the HIC and LMIC, the academic knowledge of the trainer was seen as an important element in training, with participants expressing how the expertise of the trainer was reassuring for them, in knowing that they were receiving high-quality training. Furthermore, it also led them to being reassured that any questions that they asked would be answered. The knowledge of the trainer was also seen as a facilitator in allowing them to simplify topics for the NTPs to understand. One participant also described how the expertise of the trainer created a sense of 'authority', as it was coming from a credible source.

> *When they understand the subject, they can make it simple in a way to make the student or trainee understand*. (NTP07HIC)

In the THPP in Pakistan, a cascaded model of training was successfully used, where non–mental health specialists were trained to deliver the training. However, when NTPs were asked about their views on this method of training, one participant voiced their concern, stating how the trainer needed to be an expert in the field.

> *A layperson can't teach us as much as someone who has the knowledge and expertise might be able to.* (NTP14LMIC)

Conversely, a number of participants within the UK expressed how the experience of the trainer was more important than their knowledge, and teaching from their own experience allowed the NTPs to learn about the successes and failures of the intervention techniques. Furthermore, a common statement voiced by participants was that an individual having knowledge in the area may not necessarily make them a good teacher, which would only come with experience in teaching and intervention delivery. Participants also acknowledged that expertise in the field would come naturally with experience.

> *[T]he lecturers that were taking it are people who have worked in this field for probably years, you know they've got that, got the experience. So, they can tell you things that they've dealt with and sort of how you manage that and you know, life experience that they've dealt with and what they've gone through to get to that point.* (NTP01HIC)

These views were also voiced by a few NTPs in the LMIC, who stated that the trainer needs to have skills in teaching.

> *Only those who have a good mind, who can give training and have the talent can do it. It doesn't necessarily have to be a big expert.* (NTP18LMIC)

Furthermore, one participant in the UK acknowledged how balance was essential, with a good trainer having both the knowledge and experience in the intervention.

> *Or that balance again, and it's just a clever thing and that comes from experience. If you can imagine a kind of Venn diagram where all those things overlap . . . where academic qualification and experience and delivery overlap, it's that bit which is key, I think.* (NTP05HIC)

9.1.3.2. Personal traits

During analysis of the data, the personal characteristics of the trainer emerged as an important factor by the NTPs during their training.

Approachability. A key factor which was common amongst participants in both the HIC and LMIC was the approachability of the trainer, with a number of participants expressing how the trainers were open to discussions and answering any questions that the NTP may have had.

> *If we didn't understand something, we could constantly ask the same questions.* (NTP17LMIC)

Friendly. Furthermore, the trainers being considered as friendly and welcoming was also a facilitator for the NTPs, particularly amongst the participants in Pakistan, who expressed how their initial reluctance with training disappeared after seeing the friendliness of the trainers. A number of participants valued the trainers' efforts of getting to know the NTPs, stating how it helped build a friendly relationship between them. Moreover, they emphasised how this friendly environment between the staff and NTPs allowed them to learn more, with one NTP acknowledging that a strict 'student–teacher' environment would have been a barrier for them in their training.

> *It's because of them (trainers) that we have gotten to this point . . . I used to worry a lot at the start, but they spoke to us in such a friendly manner, they introduced themselves in such a way, like we had known them for ages. They taught us in a really good way and they kept a friendly relationship with us.* (NTP09LMIC)

Respectful. When exploring the important qualities of a trainer, a key factor that was found to be common amongst the NTPs in Pakistan was the trainers showing them respect. NTPs highlighted

how respecting an individual was more important than their knowledge or expertise. Furthermore, the NTPs expressed how the trainers were also respectful in their methods of feedback, often making NTPs aware of their mistakes in a loving way so as to not break their confidence.

> *Rather than education, the person should be respectful . . . there's no point being educated if the person doesn't know how to talk to people, doesn't know how to get them to work, doesn't know how to be respectful.* (NTP08LMIC)

9.1.4. Facilitators for NTPs

A number of facilitators for the NTPs during training and intervention delivery emerged through analysis of the data. These are clustered into three sub-themes: (a) altruistic gains, (b) personal gains and (c) support from others.

9.1.4.1. Altruistic gains

In both the HIC and LMIC, seeing a positive change in others was thought to motivate the NTPs in the work that they were doing. Whilst NTPs in the UK described how seeing progression in their clients was encouragement, one NTPs also mentioned how their own experiences with receiving help for mental health motivated them to repay back to the community.

> *Long story short, I had ME [myalgic encephalomyelitis] for 10 years, chronic fatigue syndrome and CBT was very helpful to overcome that. So, I kind of thought, once I got better and I want to try and repay this for other people and help them get better which I think is most people's motivation for getting into this line of work, is to help people. Umm, so certainly that was the initial motivation to getting into that line of work. (NTP06HIC)*

Altruistic motivation was also seen as a facilitator for NTPs in Pakistan, where a number of participants expressed how seeing a change in the mothers was motivation for them to continue on with their work.

> *The mothers have improved a lot. I used to have two or three mothers, who, the first time we did groups, I noticed they were really quiet, they wouldn't say much, but from me visiting them, a lot of their home life problems have been solved. It gives me happiness.* (NTP11LMIC)

A few participants described how wanting to make a change within their community was motivation behind starting this line of work, with a number of NTPs voicing how they wanted to enhance their knowledge even further to be able to help more people.

I have an interest in this work. I want to progress and improve my village . . . if I can save people from illness, if I can make them more aware, more safe, it would make me really happy. (NTP14LMIC)

Lastly, participants who were working as lady health workers mentioned how the training improved their skills and knowledge, which was seen as facilitator for their own existing duties and also highlighted the importance of the work that they were doing.

I would go to children's houses to weigh them but I never knew that from birth up to three years how important their physical health is, I found out from the training that a child's language, his actions, they're all so important. (NTP16LMIC)

9.1.4.2. Personal gains

Personal development. When questioned about whether NTPs used learnt intervention techniques on themselves, a number of them described how practicing the psychological interventions on themselves had led to personal development. Particularly amongst participants in Pakistan, where knowledge of mental health was lacking, the majority of them mentioned how training and intervention delivery led to improvements within their own family home and their relationship with their children.

I have seen some improvements. Before I used to get worried and then I would take it out on the children. From this training I've learnt to control my anger. (NTP18LMIC)

Furthermore, NTPs in Pakistan also described how training led to an increase in knowledge and awareness not only in mental health but also in the appropriate methods for raising their children. Moreover, training led to increased confidence with a few describing how this was motivation for them to attend more training.

I've learnt a lot from this program . . . I apply all of this on my own children and how I should be raising them. (NTP12LMIC)

Similarly, NTPs in the UK also described how training led to more awareness not only with their own mental health but also in terms of feeling 'lucky' and thankful for what they had when comparing themselves to the clients that they were seeing. Furthermore, participants also cited an increased empathy towards others and an increased awareness of what may be motivating them to behave in a certain way.

I was more sympathetic or empathetic, probably more empathetic really, you know walking around this city. On the way down now, there's a lot of bustles, there's a lot going on, a lot

of people walk into you, I felt more in tune with what might be drivers behind people's unhelpful, negative behaviour because they might be driven by anxiety or stress or low mood. (NTP05HIC)

Career development. Furthermore, NTPs in the UK also expressed how previous volunteering in the community led them to wanting more and developing a career out of it.

Since I left university well really umm, I was involved in community arts and also support work. So, supporting young people and adults with learning disabilities and part-time I would be using the art stuff to work with various different people within a health and well-being setting. So, that's what led me to here. (NTP03HIC)

Feeling valued. NTPs in the UK expressed how the training itself and supervision led to the participants feeling valued, as it was a way of acknowledging the work that they had been doing. Furthermore, one participant commented on how the seriousness of training and the time that was invested into it made her feel valued and respected as an individual.

[I]t [training] makes me feel really valued as well and supported in the way it's been delivered so far, and although there are ways in way it could have been better, I can see that it's actively been improved upon, so, I'm happy with that. (NTP03HIC)

In Pakistan, the feeling of value and appreciation came from the mothers whom the NTPs were helping, with a number of NTPs describing how the mothers would praise them and acknowledge the work that they are doing for them.

Everyone says to me, 'Don't ever leave this work, you're doing good work.' (NTP09LMIC)

Furthermore, similar to respect received from the trainers (see section 9.1.3.2), respect from the community was also seen to increase value within the NTPs and considered more important than receiving payment. When comparing responses between the NTPs in both programs, one which provided a stipend and the other which did not, it was found that a majority of them stated that they would continue delivering interventions to people without receiving any form of payment.

Money isn't everything. If someone is giving you respect then you can do anything. (NTP12LMIC)

Financial benefits. However, a number of NTPs in Pakistan acknowledged how receiving monetary incentives was important to them, as it would have further acknowledged the good work that they were doing, leading to increased feelings of value. Furthermore, for some NTPs, the

intervention was their only way of earning a living, and payment would facilitate motivation even further.

> *Some of the women would say 3000 [rupees] is not enough, we do so much work and we have to gather all the women.* (NTP14LMIC)

The notion of receiving payment was also voiced by a participant in the UK, who stated that as well as highlighting the advantage of career progression for an individual, a form of payment would be an added incentive to encourage a person to attend training to deliver a psychological intervention.

> *[I]f you were able to offer payment, even if it is . . . nine pounds an hour, something like that. It's still going to be great for a student who's really interested in that world.* (NTP05HIC)

9.1.4.3. Support from others

Support from others was also seen as a facilitator for NTPs, which came in the form of (a) direct support during intervention delivery and (b) indirect support through their supervisor and family.

Direct support: This form of support was described by participants in both the HIC and LMIC who mentioned how having a co-facilitator was directly beneficial to them during intervention delivery. Participants in the UK described how having an extra individual allowed for an additional perspective on the intervention techniques being delivered. Furthermore, it also considered important from a safety viewpoint, where in a group scenario, if the intervention contents were triggering for a trainee, and they required emotional support, then one facilitator would have the ability to support them, whilst the co-facilitator would be able to continue delivering the session.

> *I think there are good reasons for having two people, practical, safety and just the ease and functionality of the course, I think it's much better.* (NTP05HIC)

In Pakistan, the co-facilitator was a psychology graduate, which was seen as a facilitator for the NTPs, as this was considered as a learning opportunity for them where they were able to receive feedback and guidance. Furthermore, it allowed the co-facilitator to step in whenever the NTPs were having any difficulties with intervention delivery.

> *If I don't know anything or if I've made a mistake, they [co-facilitator] will take over.* (NTP15LMIC)

Indirect support: Participants in both countries received indirect support from their supervisor through supervision (see section 9.1.2.6). However, a number of NTPs in Pakistan also described how support from their family members was seen as a facilitator and motivation to attend training

and deliver the intervention. The majority of the NTPs mentioned how their families would indirectly support them when they were delivering the intervention by driving them to the mothers' houses or by taking over duties of childcare or cooking at home. Moreover, a large number of them expressed how their family members would encourage them to continue on with their work, with a few citing how gaining permission from their family and their support were initial motivations to attend training and start this form of work.

> *If I ever say that I am tired, or my legs hurt then my husband will encourage me and say, 'You make your own decisions but if you are delivering something good, and people are benefitting from it then continue to be strong'.* (NTP08LMIC)

9.1.5. Barriers for NTPs

The analysis of the data revealed barriers faced by the NTPs in both attending training and in intervention delivery. These are clustered into three sub-themes: (a) other commitments, (b) reluctance from clients and their family and (c) working within limitations of the role.

9.1.5.1. Other commitments

Work: For a number of NTPs in both the UK and Pakistan, their current duties at work were described as barriers to attending training. Participants in the UK expressed that there should be a gap in between training days for trainees to be able to balance their workload with training as opposed to consecutive training days which would require the trainee to take multiple days off at work.

> *There was a couple of times when it was like three or four days of it in a week, I think, and then we were finding it too much. Umm, especially as our workload grew.* (NTP03HIC)

Similarly, in Pakistan, women who were working as lady health workers also expressed a preference for training in the evenings, as they would be committed to their own work during the day. Furthermore, one NTP truthfully stated that she worked around her own convenience, and her work as a lady health worker took priority over delivering the intervention, with another also stating how two jobs led to feelings of exhaustion. However, one participant also acknowledged how working as a lady health worker was seen as a facilitator to intervention delivery due to the similarities between the two roles.

> *I'm not going to lie to you. I used to work according to my own convenience. So, if I was working as a LHW then I wouldn't do this Roshni work.* (NTP19LMIC)

Home: For a number of NTPs in Pakistan, commitments at home were also seen as barriers to training and intervention delivery. Several participants described how their responsibilities at home led them to feel preoccupied during training. Furthermore, the majority of NTPs mentioned how they would have to find childcare to be able to attend training, with one NTP expressing her preference for training during the day when the children would be at school. Moreover, being married was also seen as a barrier, with one participant acknowledging that marriage leads to requiring permission from the family and more responsibilities at home, with another NTP stating how her husband still had not accepted the work that she is doing.

> *If a person is unmarried then you are able to get permission but when a person is married, then there are a lot of responsibilities, there's a lot of work at home.* (NTP11LMIC)

9.1.5.2. Reluctance from clients and their families

One barrier that was commonly described by participants in Pakistan was the reluctance of the mothers and their families, which was encountered by the NTPs when they would deliver the initial intervention sessions. Several participants expressed their difficulties during the first few intervention sessions due to the mother's hesitation in opening up and sharing their feelings, which may have been due to lack of trust and fearing a breach of confidentiality. NTPs also mentioned how early on during the intervention it took time for the mothers to understand the purpose of their visits, citing their low literacy levels as a potential factor. Furthermore, a number of participants also described how they were met by a mother's unhappy mother-in-law, who would show negativity towards the work that they were doing. One NTP described how they overcame this by asking the mother's family members to sit in the session so they knew they were not badmouthing them. However, for a number of NTPs, this was seen as a further hindrance, as the mothers would not be able to talk so openly in the presence of their mothers-in-law.

> *There was one time when I had only just started working, I was telling the mother about the thinking healthy program and what a healthy mother should be like . . . her mother-in-law was sitting there and she was getting angry . . . and the second time I went the mother told me that her mother-in-law didn't like what we were doing.* (NTP10LMIC)

Although this was not mentioned as a common barrier within the UK, one NTP did describe their difficulties with clients who were in denial of their mental health illness and their resistance to accept help from mental health services.

> *We had one recently where umm, they didn't want any help from any services but they needed some mental health services put in place, but they didn't believe they had poor mental health and thought everything was out to get them. So, I guess it's things like that, that are challenging. (NTP01HIC)*

9.1.5.3. Working within limitations of the role

A barrier that was revealed by NTPs predominantly in the UK was the limitations of the role. A number of participants expressed how their clients' desperation for mental health support would lead them to expect more from the NTPs beyond the limitations of their role, with some participants mentioning how clients would often confuse them for a counsellor or a therapist. Moreover, one NTP described how high expectations from some clients would lead them to sending long text messages of their issues, resulting in the NTP feeling overwhelmed, citing how responding to them with advice would be unsustainable to do alongside her additional appointments. Furthermore, a few NTPs expressed a desire for wanting more out of their current role, where they would be able to offer more support and interventions to their clients and follow up with them rather than signpost to other services.

> *I met with a lady yesterday or the day before and she was talking about people giving her pitying smiles and I asked her if she thought that I was giving her a pitying smile right now and she said, 'Yeh, but it's different because you're my counsellor' . . . and I'm like, 'I'm not a counsellor', but people are so desperate for mental health support that they ignore and you can see it, you're telling them that I'm not a counsellor and their eyes glaze over and then it's their turn to talk and they just tell you everything that's going on, all these difficult things.* (NTP04HIC)

Several NTPs mentioned how a way of managing clients' expectations was explicitly stating the limitations of their role at the beginning of the intervention session so that the clients were aware of their abilities to help.

> *Something we did on the PERSUADE training. Was kind of when we introduced ourselves was saying like, 'I'm not an expert, I'm not a psychologist, I'm not a psychiatrist. In the context of today, I'm someone that has obviously learnt these techniques', I would mention that I've applied them to myself.* (NTP06HIC)

Whilst high expectations of the client were not seen as a common barrier amongst the NTPs in Pakistan, one participant similarly did mention how they made the mothers aware of their limitations.

> *We told them that we don't have a cure, the only thing we can do is offer advice . . . We did whatever was in our limits.* (NTP11LMIC)

9.2. Results: Experts

Recruitment of experts took place between October 2019 to January 2020. In total, 13 participants were approached to participate in the study, all of whom agreed to participate (see sections 7.4.2 and 7.4.4 for sampling and recruitment procedures). Semi-structured interviews were conducted with eight participants in Pakistan and five in the UK, one of whom was the master trainer for a program in Pakistan. With the exception of one participant, all the experts had a degree in social science or mental health. Job roles varied, with all the experts in the UK working within a university setting, whilst experts in Pakistan had a role within their own research centre (see Table 9.3).

The interviews lasted between 45 to 60 minutes, and all were recorded using an encrypted recorder after receiving consent from the participants.

Table 9.3. Characteristics of Experts

Participant ID	Gender	Job Role*	Education*
EXP01HIC	Male	Mental health lecturer	BSc Psychology MSc Advanced Practice in Mental Health
EXP02HIC	Female	Director of social science at University of Salford	MA Social Work
EXP03HIC	Female	Mental health nursing lecturer at University of Salford	MSc Mental Health Nursing
EXP04HIC	Female	Cognitive behavioural psychotherapist lecturer at University of Salford	MSc CBT
EXP05LMIC	Female	Master trainer and supervisor at HDRF	BSc Psychology
EXP06LMIC	Female	Trainer and supervisor at HDRF	BSc Psychology
EXP07LMIC	Female	Trainer and supervisor at HDRF	BSc Psychology
EXP08LMIC	Female	Trainer and supervisor at HDRF	BSc Psychology, MPH
EXP09LMIC	Female	Trainer for refreshers for LTPP	MSc Clinical Psychology
EXP10LMIC	Female	Master trainer for LTPP	MSc Clinical Psychology
EXP11LMIC	Male	Trial manager/project coordinator	BSc Psychology
EXP012LMIC	Female	Supervisor of research assistants	BSc Psychology and Philosophy Diploma in Early Child Development
EXP13LMIC	Female	Community supervisor	High school education

*HDRF, Human Development Resources Foundation; LTPP, Learning through Play Plus, BSc, Bachelor of Science; MA, Master of Arts; MSc, Master of Science; MPH, Master's in Public Health

Data were analysed using framework analysis (see section 7.3.2). In the final stage of data analysis, data were organised into five themes and nineteen sub-themes (Table 9.4) representing the important factors to consider when developing training for NTPs as perceived by experts. Quotes that captured the essence of the themes and supported any interpretation were selected for presentation. Further quotes can be found in Appendix 26.

Table 9.4. Thematic framework of expert interviews

Index no.	Thematic framework - Experts
1.0	**Who are the NTPs?**
1.1	Education and professional background
1.2	Selection criteria
1.3	Motivators for working as an NTP
2.0	**Elements of training**
2.1	Target population
2.2	Relevant content
2.3	Experiential learning
2.4	Collaborative and open environment
2.5	Group size
2.6	Supervision as time for review, refresh and support
3.0	**Unique considerations for LMICs**
3.1	Challenges faced by NTPs
3.2	Selection criteria specific to LMICs
3.3	Flexibility of training
3.4	Motivators for the trainer
4.0	**Trainer attributes**
4.1	Experience vs expertise
4.2	Challenges for the trainer
4.3	Facilitators for the trainer
5.0	**Why is information on training lacking?**
5.1	Reluctance to disclose
5.2	Outcome focused
5.3	Importance of guidelines

9.2.1. Who are the NTPs?

This theme represents the factors that need to be considered when selecting and training NTPs as perceived by experts. The analysis revealed three sub-themes: (a) education and professional background, (b) selection criteria and (c) motivators for working as an NTP.

9.2.1.1. Education and professional background

When reflecting on the level of education and the professional background of the NTPs who attended training, the experts in the HICs stated how although the level of experience varied, most NTPs had some form of experience in mental health, which was either through a formal

qualification or through working in charity sectors. In contrast, in the LMIC, the level of education was minimal, with most NTPs having only completed high school. However, the experts also acknowledged how the NTPs working as LHWs also had training to deliver routine healthcare to the mother and child, which included immunisations and promoting health awareness.

> *They were non-professional from the point of view that they weren't registered nurses or registered social workers . . . But a lot of them had worked in the field of mental health or patient services or counselling types services for quite a long time. So even though they weren't qualified, they had quite a lot of experience in fields related to health and social care.* (EXP03HIC)

> *Their level of qualification is intermediate you know, and then there is some, I think a diploma course for the proper training of lady health workers because the main work is around the vaccination and polio.* (EXP10LMIC)

9.2.1.2. Selection criteria

Data analysis revealed the difference in the criteria that needs to be considered when selecting NTPs to train in both HICs and LMICs. In the HIC, one expert described how having experience and an understanding of mental health was important as well as having a natural ability to speak to others to aid in delivery of the intervention. However, education was deemed as important in the LMIC, with one expert stating how it was necessary for the NTP to have at least 10 years of education. Moreover, having similar characteristics to the mother was considered beneficial, as it would allow her to use her own experiences to facilitate intervention delivery. Furthermore, analysis revealed selection criteria specific to the challenges faced by NTPs in LMICs, which are described in greater detail in section 9.2.3.2.

> *I think the fact that either they have experience or a good understanding of depression through their own experience or though work is important . . . someone who communicates well with other people, that would be really important because that's something that's a bit harder to teach. You can teach someone how to deliver three or four steps of a CBT intervention quite easily but if you have to start teaching interpersonal skills, that could take a lot longer.* (EXP01HIC)

9.2.1.3. Motivators for working as an NTP

Through data analysis, a number of motivators as perceived by experts emerged, which may be deemed as important to consider for recruiting NTPs to train and maintaining their motivation throughout the length of the intervention.

Incentives. Providing financial incentives was seen as a useful method for recruiting and retaining NTPs in both countries. Experts acknowledged that delivering an intervention and attending training and supervision sessions require commitment and time from the NTPs, and therefore, monetary incentives would be a possible way to increase motivation and keep the NTPs happy. However, experts also stated how incentives could come in alternative forms such as by providing transportation or by giving vouchers, which was a way of overcoming the issue of benefits which NTPs may be receiving by the government in the UK.

> *[I]f you're trying to recruit lay health workers as such from the community who are perhaps doing this in their own time and perhaps not financially well off, you're asking them to give two or three days for training time and then half a day every so often to deliver this workshop and attend supervision and all that, I think people would struggle to do that for free.* (EXP01HIC)

Personal gains. Experts in both countries described how highlighting the benefits for career development, as well as the opportunity to develop their own personal skills, is a motivator for the NTPs. Furthermore, the altruistic benefit was suggested as being a motivating factor, particularly amongst NTPs in Pakistan where mental health awareness was low; being told the results of the intervention was encouraging for the NTPs to continue on with their work.

> *It has also proven to be a stepping stone for them, because some of them, they have become the polio drop administrators, some of them, they have started their own small business–like shops in one of their rooms, some of them have become teachers.* (EXP05LMIC)

9.2.2. Elements of training

This theme represents the essential factors that need to be considered when training NTPs as perceived by experts. This theme has been divided into six sub-themes: (a) target population, (b) relevant content, (c) experiential learning, (d) collaborative and open environment, (e) group size and (f) supervision as time for review, refresh and support.

9.2.2.1. Target population

Experts expressed how when developing training it is important to know the target population that is being trained. In both countries, gauging the NTPs' level of knowledge and experience was highlighted as being essential both during the developmental phase and during implementation so the training could be adapted around the needs of the NTPs to ensure it is effective. One expert in the UK spoke about how it was important for the trainer to be responsive to the needs of the

trainees in the room. Furthermore, experts in Pakistan also discussed how it was important to consider the area where the NTPs are from, and training should be adapted to suit the local language and cultural contexts.

> *[W]e had regular meetings . . . and I think that worked very well because that allowed us to be responsive as the needs changed and emerged you know. So, that worked very well, that management, being able, retaining a sort of review and flexibility response is important. (EXP02HIC)*

> *If we are looking at area, then maybe there are things within the training that need to be adapted. For instance, if you are going to a village in Punjab, your training style, the examples that you give according to the culture, those will be slightly different, but if you are going to Karachi to give training, to a village in Sindh, that would maybe be slightly different.* (EXP07LMIC)

9.2.2.2. Relevant content

When discussing the content of training, the notion of training being balanced and credible to ensure training is relevant to the NTPs emerged as critically important elements as perceived by the experts.

Balanced. Experts described how it is important for training to be balanced in providing not only knowledge around mental health but also intervention skills. Training in the recognition of mental health symptoms and knowing when to refer to a professional was highlighted as a crucial aspect of teaching. One expert mentioned how a good understanding of mental health would aid the NTP in the intervention delivery itself and facilitate empathy. However, it was also acknowledged that in-depth training in mental health was not necessary, and an emphasis should be placed on skills.

> *[I]f you are going to do a mental health awareness session which introduces different mental health conditions and what they look like, what the symptoms are and that kind of stuff, and about how you know, things you need to look for and refer on for, umm and then look at psychosocial interventions I think that's a good thing. Because I don't know how you can do one without the other.* (EXP03HIC)

Credible. Experts highlighted the importance of providing evidence-based content in training but acknowledged that the level that the NTPs need to be aware of is not crucial and often is not a concern of trainees, who would prefer to focus more on the practical application of techniques. Moreover, one expert stated how often there is little or no evidence available, and the purpose of a program will be to generate evidence to widen the pool of knowledge. Furthermore, experts

mentioned the importance of reviewing the training through feedback and assessment of the NTPs' knowledge to ensure that it is effective and serving its purpose.

> *Obviously, it's really important to teach evidence-based approaches, but I don't think students who work in the real world are as worried about who it was that advocated a particular approach. They're more interested in how to use whatever technique it is.* (EXP03HIC)

> *It [assessments] gives you an idea about the training . . . it gives you the chance to improve on those things. Secondly, the content that you have taught them, it gives you an idea in regards to whether it's ok or not, whether the next person would be able to understand it or not.* (EXP08LMIC)

9.2.2.3. Experiential learning

In line with the theme of experiential learning (section 9.1.2.3) from the NTP interviews, experts also discussed the benefits of incorporating experiential learning within training, which came in the form of role-plays and discussions. Most of the experts acknowledged the diversity in the preference of learning styles, with some people favouring didactic teaching over interactive sessions. However, some mentioned how role-play was important from a learner's perspective to allow the opportunity to practice techniques and also observe fellow trainees. Furthermore, experts in the LMIC also expressed how role-play was a way of assessing understanding and providing feedback to the NTPs. Experts also described how it was important to encourage NTPs to share their own experiences and bring their own examples into the classroom so as to allow the opportunity to learn from each other and brainstorm solutions to any problems they may be having.

> *I think role-play sessions are more engaging. These role-play sessions actually give them the opportunity to practice, to rehearse; and obviously the trainers are there to give feedback on selection of words even, and the tone and obviously the content as well. So, for community health workers the role-play sessions are very important because you know it's difficult for them to engage with presentation after presentation.* (EXP10LMIC)

9.2.2.4. Collaborative and open environment

Experts described the importance of having an open and collaborative learning environment where NTPs feel comfortable to ask questions and share their opinions. They expressed how having a friendly, informal approach with the NTPs was necessary to break the student–teacher relationship, which may have been a barrier preventing the NTPs from sharing any problems.

> *[T]he most important is how you are with other people. So, if people feel comfortable and safe with you, then they are able to learn more because they are confident knowing that they can ask a question.* (EXP04HIC)

9.2.2.5. Group size

Experts mentioned how the size of the group is critical during training, where the size needs to be large enough to allow for interaction and discussion but small enough for the trainer to be able to observe and provide feedback. Furthermore, a smaller group was described as allowing for a more personal experience and providing a safer environment for the NTPs to share their own personal issues that they may be dealing with. Experts in both countries also discussed how it was important to have a contingency plan and train more individuals than necessary to adjust for any absences. Similarly, the importance of having two trainers was also mentioned in the event that one trainer is unable to deliver training; furthermore, two trainers would allow for greater opportunity for observation and feedback.

> *[I]f there is a big group then you can't give everywhere the same proper attention that you would if you had a nominal sized group . . . in one group we even had less than 10. So, in those, the learning is better, in those you can be more interactive you can be more into it. If it is a bigger group . . . maybe there is still learning but you don't get to know them that well.* (EXP06LMIC)

9.2.2.6. Supervision as time for review, refresh and support

The importance of supervision was highlighted as a way of providing support as well as a way of ensuring fidelity to the intervention.

Reviewing and refreshing. Similar to the theme of 'Supervision as time for review, reflection and revision' (section 9.1.2.6) from the NTP analysis, experts also described the importance of supervision for assessing competency of the NTP and reviewing the intervention to ensure fidelity. One expert described how assessments were essential in ensuring that a high-quality intervention was delivered and also as a way of identifying further areas of training that may be required. The need for refresher training was also highlighted by experts in Pakistan, who stated how it was also an opportunity for all the NTPs to come together and share their success stories.

> *Competency in the way that; firstly, normally in supervision we are doing role-plays so we are considering this. Secondly, we are doing live observations and within that there are three points that we look at, such as how was it the first time? What is the score like now? If that is down, then we talk about retraining in those areas.* (EXP07LMIC)

Support. Experts in both countries described how it was essential to ensure the NTPs felt supported and valued throughout the intervention, which was also described as a facilitator by the NTPs themselves (section 9.1.4.3) and may be a method of ensuring retention. Furthermore, as they are often dealing with sensitive issues, supervision is an opportunity to check the mental health and well-being of the NTP themselves and resolve any issues that they may be dealing with. In the LMIC, support also came in the form of empowerment, where experts described how they would leave decision-making up to the NTPs as a way of increasing their confidence.

> *[Y]ou're also looking at your supervisee's well-being and ethical codes of conduct and practice . . . is your supervisee talking about symptoms of burnout? Or they're feeling overloaded or something's too much? Are they struggling with an assignment?* (EXP04HIC)

9.2.3. Unique considerations for LMICs

Data analysis revealed a common theme of factors that should be considered specifically when training NTPs in LMICs. This has been divided into four sub-themes: (a) challenges faced by NTPs, (b) selection criteria specific to LMICs, (c) flexibility of training and (d) motivators for the trainers.

9.2.3.1. Challenges faced by NTPs

Experts in Pakistan described how NTPs would often face challenges when attending training and delivering the intervention. A common barrier was the NTP's family not accepting their work, with one expert stating how NTPs would complete training but would be unable to deliver the intervention due to not gaining permission from their family. Furthermore, similar to the sub-theme described in section 9.1.5.1 by the NTPs, commitments at work and at home were also mentioned by experts as a challenge commonly faced by the NTPs, often leaving them feeling overburdened with work.

> *There's many challenges at the start, 'How will we get there? How will we get back? We are interacting for the first time; we are very shy'. I mean, these are the issues. 'Our family members don't agree, or are family members agree but there is no one to go with, the journey is far, the mother isn't getting involved, how do we involve the mother, what are her issues at home?'* (EXP06LMIC)

9.2.3.2. Selection criteria

When questioned about the selection criteria used to recruit NTPs, experts described specific criteria for NTPs in the LMIC that reflect the challenges that are faced by them. Experts stated how it was important to select women from the community who were familiar with the area and family

dynamics of individual households and who were also able to speak the local language. Furthermore, as approval from the family was seen as a barrier to training and intervention delivery, the NTPs needed to be able to move freely within the community with permission from their family.

> *When we recruit peer volunteers, they need to be having at least 10 years of schooling, umm they need to be local, umm they need to be able to move in the community uh freely, because some of the local women who actually wanted to work as peer volunteers but they were not allowed by their families to be going from home to home, so it became really difficult.* (EXP05LMIC)

9.2.3.3. Flexibility of training

Experts in the LMIC also acknowledged how when training lay people it was important to accommodate training around the needs of the NTPs to be able to encourage them to attend. Flexibility of the training time was commonly mentioned, with the time often adapted according to the commitments of the NTPs.

> *Usually, the trainings in the UK is between nine till five o'clock, uh, but in Pakistan it's a bit different. So, when you train people over there, the day starts maybe at eight o'clock and then it tends to finish by one o'clock, for the peer volunteers. Like, if you're training the professionals then it is different, you can train them nine to five, but if you are delivering the training to non-professionals, um, usually by the time it's one o'clock they want training to finish.* (EXP05LMIC)

9.2.3.4. Motivators for the trainers

Analysis of the interviews revealed motivators that were specific to experts in Pakistan, who expressed how delivering training to NTPs was a rewarding experience. Raising awareness of mental health within the communities and seeing improvements in both the NTPs and mothers' lives were described as a motivator for continuing on with their work, with experts describing the satisfaction they would get when they would receive acknowledgement for the work that they were doing.

> *I really feel that if I train 12 people in a training program, for me this is fascinating. Those 12 people will approach 1200 families, and if my training is able to reach 1200 families, in terms of child health and well-being, in terms of reducing maternal mortality or child morbidity . . . this is really fascinating for me.* (EXP11LMIC)

9.2.4. Trainer attributes

Through data analysis, a key theme of training the trainer emerged, which captures the key qualities that a trainer should have as well as challenges that may be faced, which should be taken into account when selecting a trainer for the training programme. This theme has been divided into three sub-themes: (a) experience vs expertise, (b) challenges for the trainer and (c) facilitators for the trainer.

9.2.4.1. Experience vs expertise

Similar to the sub-theme of section 9.1.3.1 from the NTP interviews, both the experience and expertise of the trainer were mentioned as an important quality for the trainer. Experts in both countries stated the importance of having experience and skills in teaching and acknowledged how being a clinical expert did not necessarily translate to being a good teacher. Furthermore, experience in delivering the intervention itself was also valued, with one expert describing how practicing the intervention on themselves facilitated training to others.

> *[Y]ou can be really good at delivering an intervention, whatever that intervention is, and a rubbish teacher, can't you? That is the reality.* (EXP03HIC)

> *I apply all of those things on myself first, everything I've learnt, some were counselling skills. Because when we go to teach someone else, only when we have practice of it on ourselves can we teach others.* (EXP08LMIC)

However, most experts expressed how a balance of understanding and experience in the intervention and skills in teaching was required to be a good trainer, with one expert stating how expertise in the intervention and delivery of training were dependent elements.

> *They certainly need to have high expertise I think, to understand the content they are delivering but also to be able to deliver that in a way that's umm particularly helpful for people. So, there's two strands to that, there's the content and there's the process of learning.* (EXP02HIC)

9.2.4.2. Challenges for the trainer

Experts in Pakistan and the UK experienced different challenges when delivering training to the NTPs. Whilst in the UK challenges included having limited time to deliver all the content of training, in Pakistan challenges came in the form of practical issues such as a language barrier and travelling a long distance to deliver training. Furthermore, experts in the LMIC expressed how training in the more complicated aspects of the intervention was a challenge, as it required effort to explain concepts in a clear and simple manner to develop understanding of the NTPs.

> *The people who you are training don't have a background knowledge in regards to what you are teaching them in, so to help them understand what kind of words to use, what kind of examples to give, in what way are you going to go down to their level and teach them. So, at the start it was difficult.* (EXP08LMIC)

However, experts in both countries described how they faced challenges to change the already existing views of the NTPs. Whilst in the UK these existing views were around the NTPs' previous experiences and knowledge of mental health, in Pakistan experts spoke about the NTPs' cultural beliefs and traditions and how it often contradicted the training they were providing.

> *Our beliefs having been running for generations. Like at the start, it is in generations that if they show a child a mirror, their child will fall ill. Now, to tell them no, it's difficult to convince them no . . . to tell them logically, to tell them no, it's difficult.* (EXP12LMIC)

Furthermore, providing only the adequate amount of information required for the NTP to deliver the intervention was also seen as a challenge for the experts. In both the HIC and LMIC, experts described how it was important to be cautious as to not provide too much detail than was necessary to the NTPs, with one expert expressing her concerns that providing too much information may lead to NTPs thinking that they have as much knowledge as a registered professional and trying to solve problems themselves rather than referring on to the appropriate services.

> *You have to be cautious about going into too much depth, particularly when you are talking to people who may not have umm the educational background to build on some of the concepts you are talking about.* (EXP02HIC)

9.2.4.3. Facilitators for the trainer

Experts in both countries also described factors that facilitated training, which differed in both countries. Whilst the previous experience of the NTPs in mental health was described as a challenge, experts in the HIC also stated how the NTPs were able to share and discuss their own experiences they had had with their own clients which facilitated learning. Alternatively, experts in the LMIC described facilitators that helped build rapport with the NTPs, which came in the form of community leaders and LHWs. Furthermore, in line with sub-theme 9.1.1, experts acknowledged how being local to the community was also beneficial, as it allowed them to build trust more easily than an outsider would have.

> *We never enter a community without a community leader . . . they have a different trust for the community leader . . . this helps a lot, when the leader is introducing you, they engage with it.* (EXP10LMIC)

9.2.5. Why is information on training lacking?

This theme represents the common reasons as to why researchers may not disclose their training within journals as perceived by experts. This theme has been divided into three sub-themes: (a) reluctance to disclose, (b) outcome focused and (c) importance of guidelines.

9.2.5.1. Reluctance to disclose

A number of experts expressed how they thought that researchers may not disclose their training procedures due to a fear of it 'going into the wrong hands'. There were concerns that if a training manual was available online, it may lead to a lack of control and diminish the importance and the value that should be given training, which is necessary particularly when dealing with a vulnerable population. The relevancy of the training was also mentioned, with one expert in the UK expressing her fears that over time an online training manual may not be in line with current research and evidence. Furthermore, one expert also stated that by having a layperson deliver the intervention, mental health professionals may question their own personal values and importance. The issue of copyright and funding was also discussed, with some experts stating how it is important to consider rights to intellectual property and the commitments that are made to external funding bodies before publishing a manual online.

> *If there is a manual available online, a lot of researchers have the tendency that 'this is available so use it', without giving due consideration on the importance of training and at times you are using that manual to some vulnerable population like self-harm, you have that manual but you don't have the expertise in terms of how to use that. So, may be this is the one reason that people don't upload it so it can't be used outside.* (EXP10LMIC)

9.2.5.2. Outcome focused

A number of experts expressed that when publishing in high-impact journals, outcomes are often prioritised, and little attention is given to the training procedures carried out. The word count of journals was also mentioned, with one expert suggesting that a limit on the number of words would lead to researchers having to prioritise their results. Furthermore, they acknowledged that the improper documentation of how the training was conducted and a lack of audit trails during the implementation phase of the study may have led to it not being reported fully in publications.

> *I guess people don't focus on what happens in the classroom do they? They just focus on what comes out the other end really . . . So, they are less focused on what should happen and more focused on need and outcome. We're an outcome-driven society, aren't we? But*

sometimes we don't think about the journey and how we get to where we want to be. (EXP03HIC)

9.2.5.3. Importance of guidelines

When asked about their opinions on guidelines to ensure proper documentation of training procedures, most experts expressed their positivity, stating how it would be beneficial in providing structure and standardisation during the writing phase. One expert suggested that journals should enforce the use of guidelines as a stipulation to publication to encourage researchers to properly document their training. However, experts in the UK also voiced their concerns, stating how guidelines can often be too prescriptive and lead to researchers 'not thinking outside' and forgetting to disclose information which may be of value to the reader.

There should be guidelines which are standardised . . . definitely if you are writing, you are writing for a layperson who can easily understand your paper and they can gain knowledge from it then there should be a standard for how we can report things easily. (EXP09LMIC)

The purpose of disclosing training procedures was also discussed, with experts stating that revealing training procedures was important for other researchers to be able to learn from their mistakes and also to widen knowledge, further enforcing the need for guidelines.

[I]f you could read other people's training ideas, that would be good, because probably teams across the country are delivering the same mistakes over and over again that aren't helpful for people. So, it would be nice to see better evaluations of training so that it stops people making the same mistakes. (EXP01HIC)

9.3. Chapter summary

- This chapter presents the results of semi-structured interviews conducted with NTPs and experts in the UK and Pakistan.

- Analysis of the interviews with NTPs resulted in five key themes: who NTPs are, elements of training, trainer attributes, facilitators for NTPs, and barriers for NTPs.

- Analysis of the interviews with experts resulted in five key themes: who NTPs are, elements of training, unique considerations for LMICs, trainer attributes, and the reasons for the lack of training information.

- The next chapter will present a summary and synthesis of the results and recommended components for training NTPs.

Chapter 10. Qualitative synthesis of the non-traditional provider (NTP) and expert interview studies: Recommended training components to train non-traditional providers in psychological interventions

This chapter is an exploration of essential training as perceived by NTPs and experts. It aims to summarise and synthesise the main findings from the results and present recommendations of essential training components for training NTPs to deliver psychological interventions.

10.1. Synthesis of NTP and expert interview studies

10.1.1. Summary of main themes

10.1.1.1. Who are NTPs?

This was an important theme that emerged in both sets of interviews, which highlights the important characteristics that are needed to successfully deliver psychological interventions. The sub-theme of **shared characteristics** that emerged from the NTP interviews revealed the necessary factors which facilitated the NTPs in intervention delivery. These attributes were also reflected by the sub-theme **selection criteria,** which experts described as important to consider when selecting NTPs to train. Furthermore, the sub-themes of **knowledge in mental health** and **education and professional background** emphasise the differences in education level and experience in mental health between NTPs in Pakistan and the UK as well as highlight the misconceptions that individuals in Pakistan hold surrounding mental health. The NTPs' **capacity to deliver the intervention** was also perceived as an important element by NTPs, which was divided into *confidence* in delivering the intervention, gained through advanced preparation, revision and supervision, and *assessments*, allowing the trainers to identify who was capable enough to deliver the intervention. Lastly, experts identified **motivators for working as an NTP,** which included different forms of *incentives* and *personal gains* for the NTPs from training and intervention delivery. These motivators are particularly useful to consider when recruiting and retaining NTPs for the length of the intervention.

10.1.1.1.1. Differences between sites within countries

Differences were also noted between sites within the same country. In Pakistan, the NTPs from the LTPP exemplar were lady health workers, who therefore had more knowledge surrounding health than the NTPs from the THPP who were peers. Furthermore, the experts had stated that as the lady health workers were very busy with their existing duties, monetary incentives were essential in maintaining their motivation and ensuring their retention and commitment to the project. However, no differences were found between the exemplars in the UK, as both sets of participants were working at charity organisations that were involved with individuals suffering from mental health issues.

10.1.1.2. Elements of training

Multiple components of training emerged as important through the analysis of both NTPs and expert interviews. NTPs highlighted how it was important to consider the learning style and experience of the trainees by having **tailored training**; this idea was also reflected by the sub-theme **target population,** which emerged from the expert interviews. Experts expressed how it was necessary to gauge the experience of the individuals they are going to train as well as tailor the training to their needs, particularly in LMICs where it was important to adapt the training to the local culture and language. When discussing the **relevancy of the content** within the training programmes, experts described how it was important for the content to be *balanced* in information surrounding mental health and intervention techniques and *credible* by providing evidence-based content and theory. This notion of relevant training is also reflected by the sub-theme **solution-focused training,** which emerged through interviews with the NTPs, in which they expressed their desire for a greater focus on skills practice and solutions for issues encountered in practice to ensure that training was relevant and beneficial for them.

Experiential learning was a strong sub-theme in both studies. NTPs and experts highly valued the use of discussions and role-plays to facilitate learning, allowing for the trainees to learn from their own experiences as well as each other. Furthermore, the provision of training materials was also perceived to facilitate learning amongst the NTPs and was seen as beneficial in both the UK and Pakistan. Additionally, experts described the importance of having a collaborative and open environment to promote discussion and facilitate learning, stating how an informal teaching environment would allow trainees to feel confident enough to ask questions. Group size was also perceived by the experts to be an important factor in facilitating discussions, with many experts expressing a preference for a smaller group size, providing trainees a more personal training experience.

NTPs also perceived **accessibility of the training venue** to be an important component of training, with the majority of them expressing how training should be conducted in a central and accessible location. Furthermore, the issue of transportation was also discussed, with NTPs in Pakistan describing how the provision of transport was an incentive to attend training, further stating how a lack of transport was often a cause of anxiety and a barrier to intervention implementation.

Supervision was also perceived as a critically important element of training for both NTPs and experts to ensure fidelity to the intervention. Amongst the NTPs, supervision was viewed **as time for review, reflection and revision,** which allowed the NTPs to review and gain feedback on their cases with the supervisor as well as provided the opportunity for further learning. Similarly, amongst the experts, supervision was seen **as time for review, refreshing and support**. Experts highlighted the importance of providing *support* and ensuring the well-being of the NTPs; furthermore, they expressed the benefits of supervision in allowing NTPs to *review* their work and identify any gaps in knowledge which could be addressed during *refresher* training sessions.

10.1.1.2.1. Differences between sites within countries

Whilst no differences were found between exemplars in Pakistan with both sets of participants describing the usefulness of role-play and the benefits of supervision, differences were found in the exemplars in the UK. As training for the multi-modality practitioner exemplar was over a year long, participants expressed their dissatisfaction with still not having received the training materials. This was important, as the NTPs were working alongside attending training sessions and had expressed that having the training materials would have allowed them to refresh and consolidate any skills that they had learnt. However, this was not an issue for NTPs from PERSUADE who had received their training materials and described the benefits of being able to use it whilst delivering the intervention. Furthermore, some multi-modality practitioners expressed how there was a need to tailor training to the trainees, and having a heterogenous group with a different skill mix, often led to some of the training content being irrelevant to some individuals. Conversely, NTPs from PERSUADE did not express any dissatisfaction with the training content which may have been due to the similar background and level of experience of all the trainees.

10.1.1.3. Trainer attributes

The characteristics of the trainer were perceived as an important factor to facilitate training by both the experts and NTPs. When asked about what was more important, **experience or expertise,** both NTPs and experts stated that whilst they valued the expertise and knowledge of the trainer in their area, experience in teaching and in the intervention was more valuable for learning, with a number of them stating that a good clinician did not necessarily relate to a good trainer, and therefore, it was important for the training to have good teaching skills. Furthermore, NTPs in both the UK and Pakistan described a number of **personal traits** of the trainer that they perceived as facilitating learning, which were *approachability, friendly and respectful*. In particular, respect was highly valued amongst NTPs in Pakistan, who acknowledged how a respectful trainer made the training experience more enjoyable and facilitated learning, with some NTPs regarding respect as more important than expertise of the trainer.

Challenges for the trainer were also discussed by experts, which differed in the UK and Pakistan. Whilst experts in the UK expressed difficulties in time management, in Pakistan experts described challenges specific to training individuals from LMICs such as encountering a language barrier and difficulties in training minimally educated individuals in complex intervention components. However, similar challenges across both countries were also described, such as difficulties in trying to change the already existing views of the trainees and only providing the correct amount of information needed for intervention implementation. **Facilitators for the trainer** also differed in both countries, with experts in the UK describing that the previous mental health experience of the NTPs facilitated learning by sharing their own personal experiences with clients. Meanwhile, in Pakistan, experts spoke about how being introduced by community leaders allowed the trainers to

build rapport with the NTPs, which was also aided by the trainers being local and their ability to speak the local language.

10.1.1.4. Facilitators for the NTPs

A number of facilitators for the NTPs to attend training and implement the intervention emerged from the analysis. **Altruistic gains** were viewed as one of the reasons for delivering the intervention, with a number of NTPs describing how seeing improvements in their clients was encouraging for them to continue on with the work. Furthermore, NTPs expressed how motivation for wanting to attend training and deliver psychological interventions came from their own past experiences with receiving help for their mental health, which led to them wanting to repay this back to the community.

NTPs stated how applying intervention techniques on themselves led to improvements in their own life, which is reflected through the sub-theme **personal gains**. In particular, NTPs in Pakistan expressed how training led to greater mental health awareness and further knowledge in how to raise their children better, with a number of them acknowledging an improved relationship and better understanding with their children. Furthermore, feeling valued was highlighted by the NTPs as an important motivator, which came from being acknowledged for their work by the supervisor and through appreciation from their clients. NTPs in Pakistan also stated how receiving a stipend would have been another method of acknowledging the good work that they were doing and would have been further motivation to continue. **Support from others** was also a facilitator in intervention implementation through having another facilitator deliver the intervention alongside them and through support that was provided by their supervisors and family members. Facilitators are a crucial factor to consider when considering methods of recruiting and retaining NTPs. Motivation plays a significant role in ensuring that the NTPs continue their work for the length of the intervention; therefore, it is necessary for experts to explore ways of encouraging NTPs to ensure their satisfaction and commitment to the intervention.

10.1.1.5. Barriers for the NTPs

Analysis of the interviews with the NTPs also revealed a number of barriers that they encountered during training and intervention implementation. NTPs discussed how **other commitments** often led to challenges, with balancing existing *work* with training being the most common difficulty amongst NTPs in both the UK, all of whom were working within a health and well-being service, and Pakistan, where the majority of them had some role within the community. NTPs in Pakistan also described *home* commitments as a barrier to training and intervention delivery, with factors such as childcare, home responsibilities and family permission affecting their decision to attend training and deliver the intervention. When discussing intervention implementation, **reluctance from clients and their families** was a common barrier encountered by the NTPs. In the UK, NTPs

described difficulties in getting the clients to accept they had a mental health illness and in encouraging them to receive help. NTPs in Pakistan also faced similar reluctance from both clients and their family members, citing a lack of awareness surrounding mental health and a lack of trust as reasons for their hesitation. Finally, a barrier that emerged most commonly in the UK was the NTPs' difficulties with **working within the limitations of the role**. A number of them expressed how clients desperate for support would often have high expectations from the NTPs and often had a misconception of the role of the NTP and what they could offer, further stating how it was important to state the limitations of their role prior to the intervention to manage clients' expectations. When developing training, it is important to consider the barriers that may be faced by the NTPs, which could be addressed by incorporating them into training and offering NTPs tools and solutions to overcome them.

10.1.1.5.1. Differences between sites within countries

Differences were also found between the exemplars in Pakistan, with the NTPs in Karachi feeling overburdened by their existing duties as a lady health worker and their new role. A number of them had stated that the role as a lady health worker would always take priority over delivering the intervention, with the experts also stating that training time was organised around the schedule of the lady health workers. However, this was not a concern for the NTPs from the THPP as they were peer volunteers and many of them were not working. Differences in barriers were also noted for the exemplars in the UK. As the multi-modality practitioners were seeing regular clients, they expressed difficulties in getting clients to accept they had a mental illness and were often met with reluctance. In contrast, within the PERSUADE exemplar, patients who had been screened for subthreshold depression voluntarily participated in the intervention and therefore, the NTPs were not met with hesitation.

10.1.1.6. Unique considerations for LMICs

The importance of considering factors that may be specific to individuals from LMICs during the development of training warranted unique considerations for LMICs as its own theme, which emerged following the analysis of the expert interviews. The sub-theme **challenges faced by NTPs** reflects the barriers that NTPs in LMICs may face when training to deliver psychological interventions. Experts described how often an NTP's family would be a barrier to attending training or implementing the intervention, with the majority of them requiring permission from their family. This barrier is also expanded through the sub-theme **selection criteria specific to LMICs**, as experts in Pakistan stated how freedom to move within the community was an important consideration when selecting NTPs to limit the possibility of encountering this challenge. Furthermore, as previously mentioned in section 10.1.1.5, commitments at home were also a specific challenge to LMICs, with a number of NTPs having to balance existing duties at home with intervention delivery.

Flexibility of training is also an important consideration when developing training for individuals from LMICs, with experts stating how, as the majority of the individuals were taking part in training for the first time, it was important to be flexible around their needs. This theme is also strengthened by the sub-theme target population, as it is necessary to consider who the target population who will be receiving training during the development phase.

As mental health knowledge in LMICs is low, **motivators for the trainers** in Pakistan included knowing that they were raising mental health awareness and making a difference within communities. Furthermore, experts stated how NTPs would often praise them and acknowledge the positive changes that they have made to their lives. These unique considerations for LMICs are important factors which should be taken into account when developing training for individuals that belong to LMICs.

10.1.1.7. Why is information on training lacking?

This theme incorporates factors that emerged when experts were questioned on their views on the reasons for improper documentation of training. A number of experts cited the researcher's **reluctance to disclose** as a reason for a lack of reporting, suggesting anxiety over research not being used for its intended purpose and a fear of it going into the wrong hands as a cause, particularly due to the sensitive nature of the work and the vulnerable population that it aims to serve. Furthermore, commitments made to external funding bodies and rights to intellectual property were also proposed as reasons for a lack of documentation. The notion of researchers being **outcome focused** warranted its own sub-theme because of the emphasis experts placed on the reason for improper documentation being due to researchers and journals focusing on results of the intervention, leading to prioritising the dissemination of the outcomes and often overlooking the training process. Lastly, when asked about their **opinions on guidelines**, most experts expressed their positivity, stating that it would encourage reporting, facilitate standardisation and also allow for other researchers to learn from fellow researchers' experiences. However, experts also voiced their concern with the notion that guidelines can be too prescriptive and prevent the researcher from thinking beyond them. This theme is particularly important, as it highlights factors that have led to improper reporting of training, allowing us to brainstorm solutions to overcome these challenges and encourage proper documentation of training, which will further add to the evidence base of important components required to train NTPs to effectively deliver psychological interventions.

10.1.2. Recommendations for training

A major part of the analysis of both studies involved identifying the important components of training as perceived by both sets of participants. This addresses one of the main aims of the

thesis: to identify essential components for training NTPs. The training components identified as important in either the NTP interviews, the expert interviews or both were classified into the following:

I) Pre-training planning
II) Training format/mode of delivery
III) Training methods
IV) Trainer considerations
V) Implementation strategies
VI) Dissemination strategies

Each training component is presented in Table 10.1 showing which of the themes the training component was deemed to belong to and whether this came from the analysis of the NTP interviews, the expert interviews or both.

Table 10.1. Recommended training components as identified by NTPs and/or experts

Training components	**Theme/sub-theme**	**NTP**	**EXP**
Pre-training planning			
Selection criteria of NTPs			
Sharing similar characteristics	Who are the NTPs? / Shared characteristics Who are the NTPs? / Selection criteria Elements of training / Relevant content	X	X
Basic reading and writing skills	Who are the NTPs? / Education and professional background Who are the NTPs? / Selection criteria		X
Basic health education	Who are the NTPs? / Selection criteria		X
Family acceptance	Facilitators for NTPs / Support from others Barriers for NTPs / Other commitments Who are the NTPs? / Selection criteria Unique considerations for LMICs / Challenges faced by NTPs Unique considerations for LMICs / Selection criteria specific to LMICs	X	X
Communication skills	Who are the NTPs? / Capacity to deliver the intervention Who are the NTPs? / Selection criteria	X	X
Incentives to attend training			
Financial incentives	Facilitators for NTPs / Personal gains Who are the NTPs? / Motivators for working as an NTP	X	X
Vouchers	Who are the NTPs? / Motivators for working as an NTP		X
Career progression	Facilitators for NTPs / Personal gains Who are the NTPs? / Motivators for working as an NTP	X	X
Skill development	Facilitators for NTPs / Personal gains	X	X

Table 10.1. Recommended training components as identified by NTPs and/or experts

Training components	Theme/sub-theme	NTP	EXP
	Who are the NTPs? / Motivators for working as an NTP		
Pre-training evaluation			
Gauging experience in mental health	Who are the NTPs? / Knowledge in mental health Elements of training / Tailored training Who are the NTPs? / Education and professional background Elements of training / Target population	X	X
Education level of NTP	Who are the NTPs? / Knowledge in mental health Who are the NTPs? / Education and professional background	X	X
Assessing learning needs	Elements of training / Target population		X
Evaluating expectations	Elements of training / Target population		X
Tailored training			
To local language and culture	Elements of training / Target population Unique considerations for LMICs / Flexibility of training		X
To learning needs	Elements of training / Target population Elements of training / Tailored training	X	X
Site preparation			
Central location	Elements of training / Accessible training venue Unique considerations for LMICs / Challenges faced by NTPs Trainer attributes / Challenges for the trainer	X	X
Available transport	Elements of training / Accessible training venue Unique considerations for LMICs / Challenges faced by NTPs	X	X
Training environment	Elements of training / Collaborative and open environment		X
Review training content	Elements of training / Relevant content		X
Training format/mode of delivery			
Didactic training			
Evidence-based content	Elements of training / Relevant content		X
Background information surrounding mental health condition	Elements of training / Solution-focused training Elements of training / Relevant content	X	X
Recognition of mental health symptoms	Elements of training / Solution-focused training Elements of training / Relevant content	X	X
Referral pathways	Elements of training / Solution-focused training Elements of training / Relevant content	X	X
Didactic/lecture-based presentations	Elements of training / Solution-focused training Elements of training / Relevant content	X	X
Interactive training	Elements of training / Experiential learning Elements of training / Solution-focused training	X	X

Table 10.1. Recommended training components as identified by NTPs and/or experts

Training components	Theme/sub-theme	NTP	EXP
	Elements of training / Collaborative and open environment		
Materials			
Provision of training materials	Elements of training / Training materials	X	
Materials after training	Elements of training / Training materials	X	
Materials before training	Elements of training / Training materials	X	
Training manuals linked to training content	Elements of training / Training materials	X	
Group training			
Peer learning	Elements of training / Experiential learning Elements of training / Collaborative and open environment Elements of training / Group size	X	X
Peer support	Elements of training / Experiential learning Elements of training / Collaborative and open environment Elements of training / Group size Elements of training / Supervision as time for reviewing, refreshing and support	X	X
Group composition			
Small group size	Elements of training / Tailored training Elements of training / Experiential learning Elements of training / Group size	X	X
Skill mix (homogenous)	Elements of training / Tailored training Elements of training / Experiential learning	X	X
Skill mix (heterogenous)	Elements of training / Tailored training Elements of training / Experiential learning	X	X
Timings			
During the day	Barriers for NTPs / Other commitments Unique considerations for LMICs / Challenges faced by NTPs Unique considerations for LMICs / Flexibility of training	X	X
Flexible timings	Barriers for NTPs / Other commitments Unique considerations for LMICs / Challenges faced by NTPs Unique considerations for LMICs / Flexibility of training	X	X
Gaps between training days	Elements of training / Solution-focused training	X	
Setting			
University	Elements of training / Accessible training venue Trainer attributes / Experience vs. Expertise	X	
Stimulating	Elements of training / Accessible training venue Trainer attributes / Experience vs. Expertise	X	
Off-site	Elements of training / Accessible training venue	X	

Table 10.1. Recommended training components as identified by NTPs and/or experts

Training components	Theme/sub-theme	NTP	EXP
On-site	Elements of training / Accessible training venue	X	
Training methods			
Case studies			
Case study discussions	Elements of training / Experiential learning	X	X
Video case presentations	Elements of training / Experiential learning	X	X
Demonstration role-play			
Live	Elements of training / Experiential learning	X	X
Video/DVD	Elements of training / Experiential learning	X	X
Real-play	Elements of training / Experiential learning	X	X
Role-play (general)			
Playing each role	Elements of training / Experiential learning Elements of training / Solution-focused training	X	X
Playing observer	Elements of training / Experiential learning Elements of training / Solution-focused training	X	X
Playing client	Elements of training / Experiential learning Elements of training / Solution-focused training	X	X
Playing therapist	Elements of training / Experiential learning Elements of training / Solution-focused training	X	X
With observer feedback	Elements of training / Experiential learning Elements of training / Solution-focused training Elements of training / Supervision as time for review, refresh and support	X	X
Group discussions	Elements of training / Experiential learning	X	X
Diary keeping of training	Elements of training / Training materials	X	
Skills practice			
Rehearsal techniques	Elements of training / Solution-focused training Elements of training / Supervision as time for review, reflection and revision Elements of training / Supervision as time for review, refresh and support	X	X
Skills practice homework	Elements of training / Experiential learning	X	X
Audio-recorded feedback	Elements of training / Solution-focused training Elements of training / Supervision as time for review, reflection and revision Elements of training / Supervision as time for review, refresh and support	X	X
Trainer considerations			
Trainer attributes			
Academic knowledge	Trainer attributes / Experience vs. Expertise	X	X
Clinical experience	Trainer attributes / Experience vs. Expertise	X	X
Teaching experience	Trainer attributes / Experience vs. Expertise	X	X
Approachability	Trainer attributes / Personal traits	X	
Friendly	Trainer attributes / Personal traits	X	
Respectful	Trainer attributes / Personal traits	X	

Table 10.1. Recommended training components as identified by NTPs and/or experts

Training components	Theme/sub-theme	NTP	EXP
Supportive	Elements of training / Supervision as time for review, refresh and support Facilitators for NTPs / Support from others	X	X
Flexible	Unique considerations for LMICs / Flexibility of training Elements of training / Tailored training Elements of training / Target population	X	X
Building rapport	Trainer attributes / Personal traits Training attributes / Facilitators for the trainer	X	X
Multiple trainers	Elements of training / Group size		X
Trainer benefits			
Creating mental health awareness	Unique considerations for LMICs / Motivators for the trainer		X
Rewarding	Unique considerations for LMICs / Motivators for the trainer		X
Implementation strategies			
Site preparation	Elements of training / Accessible training venue Unique considerations for LMICs / Challenges faced by NTPs	X	X
Address barriers for trainers			
Language barrier	Trainer attributes / Challenges for the trainer		X
Change existing views of NTPs	Trainer attributes / Challenges for the trainer		X
Training in complex aspects of intervention	Trainer attributes / Challenges for the trainer		X
Limitations of role	Trainer attributes / Challenges for the trainer		X
Time management	Trainer attributes / Challenges for the trainer		X
Address barriers for NTPs			
Work commitments	Barriers for NTPs / Other commitments Unique considerations for LMICs / Challenges faced by NTPs Elements of training / Experiential learning	X	X
Family responsibilities	Barriers for NTPs / Other commitments Unique considerations for LMICs / Challenges faced by NTPs	X	X
Transportation	Elements of training / Accessible training venue Unique considerations for LMICs / Challenges faced by NTPs	X	X
Limitations of the role	Barriers for NTPs / Working within limitations of the role	X	
Managing client expectations	Barriers for NTPs / Working within limitations of the role	X	
Difficult clients	Barriers for NTPs / Reluctance from clients and their families Barriers for NTPs / Working within limitations of the role	X	
Solution-focused training	Elements of training / Solution-focused training	X	
Recruiting and retaining NTPs			

Table 10.1. Recommended training components as identified by NTPs and/or experts

Training components	Theme/sub-theme	NTP	EXP
Making them feel valued	Facilitators for NTPs / Personal gains Elements of training / Supervision as time for review, refresh and support	X	X
Making them feel respected	Trainer attributes / Personal traits Elements of training / Supervision as time for review, refresh and support	X	X
Altruistic benefit	Facilitators for NTPs / Altruistic gains Who are the NTPs? / Motivators for working as an NTP	X	X
Incentives	Facilitators for NTPs / Personal gains Who are the NTPs? / Motivators for working as an NTP	X	X
Personal development	Facilitators for NTPs / Personal gains Who are the NTPs? / Motivators for working as an NTP	X	X
Providing support	Elements of training / Supervision as time for review, reflection and revision Facilitators for NTPs / Support from others Facilitators for NTPs / Personal gains Elements of training / Supervision as time for review, refresh and support	X	X
Contingency planning	Elements of training / Group size		X
Supervision			
Emotional support	Elements of training / Supervision as time for review, reflection and revision Elements of training / Supervision as time for review, refresh and support	X	X
Case load supervision	Elements of training / Supervision as time for review, reflection and revision Elements of training / Supervision as time for review, refresh and support	X	X
Supervisor feedback	Elements of training / Supervision as time for review, reflection and revision Elements of training / Supervision as time for review, refresh and support	X	X
Technology based	Elements of training / Supervision as time for review, refresh and support		X
Peer support	Elements of training / Experiential learning Elements of training / Supervision as time for review, reflection and revision Elements of training / Supervision as time for review, refresh and support	X	X
Refresher sessions	Elements of training / Supervision as time for review, reflection and revision Elements of training / Supervision as time for review, refresh and support	X	X
Competency assessments	Elements of training / Supervision as time for review, refresh and support		X
Dissemination strategies			

Table 10.1. Recommended training components as identified by NTPs and/or experts

Training components	Theme/sub-theme	NTP	EXP
Consider rights to intellectual property	Why is information on training lacking? / Reluctance to disclose		X
Audit trail of training	Why is information on training lacking? / Outcome focused		X
Journal requirements	Why is information on training lacking? / Outcome focused		X
Guidelines for reporting training	Why is information on training lacking? / Importance of guidelines		X

Training components recommended in Table 10.1 emerged from interviews with NTPs and experts in both the UK and Pakistan. However, some components are country specific and were not mentioned as important elements of training by participants in both countries. Therefore, the following Venn diagrams presented (see Figures 10.1, 10.2, 10.3, 10.4 and 10.5) show the distribution of the training components recommended in HICs, LMICs or both. Information presented in the overlapping area of the circles represent the training components that were expressed as being important by participants in both the HIC and LMIC. *Dissemination strategies* of training were discussed by experts in both the UK and Pakistan, and therefore, it was not considered necessary to present the information in a Venn diagram.

Figure 10.1. Pre-training planning components recommended in HIC and LMICs

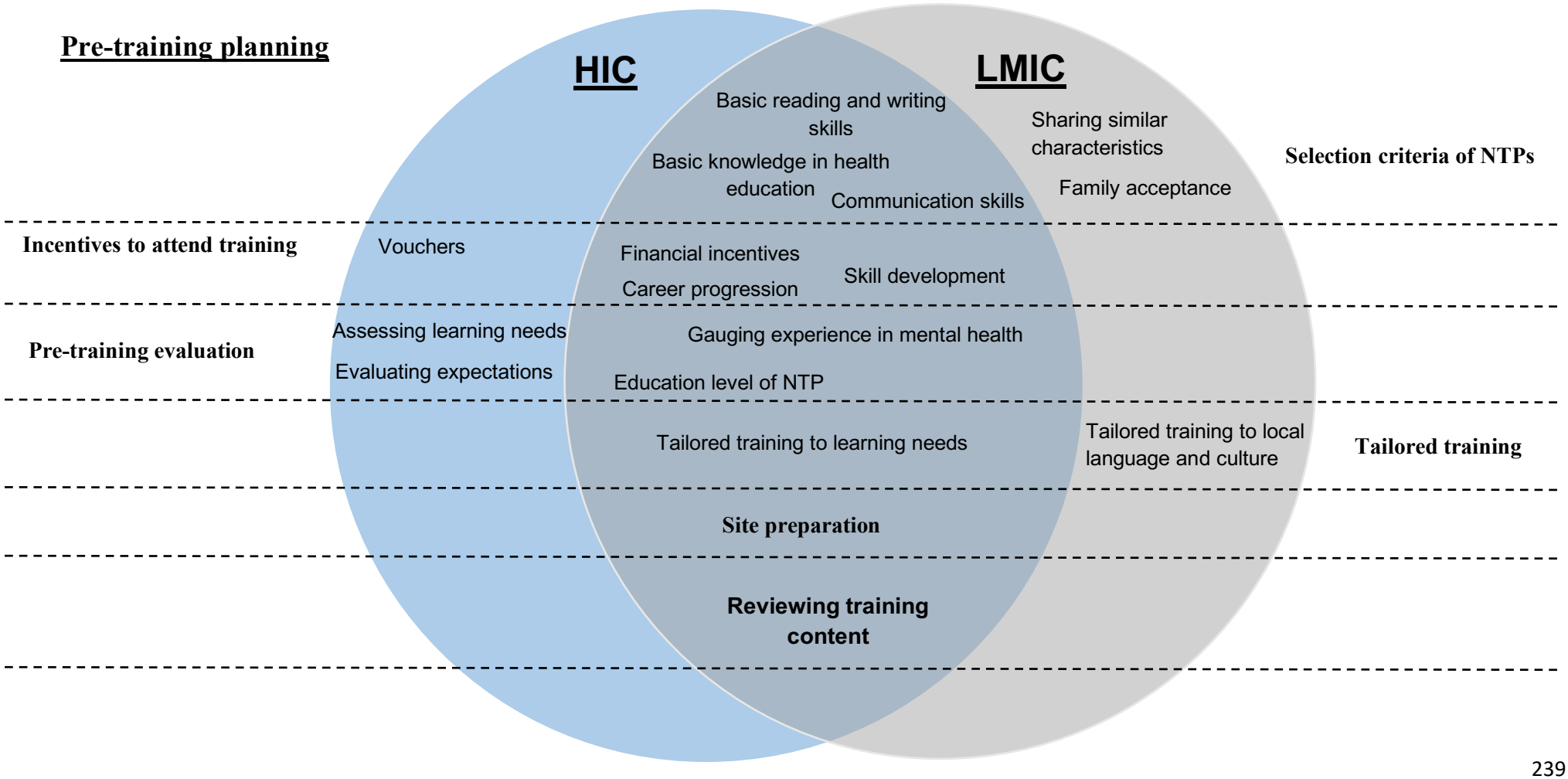


Figure 10.2. Training format and mode of delivery components recommended in HIC and LMICs

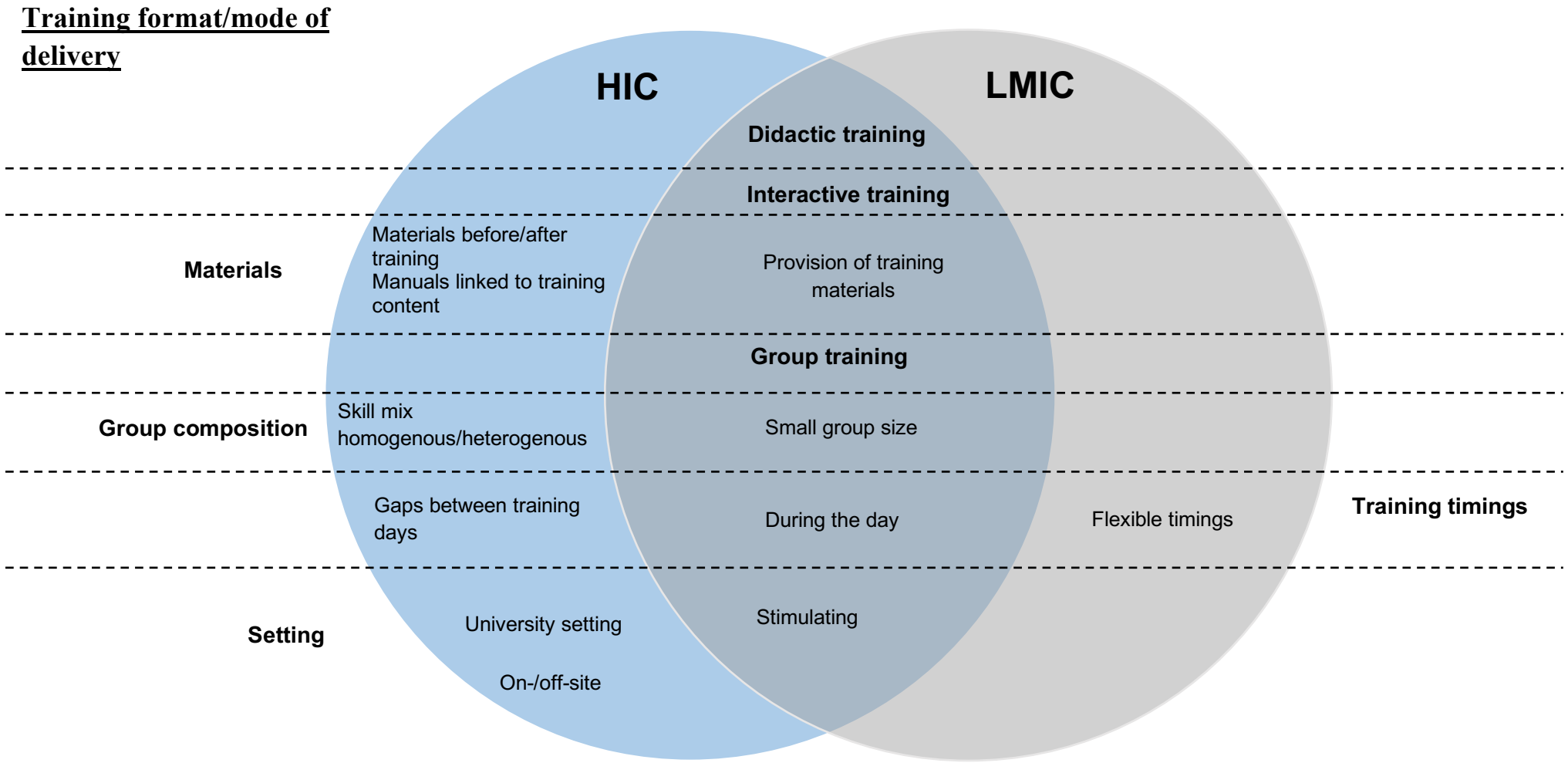


Figure 10.3. Training method recommended in HIC and LMICs

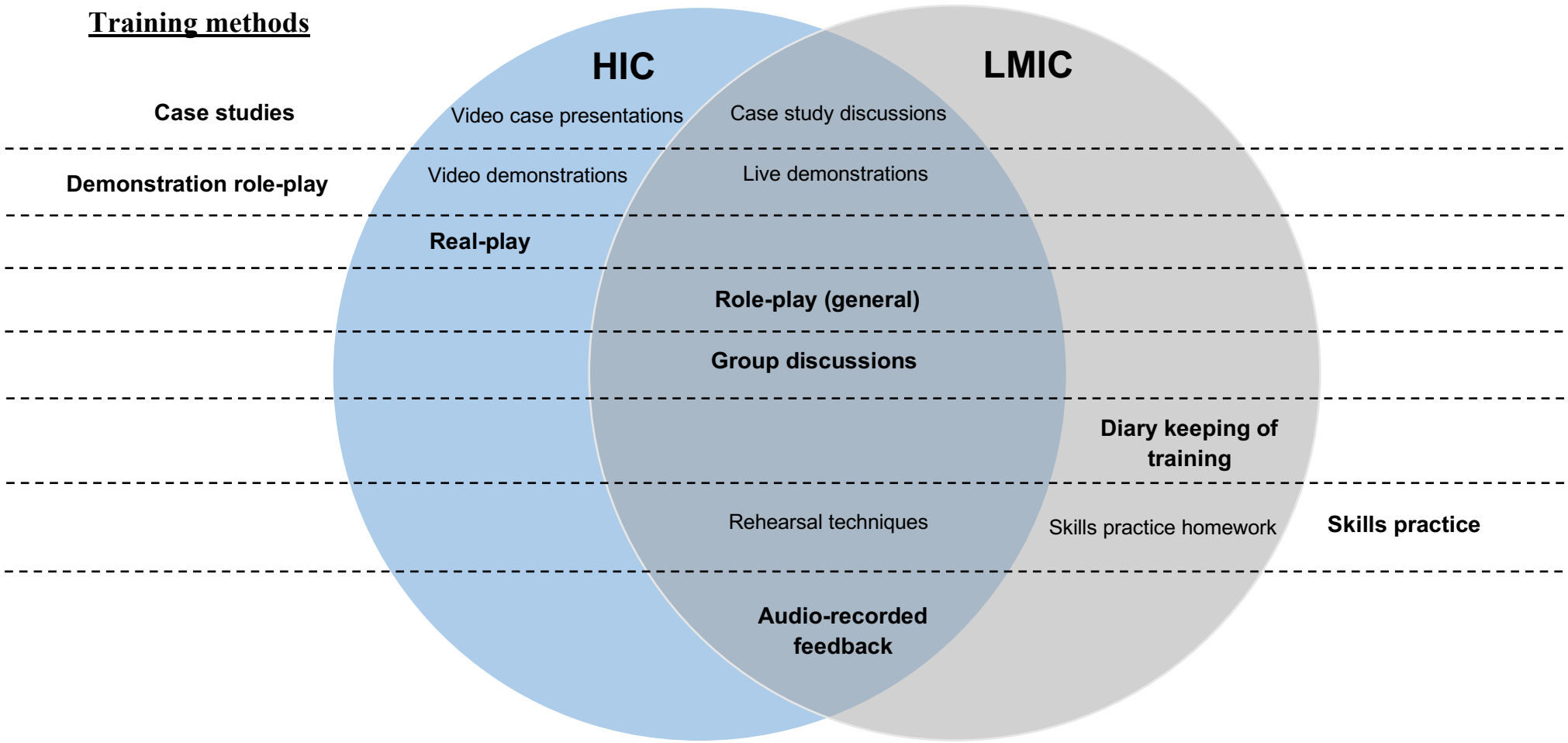


Figure 10.4. Recommended trainer considerations in HIC and LMICs

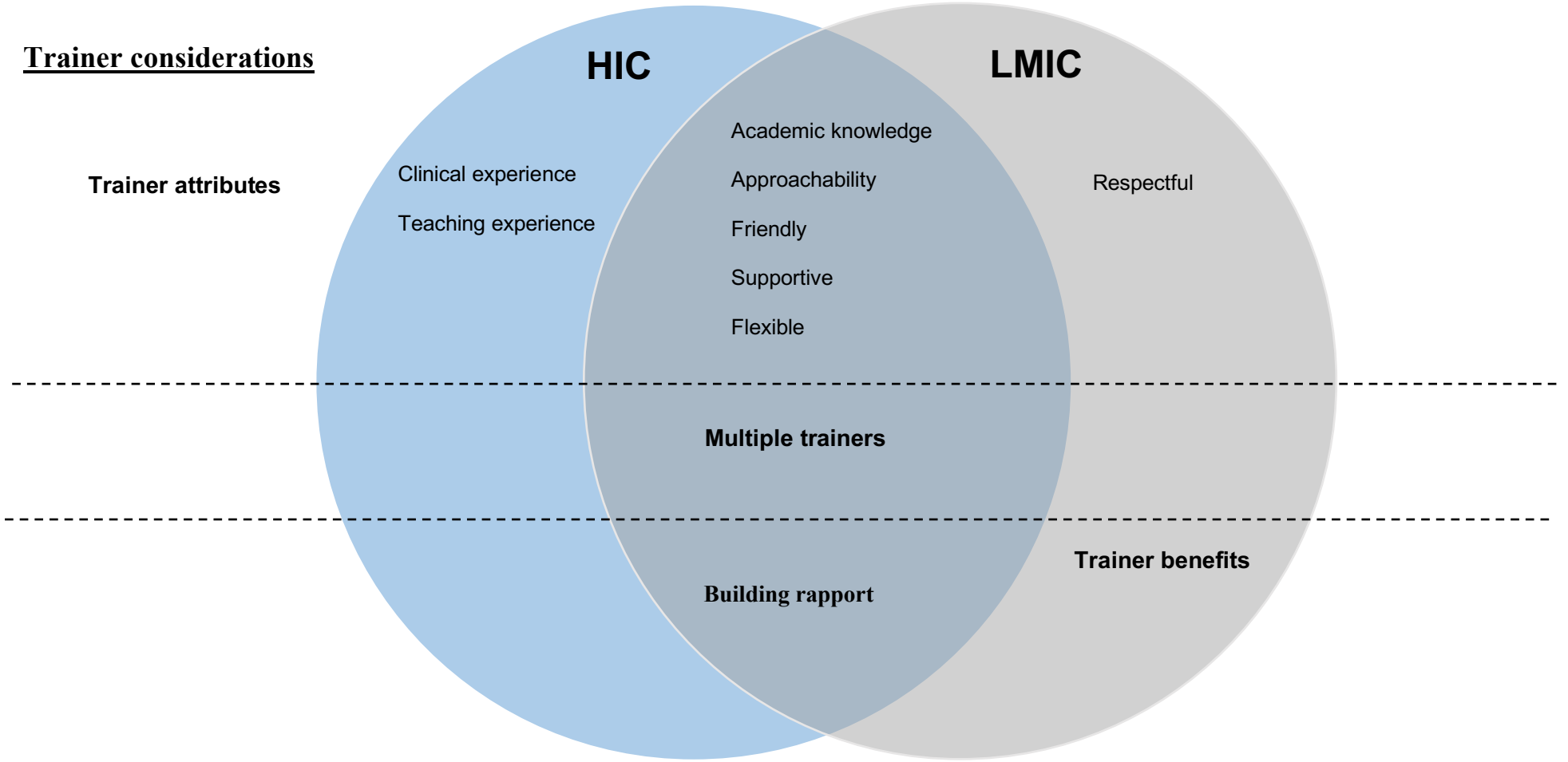
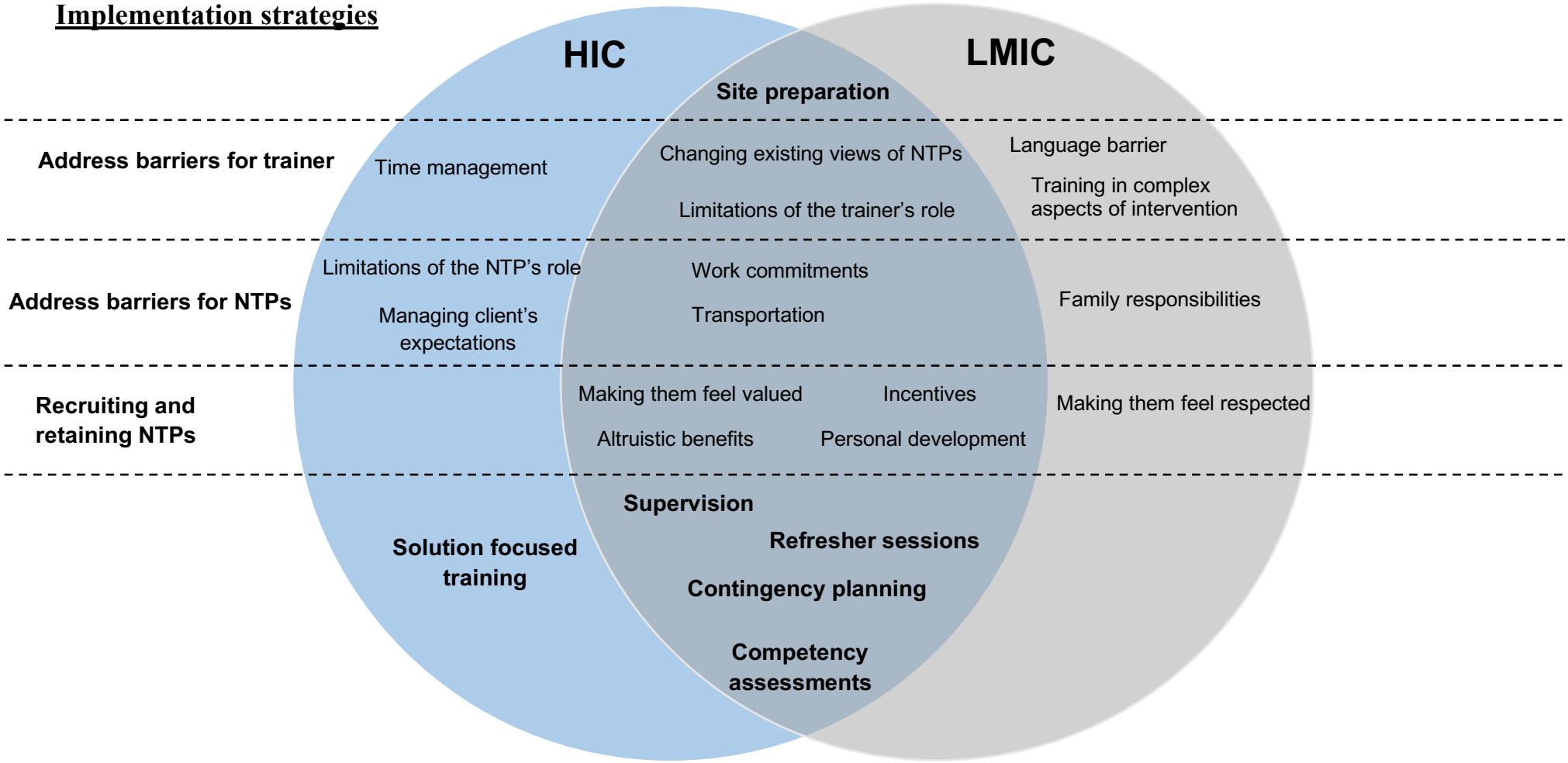


Figure 10.5. Recommended implementation strategies for training in HIC and LMICs



10.2. Chapter summary

- This chapter presents recommended training components as perceived by experts and NTPs in Pakistan and the UK, which can be used to inform the design of training programs to successfully train NTPs to deliver psychological interventions.

- Whilst evidence on the training of LHWs in LMICs exists, this research can be used in the quest to add to the database of evidence for training these individuals in HICs and especially ethnic minorities who are originating from LMICs.

- The next chapter will present the findings in relation to the existing literature.

Chapter 11. Discussion

In this chapter, the key findings will be highlighted and interpreted in relation to the current literature. Methodological strengths and limitations of the studies will be discussed, and lastly, future recommendations for research in this area will be presented.

11.1. Summary of the problem

CMDs have a global lifetime prevalence of 29% (Steel et al., 2014), with depressive disorders being ranked as the largest contributor to non-fatal disease burden (WHO, 2017a), placing it as a public health priority which requires the identification and implementation of interventions to reduce its burden. Whilst several evidence-based pharmacological and psychological treatments are available for a range of mental disorders, it is estimated that these treatments are only able to reduce the disease burden by about 40% (Andrews et al., 2004). Globally, 90% of individuals with mental disorders do not receive treatment (Wang et al., 2007), with a scarcity of skilled human resources being suggested as a major barrier to increasing access to treatment (Patel et al., 2011). This has led to a shift towards collaborative models of care delivery such as task-shifting in which laypeople with no experience in mental health are trained to deliver psychological treatments, with a number of studies showing promising results (Bass et al., 2006; Rahman et al., 2008).

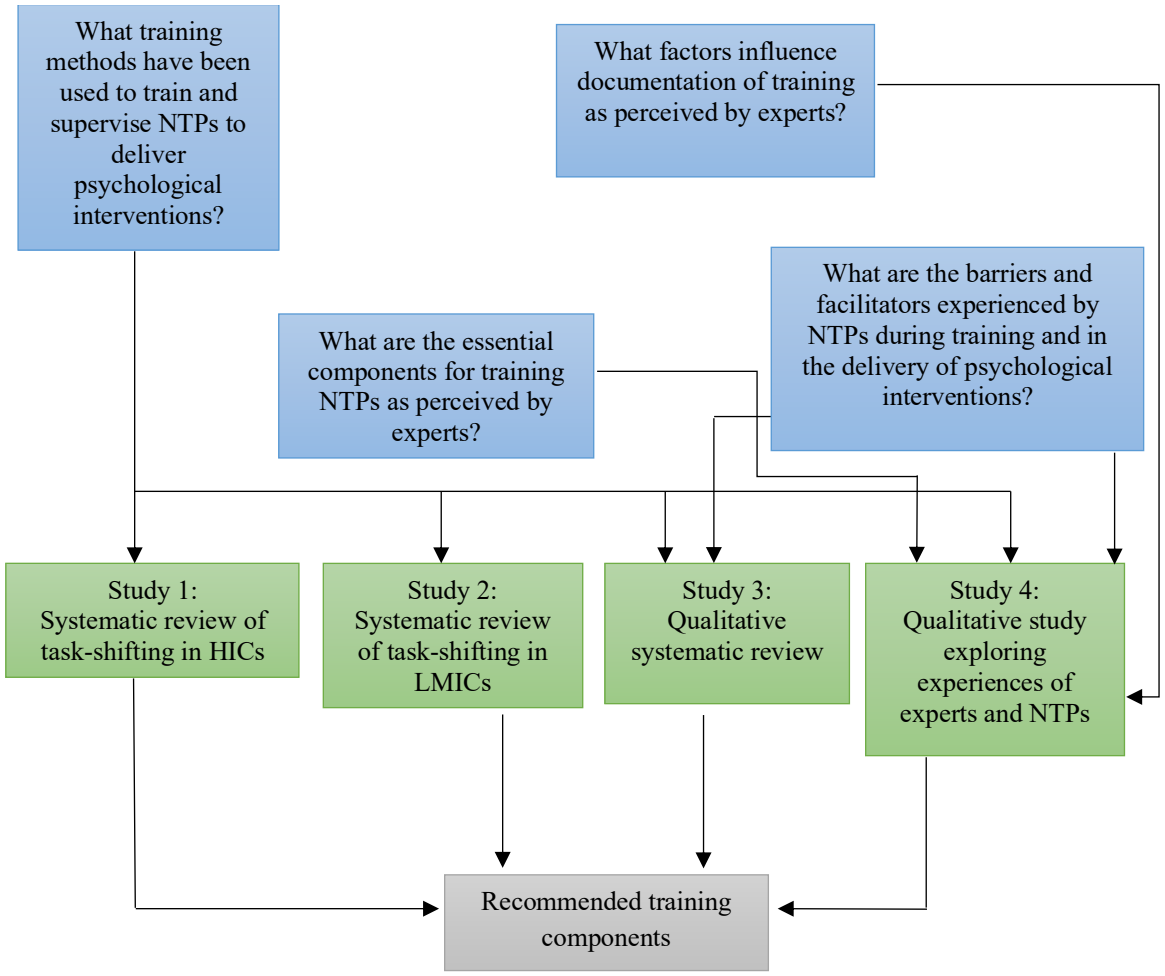
However, this has led to the emergence of empirical questions such as how to best train people to become NTPs in a sustainable way and how many training, supervision and booster sessions will be needed to ensure the high-quality delivery of treatments (Holmes et al., 2018). Although there are many studies using a task-shifting approach to deliver psychological interventions (Bolton et al., 2014; Patel et al., 2010), there is a lack of evidence regarding effective training methods that equip these lay individuals with the skills required to successfully manage people with mental health problems. Furthermore, any evidence on training and supervision that exists stems from LMICs (Atif et al., 2019), where the task-shifting approach is most commonly used to address health worker shortages, with there being little to no knowledge on effective methods for training lay workers in HICs. Therefore, this supports the need for research to explore strategies on how to train lay workers in both LMICs and HICs. Building evidence on essential training components can lead to the development of effective training programs for LHWs, which may subsequently increase the chances of them delivering high-quality care and reducing the burden on individuals with CMDs.

11.2. Summary of main findings

11.2.1. Overview of thesis aims

The aims are outlined in Figure 11.1 and were addressed in four studies: (1) a systematic review for identifying essential components of NTP training and supervision through task-shifted psychological interventions in HICs, (2) a systematic review for identifying essential components of NTP training and supervision through task-shifted psychological interventions in LMICs and the lessons learnt, (3) a qualitative systematic review exploring the experiences of LHWs trained in task-shifting psychological interventions and (4) a qualitative study exploring the experiences of experts and NTPs involved in training for a task-shifted psychological intervention. These studies informed the development of recommended training components. An overview of the thesis aims and methodology is presented in Figure 11.1 below.

Figure 11.1. Overview of thesis methodology



11.2.2. Studies 1, 2 and 3: Systematic reviews identifying essential components of NTP training and supervision through task-shifted psychological interventions

Study 1 was a systematic review exploring the training and supervision that was provided to NTPs who were trained to deliver psychological interventions in HICs. Eighteen studies were identified, but it was not possible to make any definite conclusions about the essential components for training NTPs due to poor reporting on the training and supervision. Recommendations from the review include the suggestion that training should be delivered by a mental health professional and that the duration should be at least a week long. Furthermore, a mixed-methods approach should be used, which incorporates both didactic and experiential learning. Additionally, supervision is necessary and should be conducted biweekly; the aim of supervision should be to review specific cases and discuss any problems arising.

Similarly, study 2 was a systematic review exploring the training and supervision that was provided to NTPs who were trained to deliver psychological interventions in LMICs. Thirty studies were identified, from which eight recommendations created from task-shifting interventions in LMICs were suggested, which could inform successful implementation of this approach within HICs. However, the review concluded that regulations from organisations that oversee the implementation of psychological treatments may limit the type of providers who can provide these services in HICs, such as the requirement to have specific qualifications or accreditations. Therefore, there is still a need to determine if and how NTPs can deliver psychological therapies in HICs.

A total of 14 studies were included in study 3, which aimed to explore the experiences of NTPs in both the training and delivery of psychological interventions. A number of key recommendations were derived from the review which can further improve the quality of training programmes for NTPs. This included the need to consider spending sufficient time within training on learning about the nature and content of the mental health condition. Furthermore, realistic expectations from the NTPs should be set, and NTPs should be made to feel supported and valued by their supervisor.

The main focus of all the papers in studies 1 and 2 was to measure the effectiveness of psychological treatments delivered by NTPs, and therefore, there was a lack of focus on the training process of the NTPs themselves. Very few studies incorporated an evaluation of the training, instead evaluating the training through its effect on patient mental health outcomes. The review identified the need for evaluating training received by the NTPs; this is a neglected area of research that, if conducted well, might inform the identification of effective training components for NTPs. Moreover, the majority of the studies included in the qualitative review focused on the NTPs' views on the intervention itself, with training and supervision only encompassing a small aspect of the paper. Evaluating training through the opinions of the NTPs on their views of it and what aspects of it helped their learning would also provide insights into why a training programme might positively or negatively affect outcomes. Furthermore, the lack of information highlights the need for

a reporting checklist to standardise the documentation of training further allowing for the identification of effective training components, as well as making training replicable for future use.

11.2.3. Study 4: A qualitative study exploring the experiences of experts and NTPs involved in training for a task-shifted psychological intervention

Semi-structured interviews were conducted with NTPs in Pakistan and the UK, who attended training to deliver psychological interventions for mental health conditions. Their experiences on training and supervision and any barriers and facilitators they encountered during intervention delivery were explored. This led to the development of five key themes: who NTPs are, elements of training, trainer attributes, facilitators for NTPs and barriers for NTPs.

Semi-structured interviews were also conducted with experts in Pakistan and the UK, who took part in training NTPs to deliver psychological interventions. The experts were asked about their views on the essential components for training NTPs, as well as factors that they believe influence the documentation of training. Analysis led to the emergence of five key themes: who NTPs are, elements of training, unique considerations for LMICs, trainer attributes and why information on training is lacking.

11.3. Interpretation of the main findings

In the synthesis of the results, the findings were organised into recommended training components which were classified into the following groupings: (I) pre-training planning, (II) training format/mode of delivery, (III) training methods, (IV) trainer considerations, (V) implementation strategies and (VI) dissemination strategies. Due to the number of training components identified, key components within each grouping will be discussed in relation to evidence from existing literature.

11.3.1. Pre-training planning

11.3.1.1. Selection criteria

Establishing a selection criterion prior to the development of training is an essential factor when considering what type of individuals will be trained to deliver the intervention. The process of selecting trainees is crucial to the ultimate success of the training and intervention, with studies suggesting that trainee characteristics can have an effect on training transfer, defined as the use of trained knowledge, attitude and skills back on the job (Burke & Hutchins, 2007). Studies suggest factors such as the trainee's cognitive ability (Baldwin & Ford, 1988), self-efficacy (Chiaburu & Marinova, 2005), motivation (Tziner et al., 2007), personality (Vignoli & Depolo, 2019) and work experience (Lim, 2001) can all have an impact on learning and consequently how they perform in the job.

The training component *selection criteria of NTPs* encompasses the desirable characteristics of the NTPs that are perceived to be beneficial during the delivery of psychological interventions. Factors such as having basic reading and writing skills and knowledge in health education are important for training NTPs successfully. This is supported by task-shifting studies that included the need for NTPs to have a minimum of eight years of education during the selection criteria (Rahman et al., 2008; Wong et al., 2020). Lack of adequate knowledge may lead to biases and misinformation about mental disorders and may lead to the trainee feeling incompetent in caring for people diagnosed with mental disorders (Faregh et al., 2019). Moreover, communication and interpersonal skills of the NTP are also deemed important factors, as the NTP will have to build a therapeutic relationship with the client (Kornhaber et al., 2016). This is in line with studies using a task-shifting approach which included the requirement for NTPs to have basic communication skills (Fuhr et al., 2019; Patel et al., 2017), which in some cases was assessed through interviews (Armstrong, 2010; Stanley et al., 2014).

This training component also takes into consideration any barriers which NTPs or experts may have expressed as hindering intervention delivery. For example, it is important to consider the culture and patriarchal and hierarchal family structures when recruiting women from LMIC settings. In such settings, women are often placed at a subordinate and disempowered position, where freedom of movement is constrained (Jejeebhoy & Sathar, 2001) and opportunities for education are restricted (Ghazi et al., 2011). Therefore, it is necessary to select individuals who have an ability to freely move within the community. This is also reflected by studies conducted in Pakistan and India in which women were selected on the basis of their ability to move within the community (Ali et al., 2010; Fuhr et al., 2019; Sikander et al., 2019). However, this may lead to equality issues as choosing individuals who already have freedom of movement, means that opportunities will only be given to those who already have opportunities. However, strategies can be put in place to overcome barriers to movement. For example, the exemplars in Pakistan provided transport to the women attending training, however, this also depended on initial approval from the family.

Moreover, when recruiting trainees from LMICs, it is important to consider selecting individuals who may share similar characteristics to their target clients such as culture, language and even gender. In LMICs, being local is a significant factor contributing to the perceived trustworthiness of the NTPs (Atif et al., 2016), with studies showing preferences for local peers because it enhanced trustworthiness and encouraged individuals to share their problems (Alcock et al., 2009; Shroufi et al., 2013; D. R Singla et al., 2014). The importance of matching culture is also supported by the findings of Murphy et al. (2008), where mentor mothers expressed challenges in providing support to women where ethnic and cultural differences existed, due to a lack of understanding of important cultural differences and a fear of causing offence. The impact of peer support has been demonstrated in a number of studies in HICs, with positive effects including improved empowerment, quality of life and self-esteem (Davidson et al., 2006; Repper & Carter, 2011;

Resnick & Rosenheck, 2008). However, when selecting individuals with experience of a mental illness to train, it is important to consider their own mental health, which is reflected in one of the included studies from the HIC review, in which psychological stability was included as a requirement when recruiting mentor mothers (Prosman et al., 2014).

11.3.1.2. Incentives to attend training

When recruiting NTPs to train, it is important to offer *incentives* and highlight the benefits to the NTPs, particularly as training, intervention delivery and subsequent supervision can be time-consuming. This notion of incentives was especially important amongst NTPs in Pakistan who were from a more deprived sociodemographic background, where financial aids were regarded positively and encouraged them to attend training. This demand for payment being influenced by the socioeconomic background of the trainees is supported by Singla et al. (2014), who found that there was a greater demand for a fixed salary in urban Goa whereas in rural Rawalpindi, a greater emphasis was placed on the positive work that the peers were doing. Nevertheless, some form of material recognition for their work was required, which came in the form of certificates and travel allowance. However, the desire for financial remuneration may not be solely reliant on socioeconomic conditions, with a review by Walker and Bryant (2013) conducted in developed, urbanised settings showing that financial benefit was the most significant factor for peer's motivation. Experts in the UK also mentioned how it is important to take into account government benefits that may be affected by providing monetary incentives, suggesting vouchers as a way of overcoming this barrier. Furthermore, it is recommended that benefits such as the opportunity to develop skills and progress in their careers should also be highlighted to the NTPs as a way of encouraging them to attend training. Findings of the Canada Survey of Giving, Volunteering and Participating found that volunteers reported that their volunteering experience provided them with interpersonal skills, communication skills, increased knowledge and organisational and managerial skills (Hall, 2006). Further evidence shows that peer support workers see their peer support worker role as a stepping stone back into employment (Craig et al., 2004; Mowbray et al., 1996), and volunteering can lead to improved job opportunities (Hall et al., 2001). Highlighting the benefits of training is particularly important amongst NTPs of more deprived socio-demographic backgrounds, where the opportunity to receive training of this form is often rare (Atif et al., 2019). In their study using refugees and asylum seekers as lay therapists, Chiumento et al. (2021) recommended providing training certificates to build their CVs for future opportunities. Furthermore, the authors also acknowledged the need to provide extensive logistical support, for example, by reimbursing expenses and providing childcare and refreshments (Chiumento et al., 2021).

11.3.1.3. Pre-training evaluation/tailored training

Based on the qualitative interviews, conducting a *pre-training evaluation* of the NTPs' knowledge and experience in mental health is also essential prior to training to be able to *tailor the training to*

their needs to ensure it is relevant and beneficial. Experts within this study recognised the need to adapt training to suit the local language, culture and education of the NTPs. In India and Pakistan, the THP was found to be acceptable by mothers when it was adapted to allow for delivery by local women from the community (Atif et al., 2017). Furthermore, experts expressed the usefulness of knowing the level of the NTPs' knowledge to be able to allocate training time efficiently. Pre-training evaluation provides the means to tailor training as well as acting as a baseline measure to assess the effects of training on knowledge following training. A useful method of assessing pre-training knowledge could be through the use of a mental health–related knowledge, attitudes and practice survey, which was used by one of the included exemplars to evaluate training. This quantitative method can reveal characteristic traits in knowledge, attitude and behaviours about health related to religious, social and traditional factors. Furthermore, it highlights misconceptions or misunderstandings that may represent obstacles to the goals that are to be implemented and potential barriers to behaviour change (e.g., awareness about mental health) (Gumucio et al., 2011). Although pre-training evaluation is important to design relevant training, trainees may not recognise their learning needs before training, particularly in cases where they are receiving training for the first time (i.e., trainees from more deprived sociodemographic backgrounds). Therefore, it is important for the trainer to play a key role by assessing and monitoring the NTPs' learning needs throughout the training.

Although described in this section during the pre-training phase, it is important to note that evaluation is an iterative process that should be occurring throughout the training process. To serve the purpose it is designed for, evaluation should include getting ongoing feedback, i.e., from the trainee, the trainer and the trainee's supervisor to improve the quality of the training and identify if the trainees have achieved the goals of training (Singh, 2013). The most widely used framework for classifying evaluation is the Kirkpatrick model (Kirkpatrick, 1996), consisting of four levels: (1) reaction (to training), (2) learning (changes in knowledge, skills or attitude), (3) behaviour (changes in performance behaviour) and (4) results (the contribution of the training on the organisation). However, as evident from the studies included in a review of mental health training by Caulfield et al. (2019), there is a lack of training evaluation at the reaction level, with learning and behaviour being the most common outcome measures. Whilst learning, behaviour and results are the most useful measures in training evaluation as an indicator of effectiveness (Arthur Jr et al., 2003), reaction measures allow to gain feedback on the training itself, allowing researchers to review training content, adapting it to the needs of the trainee and therefore improving subsequent training sessions (Kirkpatrick, 1979).

11.3.1.4. Collaborating with local health and well-being organisations

Evidence has shown the benefits of linking with the local health system or key organisations such as health and well-being services to facilitate the delivery of the intervention (Atif et al., 2016). Glenton et al. (2013) found that the collaboration of health professionals and LHWs increased

LHWs' acceptability and credibility as well as reduced the health professionals' workload. Linking with the local health systems may also help address the barrier of reluctance from clients and their families, which is encountered by NTPs in the current study. Linking can allow partnerships with community organisations to be formed which might facilitate the introduction of the NTPs as well as help during the identification and recruitment process. This is further supported by the sub-theme *'collaborative working with other healthcare professionals'* (section 6.3.5.3), which emerged from the qualitative review. The review emphasised the importance of collaborating with already trusted healthcare professionals within the community, which could lead to greater levels of acceptability amongst NTPs. Moreover, it is important to recognise that partnerships between academics, public and voluntary sector organisations are crucial to the successful implementation and maintenance of community health promotion (Dennis et al., 2015; Riggs et al., 2014). Although collaborating with local health systems and organisations was not covered within the scope of this PhD, links to Lady Health Workers were identified through interviews with participants in Rawalpindi. The peer volunteers were introduced by the Lady Health Workers upon their initial first meeting with the mothers, which increased their acceptability and reduced their reluctance. Future research can be carried out to explore these links further to examine the effects of collaborating with local health organisations.

Furthermore, evidence suggests that the involvement of key stakeholders such as service users and members of relevant organisations in the development and delivery of training is a key facilitator in promoting acceptance of training (Scantlebury et al., 2018). Gaining insights into the perspective of people suffering from mental illness has been found to be beneficial in making the training more realistic as well as encouraging the notion of working with mental health service users (Rani & Byrne, 2012).

Some of the pre-training methods can also be seen as implementation strategies, such as *site preparation*, *incentives to attend training* and *building trust with trainees,* which can all help in the implementation of the training and intervention. Addressing these issues before training would reduce the time needed to cover these issues during training, allowing for more time to be spent on actual training content, which could add to the credibility of training if this prior preparation helps the implementation to be more realistic and achievable.

11.3.2. Training format/mode of delivery

11.3.2.1. Didactic training

Didactic training methods were seen as effective for some parts of training, with both NTPs and experts viewing lectures as a useful method for delivering information regarding mental health conditions. This is in line with McHugh and Barlow (2012), who stated that didactic training can be beneficial to provide information on the procedural elements of the intervention, its timing and structure as well as help identify patients for whom the intervention would be relevant and

strategies for problem-solving complications and barriers to implementation. Amongst a variety of studies, the didactic content in training programmes for non–mental health professionals included an introduction to mental health and mental disorders, mental health first aid, practice-based skills and mental health promotion (Armstrong et al., 2011; Buck, 2015; Shidhaye et al., 2017). Furthermore, providing evidence and theory behind background information also establishes credibility of the content of training as well as credibility of the facilitator. A study in which mental health professionals were trained in assessing and managing suicide behaviour recommended that the content of didactic training should include relevant theory and empirically based perspectives (Oordt et al., 2009).

However, in this current study, experts expressed how when training non–mental health professionals, it is important to provide short and concise information for the content to be clear and relevant to the trainees. Moreover, the dangers of providing too much information were highlighted by some experts who suggested it could lead to NTPs acting beyond the limitations of their role, suggesting that it is important to provide referral pathways for NTPs to be able to refer clients to the appropriate person or organisation. This is supported by studies that have implemented mental health training programmes for non–mental health trained professionals in which participants have deemed the provision of community-orientated content and information relating to local mental health resources as helpful (Gough & Kerlin, 2012; Tully & Smith, 2015; Walsh & Freshwater, 2009).

11.3.2.2. Interactive training

Although NTPs acknowledged the usefulness of didactic lectures, many of them expressed how learning about the evidence and theory was not as important to them as the time that was spent in skills practice. Fixsen et al. (2005) suggested that didactic training can be effective for the dissemination of information and increase provider knowledge. However, it is limited in the extent to which it produces consistent or sustained behaviour change (Beidas & Kendall, 2010). Alternatively, *interactive training* involving group discussions and interactions between the trainees and the trainer was the preferred format of training, allowing for the facilitation of learning from other people. Existing literature provides evidence that one-day educational sessions that offer little opportunity to interact or practice skills have little to no impact on learning outcomes whereas interactive sessions that feature a chance to practice knowledge and skills and allow for interaction enable learners to process and apply information and can influence clinical practice (Bluestone et al., 2013; Davis et al., 1999).

In this thesis, both experts and NTPs stated how group discussion was beneficial to listen and learn from other trainees' experiences in the room, particularly in the UK where the trainees all had different professional backgrounds and areas of expertise. Interprofessional learning, in which individuals of different professional backgrounds learn from each other, has been found to lead to

positive changes in behaviours, service delivery and patient care outcomes (Hammick et al., 2007). Conversely, as highlighted by NTPs in the UK, it is important to consider training individuals of similar professional backgrounds together so as to ensure that the training content is relevant to their learning needs. This is supported by a qualitative review by Scantlebury et al. (2018) exploring the experiences of non–mental health professionals receiving mental health training, who found that content of training was perceived to be more suitable when it was tailored to the trainee's organisation and the common problems faced by them in their everyday work.

It is also important to consider that trainees from LMICs with no prior experience of training and minimal education may not know their preferred learning style. This is evident from the findings presented in this thesis, where NTPs in Pakistan did not voice their opinion on their preferred learning style, which may be due to their limited time spent in education. However, the findings from experts and NTPs in both countries suggest that a mixture of didactic and interactive learning is an effective strategy. In the wider literature on task-shifting, studies that have trained these minimally educated NTPs in LMICs have used a combination of classroom-based lectures, skills practice and interactive discussions (Chibanda et al., 2011; Joag et al., 2020; Jordans et al., 2019). The use of a mixed-methods style of learning is also supported by a review of mental health training for health workers in Africa conducted by Liu et al (2016), who found that that 90% of studies used mixed educational techniques, combining didactic sessions with clinical or interactive training, which have been found to be more engaging and increase retention of material for trainees (Khan & Coomarasamy, 2006).

11.3.2.3. Training materials

Both NTPs and experts expressed the usefulness of providing *training materials* such as handouts, training manuals and presentation slides for learning as well as for facilitating revision and preparation prior to delivering the interventions. Some NTPs expressed their unhappiness at receiving training materials after the training had ended, with some stating how they still had not obtained the materials. Therefore, it is important to ensure the provision of materials prior to commencing training, allowing the trainee to write notes and facilitate their learning. The review by Scantlebury et al. (2018) found that course manuals were seen as educational and valuable aide-memoirs, suggesting they could be beneficial prior to the training to encourage early self-directed learning and after the training to enable implementation of skills learnt. Although there is little to no literature on the provision of materials for effective mental health training, studies in which NTPs have been trained in mental health education have included a lesson plan of each training session and a manual containing intervention material for the participants to take away (Jorm et al., 2004; Stanley et al., 2014). Furthermore, some NTPs highlighted the need to link the training content to the training manuals, which could aid in refreshing memory and can be essential for effective intervention implementation. However, it is important that this be highlighted in the training so that the trainees can be aware of how the manuals can help them during intervention delivery. The

provision of manuals without referring to them during relevant aspects of training may result in their improper use or non-use during intervention delivery due to a lack of understanding of its relevance, possibly leading to an NTP's low fidelity to the intervention. Evidence for the use of manuals for training in psychological therapy came from Morgenstern et al. (2001), who demonstrated the feasibility of training frontline substance abuse providers to deliver CBT using treatment manuals.

11.3.2.4. Group composition and training

Group composition and *group training* are important to consider during the development of training for NTPs. Both experts and NTPs expressed the need for small group sizes to maximise learning opportunities. Experts voiced how a small group size was optimal for the facilitation of group discussions and providing feedback. Furthermore, a large group size was viewed as hindering group participation, where trainees may feel reluctant to share their personal experiences with a larger audience. Within the wider literature on education, small group teaching is any teaching and learning occasion which brings together between two and twenty participants (Griffiths, 2008), with evidence suggesting that students both benefit from and enjoy small group work (Rudduck, 1978), which can lead to improved self-confidence and the development of teamwork and interpersonal communication (Griffiths, 2008). Small-group learning allows students the opportunity to discuss and refine their understanding of complex issues, learn to problem-solve and reflect on their feelings and attitudes (Steinert, 1996). However, small groups can easily be misused, and in the hands of an unskilled trainer, small group sessions can become one-way, didactic, lecture-like events (Jason & Westberg, 1982); therefore, the skills of the trainer are essential to maximise benefits of group learning.

Within this thesis, there is mixed evidence relating to the skill mix of the group. In Pakistan, groups were homogenous, where all the NTPs had a similar background and education level. This allowed trainees to share their experiences and learn from one another, where there was a perceived risk of heterogenous individuals being considered as an 'outsider', which may have led to trainees feeling embarrassed and reluctant to share their views. Evidence supported the idea that homogenous groups will more likely lead to cohesion and trust amongst the trainees (Porter, 1997). Trust is an important factor in the context of skills training, as when trust is present, trainees are more likely to perform the new skills without fear of being ridiculed (Jones & George, 1998).

Conversely, in the UK, groups were heterogenous, where NTPs came from different health backgrounds and had a different level of knowledge and skills, which were considered beneficial to gain a variety of experiences in the room. Support for mixed-skill-level training groups came from Ang and Hughes (2002), who found that heterogenous groups were more successful for learning than homogenous ones. Moreover, variety in skill level amongst trainees is more likely to increase the variability of practice and is therefore more likely to simulate a real-world environment (Holladay

& Quinones, 2003). However, as previously stated, in this current study, a heterogenous group was also seen to have a negative impact, as it led to aspects of training being considered irrelevant for some. Therefore, the skills of the trainer are important to be able to manage any challenges that may occur in a heterogenous group to ensure that everyone is receiving effective training.

11.3.2.5. Timings

There were similar opinions on *timings* of training, with the majority of the NTPs expressing their concerns with balancing training with prior work commitments. Furthermore, they expressed their reluctance to attend training during the evenings and weekends, as this was seen as their own personal time, which should not be allocated for work. Moreover, experts in Pakistan stated how it was important for timings to remain flexible around the commitments of the NTPs, especially if they were attending training on a voluntary basis. This is in line with Caulfield et al. (2019), who suggested that flexibility is important for optimising each training program to its particular cultural setting and available resources and is key to acceptability. A similar recommendation was also made by Armstrong et al. (2011), who acknowledged how, when training unpaid female volunteers in LMICs, it is important to accommodate training around their schedules, as they may also have familial responsibilities which may take priority.

A number of NTPs also mentioned the importance of having gaps between training days, highlighting the difficulties they would face in taking consecutive days off work to attend training. For those already working within health and well-being services, this gap in days between training was also seen as a useful method of skills consolidation, allowing for the trainees to practice what they had learnt. Within the wider literature on the training of non–mental health professionals, mixed evidence exists, with some participants preferring training to be delivered in small sessions over a longer period to facilitate the processing of information and to allow them to manage other commitments (Gough & Kerlin, 2012), whilst others found training that was condensed over a few days easier to manage (Svensson et al., 2015). Therefore, due to the variable nature of training times, the most effective strategy may be to ask trainees what is the most feasible time for them, as part of pre-training planning.

11.3.2.6. Setting

In relation to the *setting*, NTPs identified the benefits of receiving training in a stimulating learning environment. For example, NTPs within the UK expressed their contentment with receiving training at a university, as it allowed them to get into the frame of mind for learning and engage more effectively. Similarly, NTPs in Pakistan who received training at the BHU (local health centre) described how the health posters displayed on the walls aided in creating a stimulating learning environment. Furthermore, training in places such as these also highlights seriousness of the training and increases credibility of both the training itself and the trainer (Atif et al., 2019).

Moreover, NTPs expressed how off-site training, involving training away from their workplace, was preferred, as it facilitates engagement; conversely, on-site training, where training occurs at the individual's workplace, was considered to negatively affect training, as NTPs would not be able to dissociate themselves from their work commitments. This is in line with recommendations by Oordt et al. (2009), who suggested that training should occur at a location away from the clinical environment to allow trainees to avoid the distractions of patient care or administrative tasks and focus on training. In contrast, other studies have shown that the training environment was thought to be more facilitative when it was located in the participant's workplace, encouraging self-disclosure, which could occur in a relaxed and safe environment (Gough & Kerlin, 2012; Walsh & Freshwater, 2009). Therefore, it is recommended that training be held away from the working environment but in a location that has the provision of adequate resources.

11.3.2.7. Online training

During the current circumstances of the COVID-19 crisis and the social distancing guidelines in place to reduce the spread of the virus, traditional in-person training cannot be delivered. Already because of COVID-19, many face-to-face trainings and education have rapidly moved to an online format to adjust for these guidelines (Pather et al., 2020). For training healthcare professionals in clinical interventions, the current gold standard involves face-to-face workshops complemented with manuals and clinical supervision (Beidas & Kendall, 2010). However, this method of training requires a high demand of resources (Cook et al., 2008) and is limited in the extent to which it can be delivered in hard-to-reach areas (Bennett-Levy & Perry, 2009).

Online training, however, is increasing in popularity, with benefits such as widened access in multiple settings (home, work), personalised learning and regularly updated content (Cook, 2007; Cook et al., 2010; Vaona et al., 2018). Furthermore, in the current climate of the COVID-19 crisis, it allows for education and learning to continue safely (Agarwal & Kaushik, 2020). However, there are several concerns with online training, including learner isolation and a lack of peer support and competition (Vaona et al., 2018). Nevertheless, support for online training comes from a systematic review that investigated the effectiveness of online training compared to alternative methods of training in clinical interventions for healthcare professionals (Richmond et al., 2017). Results showed that online methods may be as effective as alternative methods for outcomes of knowledge and clinical behaviour.

Further evidence supporting the benefits of online training came from a study by Rahman et al. (2019) evaluating a conventional, specialist-delivered in-person training of an evidence-based intervention for perinatal depression versus technology-assisted training by routine supervisors to lady health workers in Pakistan. The findings showed that training via technology led to similar levels of competence as face-to-face training and also led to a 30% reduction in costs.

Evidence exists on the effectiveness of online training for training health workers to deliver mental health interventions. For example, when conducting online training in CBT for therapists, Fairburn et al. (2017) found 42.5% scored above competence scores immediately post training. Similarly, Rees and Gillam (2001) conducted a pilot study to evaluate a foundation course in CBT developed specifically for delivery via videoconferencing for training mental health practitioners in rural and remote areas. Findings showed a significant improvement in knowledge after training and an increase in confidence in using CBT. Support for training non-healthcare professionals using web-based training also exists, with Pereira et al. (2015) finding that educating primary school teachers in childhood mental disorders through a web-based program led to improved knowledge and understanding of mental disorders. Similarly, Hamdani et al. (2015) demonstrated the feasibility of technology-assisted training, finding improved outcomes when educating family members of children with developmental needs in behavioural skills management.

One study investigating online delivered self-directed, didactic training for police officers about autism reported an increase in police officer's confidence in identifying and interacting with individuals with autism spectrum disorder (Teagardin et al., 2012). Similarly, support for self-directed, web-based learning also comes from Cooper et al. (2017), who found that there was no difference between independent web-based CBT training and training assisted by a trainer. Furthermore, almost half of the therapists were reported to meet the threshold of competence six months after training.

However, Bennett-Levy and Perry (2009) believed that mental health training cannot solely be delivered online, and practicing therapy skills with fellow trainees through role-play would require face-to-face workshops. Furthermore, online training requires a stable Internet connection; whilst this may not be a cause of concern in resource-rich areas, in resource-poor settings this will pose a significant barrier to implementing online training (Rahman, Akhtar, et al., 2019). For example, in Pakistan, lack of access to fast, affordable and reliable Internet connections hinders the online learning process especially for those who are living in rural communities (Wains & Mahmood, 2008). A study examining the attitudes of Pakistani students towards online learning during the COVID-19 pandemic found that it cannot produce the desired results that can be achieved through conventional face-to-face learning (Adnan & Anwar, 2020). Issues highlighted included the inability to access the Internet due to technical and monetary issues, a lack of interaction with the tutor and an absence of classroom socialisation.

Despite limitations, the use of technology has expanded training options. Learners are now able to engage with training through a variety of methods such as open-access courses, allowing them to choose how, when and where they learn, facilitating learner independence (Richmond et al., 2017). Moreover, within the uncertain climate of today's world, online training allows for the continuation of learning, increasing students' morale and creating a diversion from the pandemic situation (Agarwal & Kaushik, 2020). However, due to data being collected prior to the start of the pandemic,

online training was not explored in depth within this thesis. Furthermore, as previously discussed there are greater limitations of conducting online training in rural areas of Pakistan where there is a lack of access to fast internet connections (Wains & Mahmood, 2008). Nevertheless, given the shift towards more online training, further research should be conducted on the participant's perspectives towards this method of training.

11.3.3. Training exercises/activities

A number of essential training exercises and activities were identified through interviews with both the NTPs and experts. These included methods such as case study discussions, video and live demonstrations and role-play. This is in line with recommendations by faculty development organisers in health professions education who suggest training should incorporate life-like problems and active discussion (Steinert et al., 2006). Training activities such as role-plays, skills practice and audio-recorded feedback encompass an aspect of experiential learning, defined by Kolb as 'the process whereby knowledge is created through the transformation of experience' (Kolb, 1984, p.38). This method of learning provides the NTPs with an opportunity to learn from the experiences of others as well as their own, facilitating their understanding behind the relevance of the training. Experiential learning is a popular method of training healthcare professionals and is claimed to be the most effective medium for students to acquire interpersonal skills and self-awareness (Green, 1995).

11.3.3.1. Demonstration role-play

The various forms of *role-play* were seen to be beneficial to the trainees in facilitating learning as perceived by both experts and NTPs. *Demonstration role-play*, in which the NTPs watched trainers demonstrate the intervention techniques or watched a video of a therapist and client in practice, was a method of vicarious learning allowing the trainees to learn by observation. Little evidence exists on the benefits of video demonstration in mental health training. However, Kemper et al. (2008) demonstrated the feasibility of online training using video demonstrations of communication skills during paediatric visits for mental health concerns. Using video clips can improve trainees' confidence and skills as well as knowledge (Harris et al., 2002). Furthermore, in this current study, NTPs expressed how watching the intervention techniques being performed built the credibility of the intervention and reinforced its effectiveness. Demonstration role-play can be considered an important precursor to role-play exercises, showing how to perform intervention techniques and best practices for the trainees to consider taking part in role-play exercises themselves (Jackson & Back, 2011).

11.3.3.2. Role-play (general)

Role-play was discussed at length in both expert and NTPs interviews, reflecting its popularity as a method for teaching psychological interventions. It was viewed as an effective technique for practicing intervention skills and learning from each other. Most NTPs valued role-play and expressed their desire for greater time to be spent on skills consolidation. Within the wider literature on counselling training, role-play has been viewed as an effective intervention for students to practice fundamental skills and become comfortable with the role of a therapist (Shurts et al., 2006). Furthermore, experts described how role-play was a useful method for evaluating how much the NTPs had learnt, allowing opportunities for them to provide feedback. Moreover, it was also used as a method of assessing competency of the NTP, ensuring they were following the intervention protocol and maintaining fidelity. This is supported by Miller's (1990) four-level hierarchy of clinical skills, in which level 3 refers to competence in demonstrating the ability to apply skills, which can be assessed through role-plays (Muse & McManus, 2013). Role-play was especially valued amongst participants in Pakistan, as it simplified concepts which may have been difficult to understand through theory, with Experts also expressing how role-play was a more useful technique for learning for individuals who had minimal education. This is supported by a number of studies who used role-play as a method of training NTPs in LMICs (Joag et al., 2020; Jordans et al., 2019; Musyimi, Mutiso, Ndetei, et al., 2017).

The unrealistic or 'artificial' nature of role-play was also discussed, with many experts and NTPs expressing how role-play does not reflect the real-world environment. This is line with evidence from training carers of individuals with eating disorders, who perceived role-play scenarios to be unrealistic and not reflect the real-life experiences that the trainees are faced with (Macdonald et al., 2011). However, the use of *real-play*, where the NTPs brought in their own real-life problems to the exercise, was viewed as an effective method of overcoming this, as it allowed skill practice to be grounded in real-life experiences. However, when taking part in the role of a client, researchers have noted the challenges that arise when trainees bring in their own personal history, due to a lack of awareness of the appropriate level of self-disclosure (Levitov et al., 1999). This may also lead to trainers facing an ethical dilemma after hearing a serious psychological issue from a trainee (Pawlow et al., 2007), a concern that was also mentioned by one expert in this current study. To address these challenges, researchers suggested hiring client actors to stimulate these client–therapist scenarios (Levitov et al., 1999).

Role-play can also be perceived negatively, as it can lead to anxiety amongst trainees due to lack of confidence, performance anxiety, challenging content or past negative experiences of role-play (Perryman, 2014). In particular, due to their unfamiliarity with this teaching method, NTPs in Pakistan described their initial reluctance to perform role-plays as a result of their fear of judgement from the trainers and fellow trainees. Some experts also expressed their dislike for role-plays, citing the reason for it being used too early on within training, especially when the trainees are unfamiliar with the intervention and also with each other. This is in line with evidence by Dalrymple et al.

(2007), in which one participant commented on the difficulty of a role-play feedback session with no prior experience. Therefore, timing of role-play is important, and it is recommended that before implementing role-play, trainees should become more familiar with the intervention skills through the use of demonstrations and with each other through the use of icebreakers. Furthermore, Jackson and Back (2011) stated that the initial use of demonstration role-play generates the least amount of anxiety for the trainee but allows engagement and interaction for the group.

Improper use of role-plays could lead to anxiety and negative impacts on self-efficacy, especially if the role-play is not performed well; therefore, trainees should not be forced into it and only encouraged to carry out the exercise when they feel comfortable enough to do so (Perryman, 2014). Skill-building requires an element of risk-taking from the learner, as they are trying out new behaviours in front of the group; therefore, the development of a safe learning environment by the trainer is critical (Bransford et al., 2000). The trainer plays a considerable role in ensuring that trainees understand why a particular training method is being used so that they can view it as relevant and credible. Resistance to a particular method of training may be overcome if the value of it for skill development is revealed.

11.3.3.3. Service user involvement

It might also be beneficial to consider the involvement of service users in the delivery of the training. Within the wider literature on health education, service user involvement has been found to benefit students in learning interpersonal skills (Morgan & Jones, 2009). Researchers evaluating the involvement of service users have found both barriers and facilitators including both positive and negative effects on students (Dogra et al., 2008; Rush, 2008). Students found first-hand and real experiences of the service users valuable, leading to an increase in empathy (Khoo et al., 2004). However, some students perceive service users as unqualified and lacking in teaching skills (Barnes et al., 2006). A review of the evidence on service user involvement in interpersonal skills training of mental health students concluded that it was an acceptable method and valuable in terms of developing skills and changing attitudes. Therefore, it is important to consider incorporating mental health service users within training, which may be a solution to the unrealistic nature of role-play (Perry et al., 2013). Although service user involvement was not a key feature in this thesis, given its importance, further studies should be conducted to examine the acceptability of using service users in the delivery of training as perceived by the trainees themselves. However, there may be limitations to conducting a study of this kind in LMICs where the concept of service users is not as developed due to service user organisations still being few and fragmented and where service users are often excluded from their rights to meaningly participate in decisions that may have a direct impact on their lives (Semrau et al., 2016).

11.3.4. Trainer considerations

11.3.4.1. Trainer experience

The interviews revealed a number of trainer attributes that can aid in the delivery of training. A number of NTPs appreciated the *academic knowledge* and expertise of the trainer as it increased credibility of the training. This is supported by Svensson et al. (2015), in which trainees described experienced and knowledgeable trainers as a prerequisite for the training's impact and credibility. Furthermore, it was found that answers to questions were sought amongst fellow trainees during group discussions, which offered valuable knowledge and networking opportunities, further supporting the need for a heterogenous group (see section 11.3.2.4).

However, most NTPs expressed how they valued *clinical experience* more, as it allowed the trainer to bring in their own real-life examples from practice which was important in terms of credibility in the success of the intervention itself. Oordt (2009) recommended the use of recognised experts as trainers, suggesting that there is an additional positive effect from using trainers with established recognition and credibility based on their work. However, when training lay individuals, the number of publications and professional position may not be of value to them, with evidence from this current study showing that *teaching experience* was regarded as highly important. A number of NTPs and experts voiced how good clinical skills did not necessarily reflect good teaching skills. Experience in teaching is important for the trainer to be able to answer questions effectively as well as manage situations that may occur in the training room such as those encountered during role-play. Kanowski et al. (2009) found that the prior teaching experience of the trainer was a predictor of success of a course in mental health first aid.

However, in this current study, one program used a cascaded model of training, in which local non–mental health specialists were trained by a mental health expert to deliver training to the NTPs (Atif et al., 2019). The increase in PVs' competencies suggests that the clinical experience of the trainer may not be necessary for the success of the training, which is also supported by other studies using a cascaded model of training (Murray et al., 2011; Shields-Zeeman et al., 2017). Further support for a train-the-trainer approach comes from Triplett et al. (2020), who found although not as high as master trainers, local trainers were still considered 'quite a bit' credible by CBT trainees. Although not assessed in the study, the authors suggest that local trainers were likely to have higher scores for other types of credibility, such as local knowledge.

11.3.4.2. Trainer attributes

The analysis also revealed a number of traits that were seen as having a positive effect on the training. *Flexibility* was also discussed, with a number of experts stating how it is important for the trainer to be able to adjust to the learning needs of the trainees for training to be relevant, a trait which was also positively viewed by the NTPs. This is supported by Given (2008), who stated that

because there is likely to be diversity amongst trainees in their learning styles and needs, trainers who are more flexible are likely to produce better training outcomes.

NTPs described how the *approachability* and *friendliness* of the trainer created a comfortable environment where the NTPs were open to ask questions and share their opinion. Particularly, in Pakistan, NTPs voiced how initial reluctance to attend training disappeared due to the welcoming nature of the trainers. This is in line with Dennis et al. (2013), who found that peers, providing telephone support for mothers at risk of postpartum depression, valued a friendly and caring atmosphere as well as the skill, knowledge and enthusiasm of the trainers. Building rapport with the trainees is an important factor for the trainer to be able to gain their trust, especially in LMICs where the trainers will be experiencing training of this kind for the first time. When investigating trainer attributes as predictors of training effectiveness, Ghosh et al. (2012) found that the trainer's comfort level with the subject matter and their rapport with the trainees were found to be significant predictors of trainee satisfaction. Moreover, in this current study, being respectful was highly valued amongst NTPs in Pakistan. As the participants were minimally educated women from the villages, where respect for women is often lacking (Jamal, 2012), an individual showing them respect may be critically important and particularly valued by them. In contrast, this theme was not found in the HIC, where it can be assumed that an element of respect already existed between the trainer and NTPs, as the NTPs were already professionals with knowledge and experience in mental health. However, respect is not solely specific to LMICs, with Rani and Byrne (2012) finding that in Ireland, 56% of non–mental health professional trainees attending a training program for dual diagnosis of mental health and addiction viewed respect from the facilitator to be crucial.

Lastly, providing support was also highly valued by NTPs, and therefore, it is necessary for the trainer to be *supportive* to facilitate learning during training and also during intervention implementation. This is in line with Wheelan (1990), who suggested that a trainer should (a) provide support, (b) create psychological safety, (c) provide direction, (d) show empathy and likeability, (e) create awareness of current skill levels, (f) demonstrate new skills, (g) provide opportunities for practice, (h) increase the probability of using new skills in practice and (i) encourage confidence and independence.

Although not mentioned by participants in this current study, characteristics such as being charismatic and likeable have also been shown to influence trainees' satisfaction with training (Heppner & Handley, 1981). When creating a measure of effective trainer characteristics, Boyd et al. (2017) suggested two factors which influence the effectiveness of clinical supervision in mental health settings: charisma (i.e., likeable, friendly, warm and sociable) and credibility (i.e., experienced, expert and prepared). In line with this, evidence has shown that trainer characteristics, specifically charisma, are associated with a trainee's attitudes and motivation to carry out the new skills learnt (Ajzen, 1991). Furthermore, when exploring the experiences of instructors delivering a mental health first aid training programme, Terry (2010) found that

participants highlighted a number of prerequisite skills needed to enable delivery of the training. This included preparation, prior experience in training, mental health expertise, group management skills, ability to promote reflection and managing emotional situations and flexibility.

11.3.4.3. Trainer incentives

Furthermore, as training can be time-consuming and demanding on trainers who may feel pressured by possible competing demands of their current existing work and training, it is important to highlight its benefits to them. Experts in Pakistan expressed how motivation came from knowing that they were raising mental health awareness within the community and empowering women. Furthermore, they described how this form of work was rewarding, as they were able to listen to success stories as well as see the positive outcomes from training. This is similar to the benefits described by NTPs delivering psychological interventions (Coe & Barlow, 2013). Although little evidence exists on the motivations of trainers involved in task-shifting interventions, evidence from service users involved in train-the-trainer programs have cited opportunities to make a difference as motivation for becoming a trainer (Fraser et al., 2017).

Moreover, professional and personal development has also been cited a motivation by healthcare professionals who have taken on a role in teaching and supervision (Ingham et al., 2015). Furthermore, experts in both the UK and Pakistan spoke positively about their relationship with trainees, stating how trainees would come to them for advice for their own personal problems. However, it is important to consider that although a friendly trainer–trainee relationship can facilitate learning, the trainer should remain within their own professional boundaries.

11.3.5. Implementation strategies

Once training has been received, focus can shift to implementation of training. Within this thesis, analysis revealed a number of strategies that should be considered, which could take place pre-training, during the delivery of training or post training, that may have a positive effect on the implementation of the intervention for which training has been received.

11.3.5.1. Addressing barriers to delivery for trainers

Challenges for trainers may include a language barrier between the trainer and trainees, challenging the already existing views of the trainees, particularly those who have strong fixed cultural beliefs and values, difficulties in explaining complex concepts of the intervention and staying within limitations of the role. The former two challenges are particularly important to consider when training individuals from an LMIC, where education surrounding mental health is low, and knowledge, attitudes and practice will be shaped by culture (Faregh et al., 2019). In these situations, the historical, geopolitical and social contexts play important roles in communication,

which may affect training. Therefore, it is recommended that the trainers are local who may have relevant knowledge about idioms and explanatory models, which they can integrate into training delivery (Faregh et al., 2019). This is supported by Atif et al. (2019), who found that the use of local trainers was beneficial to training delivery and made them seem more relatable to the PVs.

Furthermore, although not addressed by participants in this current study, it is important to note that as NTPs are individuals with no formal mental health training, it is crucial to have a plan and support for clinical emergencies (Murray et al., 2011). As mentioned in section 11.3.2.1, this may include providing NTPs with adequate resources and a referral pathway to refer clients to more appropriate services, but it may also involve the need for a collaborating mental health specialist to manage high-risk situations.

11.3.5.2. Addressing barriers for NTPs

Similar challenges may be encountered by NTPs working with clients from LMICs who may be resistant to receive treatment due to their stigmatising cultural beliefs (Saxena et al., 2007). Studies in LMICs have shown that individuals prefer not to disclose their problems with health professionals or even their own relatives (Shibre et al., 2001). However, this reluctance to access treatment may not just be a culture-specific issue, as evident by interviews with NTPs in the UK, with a number of them expressing how helping the client acknowledge their problem and accept treatment was a challenge. In the wider literature, studies suggest that building a trusting relationship between the therapist and client can be a way of overcoming this barrier and implementing behaviour change (Rugkåsa et al., 2014). In the UK, NTPs also voiced their difficulties with managing clients' expectations and confusion with their role, with a number of clients expecting a 'cure' to their problems or regarding the NTP as a healthcare professional. Similarly, in a study investigating peer support from mothers, Murphy et al. (2008) reported some misunderstanding of the mentor mother's role, with some mothers believing that their mentors were health or social care professionals. Furthermore, differences in boundaries may arise between NTPs and traditional professionals, particularly when interventions are delivered by peers, as they may be viewed more like friends (O'Hagan, 2011). Therefore, peer support workers highlight the importance of establishing clear, personal boundaries with clients (Rebeiro Gruhl et al., 2016).

Several practical barriers to implementation were also revealed, such as balancing existing work duties with intervention delivery, responsibilities at home and lack of transportation, the latter being particularly important in Pakistan. Evidence indicates that walking long distances due to a lack of transportation and a risk of assault in high-risk areas can contribute to stress for women in LMICs (Nkonki & Daniels, 2010). Furthermore, for women in LMICs, familial disapproval can often be found as a barrier to work due to husbands seeing long hours and travel inappropriate for women or a waste of time (Khan et al., 1998). Therefore, it is necessary to address barriers so that problems can be pre-empted and solutions generated either during the pre-training planning phase

or during the delivery of training. Training in tools and solutions to overcome anticipated challenges can increase the relevancy of the training and boost self-confidence in the skills covered. However, this can be difficult, as raising barriers or discussing them openly may lead to anxiety and a loss of self-efficacy for the trainee. Therefore, it is necessary for the trainer to be skilled and experienced to be able to provide confidence and encouragement to the trainees to allow for successful implementation (Given, 2008).

11.3.5.3. Retaining NTPs

Whilst recruiting trainees is an important factor to consider during pre-training planning, it is also important to ensure that the trainees remain for the duration of the intervention. Analysis revealed several methods for keeping NTPs motivated and ensuring their retention. Experts highlighted the importance of making them feel valued and respected by acknowledging the work they are doing and by providing them support through supervision. This is consistent with findings that suggest that training and supervision can provide continuous motivation for peer counsellors (Nankunda et al., 2006) and CHWs (Greenspan et al., 2013). Furthermore, support from the family is also an important source of motivation. In this study, in Pakistan, support from the family came in the form of encouragement, transportation and helping with household chores and childcare. This is consistent with findings from Greenspan et al. (2013), who found that CHWs' motivation came from moral, financial and material support from their families. Moreover, as reflected by the exemplars in Pakistan, training courses can often support the NTPs during their training and intervention delivery by providing transport, delivering training at times most suited to the NTPs and also supporting them in discussions with their husband and mother-in-laws.

Furthermore, altruistic benefits can influence the NTPs' motivation to continue (Glenton et al., 2013), which includes their desire to contribute to and serve the community (Malema et al., 2010). When examining the LHWs' role in public health programmes, South et al. (2014) found that altruism, commitment to a community and social rewards for both the LHW and recipient were common themes for pursuing voluntary work. Moreover, within this current study, a number of NTPs highlighted how training and intervention delivery led to personal development. This is supported by evidence that suggests that peer support can lead to a higher sense of empowerment in their own recovery journey, improvements in self-esteem and confidence and feeling more valued and less stigmatised (Davidson et al., 2012; Mowbray et al., 1998; Nankunda et al., 2006). The qualitative review by Scantlebury et al. (2018) found that mental health training also led to increased awareness of mental health and increased compassion, sensitivity and patience towards individuals with a mental illness. Within this current study, NTPs in Pakistan also expressed their happiness at receiving recognition and respect from their recipients and the community, which is particularly important in LMICs (Glenton et al., 2013).

WHO (2007) recommends that when recruiting and retaining NTPs, opportunities for career progression should also be highlighted to them, as it offers both personal and financial incentives. Motivators for CHWs in Tanzania included hope for future financial gain or employment within healthcare (Greenspan et al., 2013). Similarly, personal benefits for peers in Fogarty and Kingswell (2002) included the opportunity for further education and new jobs since joining a peer support service. Furthermore, WHO (2007) also recommended that countries consider financial and/or non-financial incentives as means of retaining and enhancing the performance of health workers. A review exploring the barriers to implementation of peer worker roles in mental health services found that many peer workers across different settings complained about poor or lack of financial compensation, which they perceived to reflect the lack of credibility of peer worker roles (Vandewalle et al., 2016). This is supported by Gates and Akabas (2007), who found that low pay for peer support workers was associated with low job security and a devaluing of the role. Offering pay and potentially stable employment may not only provide NTPs opportunities to develop health careers (South et al., 2014), but financial incentives may also allow more economically disadvantaged NTPs to worry less about income-generating activities and devote more time to intervention delivery (Greenspan et al., 2013). However, providing financial compensation may not be sustainable in poor-resource settings (Glenton et al., 2010) and may raise expectations that can lead to demotivation if unmet (Bhattacharyya et al., 2001). Therefore, it may be necessary to explore alternative methods of compensation such as loans (Glenton et al., 2010) or performance-based incentives (Eichler, 2006). When discussing the ethics of task-shifting, Mundeva (2018) recommends that policymakers consider the burden that lack of remuneration may place on the individual, and they should provide a minimum standard compensation to alleviate it. This may come in the form of providing resources such as bicycles, umbrellas, backpacks and medications to avoid individuals encountering unfair burdens as a result of their work.

These methods for ensuring retention are in line with Murray et al. (2011), who suggested that staff attrition can be prevented by including organisational support, monetary compensation, adequate time allowance and highlighting any opportunities for advancement which may involve taking on supervisory responsibilities. Experts also discussed the importance of contingency planning, by training more trainees than necessary in the case where a trainee leaves midway through the intervention. This is supported by Murray et al. (2011), who acknowledged the importance of planning in advance for attrition by training a large number of NTPs, knowing that some may not demonstrate competency in the intervention, and some may leave the project. In the same way, the authors also acknowledged the importance of having multiple trainers during training in case one trainer is unable to attend training. Furthermore, having more than one trainer allows for greater opportunities for feedback for the trainees and also increases the credibility of the training.

11.3.5.4. Supervision

Experts and NTPs both highlighted the benefits of *supervision* in providing emotional support to the NTPs, which was cited as critically important, as intervention delivery can be an emotionally demanding task. This is in line with Daniels et al. (2010), who found that supervision provided emotional support and motivation and built up the self-esteem of peer counsellors. However, evidence has found that peer workers often describe their supervision as superficial, which focuses on task performance rather than emotional concerns and personal development (Vandewalle et al., 2016). A lack of opportunities to discuss responsibilities and emotional concerns may lead to potentially detrimental effects on NTP well-being (Mowbray et al., 1998); therefore, it is important that supervisors allow the NTP the chance to discuss any emotionally difficulties they may be having. Furthermore, ongoing training and adequate supervision also ensure NTPs do not experience burnout in their positions (Visser & Mabota, 2015). In the wider literature, supervision has also been found to lead to an increase in therapist self-awareness, skill development and self-efficacy (Wheeler & Richards, 2007).

Supervision can ensure adherence to the intervention, allowing the trainee and supervisor to review cases and discuss challenges, and provides an opportunity for the supervisor to deliver feedback and highlight any areas where further training may be needed (Beidas & Kendall, 2010). Supervision allows for monitoring, which has been linked to positive outcomes (Barber et al., 1996), and for the identification of issues with the intervention. Monitoring adherence to the intervention may be conducted through audio recordings of the session (Stanley et al., 2014), live observation of sessions (Rahman et al., 2016), role-play observations (Khan et al., 2017) and counsellor self-reports (Markle-Reid et al., 2014). Furthermore, training alone may not be sufficient for effective intervention implementation, with evidence suggesting post-training support via supervision is one of the strongest predictors of actual behaviour change (Fixsen et al., 2005). This also holds true for studies in LMICs, where supervision has been perceived as the most valuable part of training (Rahman, 2007). The importance of supervision is also highlighted by WHO (2007), which suggested that supportive supervision and clinical mentoring be regularly provided to all health workers. Furthermore, they suggest that those who are providing supervision or mentoring should be competent and have appropriate supervisory skills themselves. Evidence suggests that collaborating with newly trained supervisors to assess competence and intervention adherence allows for the successfully implementation of supervisory programmes (Murray et al., 2011), with studies encouraging the training of new supervisors to address the logistical issues associated with supervision, i.e., being time-consuming and resource demanding (Murray et al., 2011).

Furthermore, refresher sessions can be useful to address problems in practice, reinforce and develop skills and are important factors in retaining the motivation of NTPs (Bhattacharyya et al., 2001), particularly when trainings are short and NTPs have low levels of education. However, opportunities for further training can be limited, with NTPs in this current study expressing the need for further training. This is also consistent with the findings from Dennis et al. (2013), who found

that 80% of PVs expressed a desire for ongoing educational sessions to refresh their skills. Therefore, it is important that NTPs receive ongoing training and support throughout the intervention, which would also ensure fidelity to the intervention. However, further training requires additional resources and may lead to further costs which may not be feasible in resource constrained countries.

Furthermore, fidelity can also be ensured through competency assessments prior to implementation and throughout the length of the intervention to assure that quality of the intervention is being maintained. ENhancing Assesment of Common Therapeutic factors is a useful tool which can be used by trainers for measuring therapist competence (Kohrt et al., 2015). As well as being used to evaluate trainees post training and throughout the intervention, this tool can also be used to select non-specialist health workers to participate in training and non-specialist health workers with prior experience to become trainers and supervisors and is therefore an important tool to consider during the pre-training planning phase.

11.3.6. Dissemination strategies

Dissemination of research is a key aspect of the research process, and whilst the publication of outcomes from task-shifting in mental health is adequate, there is a lack of focus on addressing the methods used to train the individuals task-shifting the interventions. This was also found in a systematic review exploring the training of non–mental health professionals, with the author stating that descriptions of training interventions and their delivery were generally insufficient for reproduction (Booth et al., 2017). Similarly, a number of reviews exploring NTP-delivered interventions for mental health have identified several methodological limitations and inconsistencies in reporting training methods in published studies (Barnett et al., 2018a; Barnett et al., 2018b; Kohrt et al., 2018; Singla et al., 2017). This makes it difficult to draw conclusions about the amount of training or ongoing support that NTPs need to implement psychological therapies with fidelity because these descriptions often provide limited details (Barnett et al., 2018a; Barnett et al., 2018b). Disclosing training procedures to the public can increase the database of evidence on training NTPs to deliver psychological interventions, allowing fellow researchers to learn from existing work. Experts offered a number of factors that researchers should consider when reporting their training process in publications.

First, it is important to take into account any commitments that may have been made to external funding bodies and to consider who owns the *rights to the intellectual property,* which may be a barrier for the researcher in disclosing the training process. A similar idea is expressed by Wilson et al. (2010), who stated that there seems to be a lack of clarity between funding bodies as to what represents dissemination, with expectations and guidance provided to researchers varying between funding agencies. The author recommends the use of a number of theoretically informed frameworks available to researchers to guide them in dissemination planning and activity, such as

a framework developed by Dobbins et al. (2002), for the dissemination and utilisation of research evidence in healthcare decision making; and a dissemination framework created by the Economic and Social Research Council (2004) for use by grant applicants and holders detailing a step-by-step guide on planning and prioritising research communication.

Second, a number of experts suggested that improper documentation during the training phase leads to an inability to disclose training methods during dissemination; therefore, it is imperative that researchers ensure that they keep an *audit trail of training,* which they can refer back to in the future. An audit trail in research consists of a detailed collection of documentation regarding all aspects of the research and can be important in providing justification of the processes carried out in the study (Given, 2008).

Third, experts suggested that the lack of reporting may be due to the journal's word count limitations or a focus on the outcomes. This is in line with Murray et al. (2011), who suggested that published randomised trials of outcomes tend to focus their attention on reporting study procedures and outcomes, and the lack of focus on implementation processes makes it difficult to determine the best strategies to replicate and scale up efforts for non-specialist health workers to support or deliver psychological interventions. There is pressure on researchers to publish due to institution evaluations and the desire for recognition and employment (Levsky et al., 2007), which may lead authors to focus on the publications of their outcomes and overlook the training process. Therefore, journals should include a stipulation for publication that training procedures should be disclosed, which may be included in the appendix or as supplementary materials to overcome the word count barrier.

Lastly, it is recommended that *guidelines for reporting training* be used to encourage more standardised and comprehensive reporting. This approach has been widely used to enhance reporting of trials (Schulz et al., 2010) and systematic reviews (Moher et al., 2009). However, experts acknowledged the prescriptive element to using guidelines; therefore, they should be used as recommendations to follow, allowing for flexibility rather than a strict set of procedures. Furthermore, whilst factors such as endorsement by journals and funders have an important role to play, their usability and perceived need by researchers will be a determining factor in their acceptability (Burford et al., 2013). Therefore, further research into the needs of researchers should be conducted.

11.4. Essential components for training

In section 10.1.2, a table of recommended training components is presented to synthesise the findings in this study, with six groupings: (1) pre-training planning, (2) training format/mode of delivery, (3) training methods, (4) trainer considerations, (5) implementation strategies and (6) dissemination strategies (Table 9.1). The discussion of the findings in relation to the existing

literature and also taking into account evidence from the studies included in the systematic reviews led to the development of a taxonomy of essential training components (Table 11.1). This is based on the taxonomy of training intervention components identified by Perryman (2014).

A total of 121 training components were identified, grouped into 11 categories. The grouped training components were divided into three phases: pre-training, training delivery and post-training.

The taxonomy can be used to inform the design and delivery of training for NTPs who will be delivering psychological interventions. As this taxonomy has been developed from evidence built up from HICs and LMICs, it can be applied in both high- and low-income settings. It is important to note, however, that the use of any of the training components in the taxonomy should be considered in relation to the aims and objectives of the training, the context of the group and the setting in which the training is occurring. Researchers can use this taxonomy to select training components deemed most appropriate to the context in which they are delivering training. The last column in the table shows the source of the training components, whether it was identified through studies included in the systematic review, the NTP and expert interviews or in the wider literature.

Table 11.1. Taxonomy of essential components for training NTPs in psychological interventions

Key: A – Systematic review of HICs, B – Systematic review of LMICs, C – Qualitative review, D - NTP and expert interviews

Training components	Definition	Evidence
PRE-TRAINING		
Pre-training planning/preparation		
Arrange collaboration with local health system	Linkage with key organisations to facilitate the delivery of the intervention and boost credibility of NTPs	B, C
Service user involvement	Involve service users in the development of training and intervention	Morgan & Jones (2009)
Establish selection criteria of trainees	Prior to recruitment, identify trainee prerequisites based on intervention recipient	A, B, C, D
Adequate resources to conduct training	Ensure there are adequate resources to conduct training, e.g., cost, site, trainers	A, B, D
Plan and support for clinical emergencies	Ensure there is a plan and support in place for clinical emergencies that may be encountered by NTPs, e.g., link with mental health specialist	Murray et al. (2011)

Table 11.1. Taxonomy of essential components for training NTPs in psychological interventions

Key: A – Systematic review of HICs, B – Systematic review of LMICs, C – Qualitative review, D - NTP and expert interviews

Training components	Definition	Evidence
Anticipate barriers to implementation	Review existing literature and/or ask experts and trainees about perceived possible barriers to intervention delivery and plan training to address these	D
Contingency planning	Recruit and train extra trainers and NTPs to account for staff attrition	B, D
Pre-training evaluation	Conduct a pre-training evaluation on trainees, e.g., assess learning needs, expectations, past experiences, knowledge and skill	D
Review training content	Review training content with a multidisciplinary team prior to and throughout training to ensure relevancy of content	D
Tailoring content to learning needs	Ensure training is relevant to the learning needs of trainees by incorporating findings from the pre-training evaluation in the training content	D
Accessible training environment	Identify a training site that is fully accessible to all trainees to ensure maximum attendance	D
Incentives to attend training		
Certificates of attendance	Inform trainees that they will receive a signed training certificate of attendance	Singla et al. (2014)
Financial incentives	Inform trainees that they will receive money for attending training	A, B, C, D
Arranging transport	Provide travel arrangements for trainees to encourage attendance	A, B, C, D
TRAINING DELIVERY		
Content		
Structuring training	Deliver structured training by having clear objectives, time scales and highlighting these to the trainees	D
Identify learning objectives	Ask trainees what they would like to learn or what skills they would like to obtain from training	D
Tailoring training	Tailoring training content to the needs of the training identified on the day	D
Training in screening of MHC	Provide training in screening of target mental health condition, which may include the use of validated screening instruments	A, B, C, D

Table 11.1. Taxonomy of essential components for training NTPs in psychological interventions

Key: A – Systematic review of HICs, B – Systematic review of LMICs, C – Qualitative review, D - NTP and expert interviews

Training components	Definition	Evidence
Training in symptom recognition	Provide training in recognition of target mental health symptoms	A, B, C
Information in mental health condition	Provide basic education on the target mental health condition	A, B, C, D
Training in identification of risk	Provide training in identifying risk of harm to intervention recipient or risk of harm to others	A, B, D
Referral pathways	Provide trainees with resources to be able to refer intervention recipient to specialist services	D
Training in ethics and confidentiality	Incorporate code of conduct, ethical and confidentiality guidance within training	A, B, D
Time management skills training	Training in time management skills to help address intervention implementation challenges	D
Communication skills training	Training in skills to be able to effectively communicate with intervention recipient	A, B, C, D
Intervention skills training	Training in skills required for effective intervention implementation	A, B, C, D
Address barriers to implementation	Provide tools and solutions to barriers that may be encountered during intervention implementation	D
Training methods (exercises, activities, modes of delivery)		
Case studies	Provide trainees with examples of individuals with mental health problems, social or psychological concerns	A, B, D
Case study discussions	Prompt discussions of case studies in groups	A, B, D
Demonstration role-play (live)	Trainers conduct role-play of the intervention in front of the training group	A, B, D
Demonstration role-play (DVD/video)	Show demonstration of the intervention (i.e., real or simulated) using video or DVD	A, B, D
Demonstration role-play (using actors)	Show demonstration of the intervention using actors to play the intervention recipient	Levitov et al. (1999)
Discussion	Ask trainees to discuss their views and experiences on a particular topic	A, B, D
Experiential learning	Provide trainees with opportunities to learn from experiences to gain knowledge and skills, e.g., trainer's own clinical experience	A, B, C, D

Table 11.1. Taxonomy of essential components for training NTPs in psychological interventions

Key: A – Systematic review of HICs, B – Systematic review of LMICs, C – Qualitative review, D - NTP and expert interviews

Training components	Definition	Evidence
Online videoconferencing training	Deliver live training through videoconferencing	Rees & Gillam (2001)
Online, self-directed, didactic training	Deliver training modules via a website	Cooper et al. (2017)
Face-to-face, group training	Deliver face-to-face training to groups	A, B, C, D
Peer learning	Provide training that allows trainees to learn from each other	A, B, C, D
Peer support	Provide training that allows trainees to support each other	A, B, D
Homework tasks	Set trainees homework tasks to assess knowledge acquisition and skills development	B, D
Icebreakers	Incorporate activities that aim to introduce individuals within the group and promote bonding.	A, B
Interactive training	Involve trainee participation throughout the training by encouraging participation interaction between trainees and with the trainers	A, B, D
Lecture-based presentations	Deliver didactic presentation of information with no interaction	A, B, C, D
Interactive presentations	Deliver presentation of information with participation from trainees, e.g., encourage questions, sharing of experiences	A, B, D
Materials	Provide materials to support the training, e.g., handouts	A, B, C, D
Materials (after training)	Provide materials such as manuals or further reading for trainees to take away	D
Materials (before training)	Provide preparatory materials such as manuals or background reading that trainees can access before training	D
Materials (during training)	Provide training such as slide presentations and exercises that are to be used during training	D
Materials (training manuals)	Provide training manuals with intervention content and implementation procedures and guidelines	D

Table 11.1. Taxonomy of essential components for training NTPs in psychological interventions

Key: A – Systematic review of HICs, B – Systematic review of LMICs, C – Qualitative review, D - NTP and expert interviews

Training components	Definition	Evidence
Materials (training manuals linked to training content)	Ensure the training manual is linked to training content and that the manual is referred to during training	D
Mix of lectures and interactive presentations	Include a mixture of didactic and interactive presentations to ensure different learning styles are met	A, B, C, D
Roaming trainers	Move around the room during activities and exercises to ensure trainees' understanding and offer feedback	D
Real-play	Ask trainees to bring their own experiences to role-play	D
Role-play (intervention skills)	Conduct role-play for intervention skills learnt	A, B, C, D
Role-play (playing observer/client/therapist)	Ask trainees to play each role, i.e., observer, intervention recipient, interventionist	D
Role-play (with peers)	Ask trainees to role-play with other trainees	D
Role-play (with actors)	Ask trainees to role-play with actors who are playing the intervention recipient	Levitov et al. (1999)
Role-play (with service users)	Use real service users to play the role of the intervention recipient, drawing on their own experiences	Perry et al. (2013)
Role-play (with feedback from trainer)	The trainer observes the role-play and provides feedback to the trainee who is playing the interventionist	A, B, C, D
Role-play (with feedback from an observer)	One or more observers provide feedback to the trainee who is playing the interventionist	D
Skills practice homework	Asking trainees to practice the new skills outside the training environment	D
Small-group exercises	Exercises that involve discussing in small groups and then feeding back to the wider group	A, B, C, D
Characteristics of the training provider/facilitator		
Trainer experience (clinical)	Include a trainer who has clinical experience in the intervention	A, B, C, D
Trainer experience (teaching)	Include a trainer who has prior teaching experience	D
Trainer expertise	Include a trainer who has expertise in the topic of the training and intervention	A, B, C, D

Table 11.1. Taxonomy of essential components for training NTPs in psychological interventions

Key: A – Systematic review of HICs, B – Systematic review of LMICs, C – Qualitative review, D - NTP and expert interviews

Training components	Definition	Evidence
Prepared	Be prepared and familiar with the training prior to training implementation	Boyd et al. (2017)
Respect	Be respectful towards trainees and any views and experiences they may offer	D
Encourage reflection	Encourage trainees to reflect on their own past experiences	Terry (2010)
Use creative strategies	Use creative strategies for training to facilitate knowledge acquisition and skills development	Rani & Byrne (2012)
Establish rapport	Establish a bond with the training group	D
Flexibility	Be flexible and responsive to the needs of the group	D
Relaxed approach	Have a relaxed approach to training to ensure training is enjoyable	Rani & Byrne (2012)
Group management	Use skills to manage the group, creating a cohesive group and a safe environment	Terry (2010)
Managing trainee distress	Use skills to manage potentially distressing situations for trainees particularly when dealing with sensitive topics	Terry (2010)
Approachability	Being approachable to allow trainees to feel comfortable in asking questions for help	D
Teach at right level	Ensure that training is presented at a level that all the trainees can understand	D
Understanding trainees' expectations	Have an awareness of trainees' expectations about the training	D
Understanding trainees' concerns	Have an awareness of trainees' concerns about the training	D
Understanding trainees' background and culture	Have an awareness of trainees' background and culture, which may influence views during training or intervention implementation	D
Charismatic	Display charisma, e.g., by being warm, likeable, sociable, friendly	Boyd et al. (2017)
Knowledgeable	Show high levels of knowledge in area by using own experiences and answering trainees' questions	D

Table 11.1. Taxonomy of essential components for training NTPs in psychological interventions

Key: A – Systematic review of HICs, B – Systematic review of LMICs, C – Qualitative review, D - NTP and expert interviews

Training components	Definition	Evidence
Engaging	Adopt an engaging style by being lively and animated	Rani & Byrne (2012)
Enthusiastic	Show enthusiasm for the training content and intervention	Dennis et al. (2013)
Supportive	Provide support to the trainees throughout training, offering help and being aware of learning needs	D
Trustworthy	Promoting trust by building rapport and establishing confidentiality	D
Multiple trainers	Include a number of trainers in the delivery of training to allow for greater feedback	A, B, D
Local facilitator	Include local trainers from the same area as the trainees	B, C, D
Service user facilitators	Include a service user in the delivery of the training	Perry et al. (2013)
Train the trainer	Conduct training of trainers by a master trainer with the aim of training a large number of local trainers with lower levels of expertise but knowledge in the local area	B, C, D
Characteristics of the training group		
Skill mix (heterogeneous)	Recruit trainees with a mix of skill levels, education and experience	D
Skill mix (homogenous)	Recruit trainees with the same skill levels, education and experience	D
Small group size	Deliver training to small groups	A, B, D
Length/duration		
Smaller sessions over a longer period	Deliver shorter training sessions (1–4 hours), over a longer period	Gough & Kerlin (2012)
Condensed training over a few days	Deliver training in block, full-day or weeklong sessions	Svensson et al. (2015)
Ongoing training	Deliver training that is ongoing rather than a one-off session, giving trainees the chance to practice skills in the real world, e.g., running workshops once a month	D
Characteristics of the setting		
Off-site training	Conduct training outside trainees' workplace	Oordt et al. (2009)

Table 11.1. Taxonomy of essential components for training NTPs in psychological interventions

Key: A – Systematic review of HICs, B – Systematic review of LMICs, C – Qualitative review, D - NTP and expert interviews

Training components	Definition	Evidence
On-site training	Conduct training at trainees' place of work	Gough & Kerlin (2012)
POST-TRAINING		
Training evaluation/competency assessment		
Using self-report questionnaire	Evaluate training by asking trainees to complete a questionnaire	A, B, D
Using valid instruments	Conduct training evaluation using validated instruments	A, B, D
Role-play observations	Conduct competency assessments by observing role-plays	A, B, D
Role-play observations using checklist	Conduct competency assessment by observing role-plays and checking off criteria on a checklist	A, B, D
Live observations	Conduct competency assessments by observing intervention sessions	A, B, D
Audio-recordings of sessions	Conduct competency assessment by assessing a percentage of audio recordings of intervention sessions	A, B, D
Supervision		
By a mental health specialist	Supervision conducted by a mental health professional	A, B, C, D
Locally trained supervisor	Supervision conducted by a local supervisor	B, C, D
Peer supervision	Involves peers getting together, sharing experiences and problem-solving	A, B, C
Group supervision	Involves supervision conducted in a group format	A, B, C, D
Individual supervision	One-to-one supervision between supervisor and supervisee	A, B, C, D
Face-to-face supervision	Supervision conducted in person, face-to-face	A, B, C, D
Technology-based supervision	Supervision conducted over the phone or videoconferencing	B, D
Fortnightly	Supervision conducted every two weeks	A, B, C, D
Monthly	Supervision conducted once a month	A, B, C, D
Audio-recorded feedback	Feedback on audio recordings is provided during the supervision session	A, B, C, D

Table 11.1. Taxonomy of essential components for training NTPs in psychological interventions

Key: A – Systematic review of HICs, B – Systematic review of LMICs, C – Qualitative review, D - NTP and expert interviews

Training components	Definition	Evidence
Reviewing cases	Cases are reviewed and discussed during supervision, and any challenges are addressed	A, B, C, D
Well-being support	The emotional well-being of the supervisee is addressed during supervision	A, B, C, D
Refresher sessions	Inform trainees that another training session will take place in the future to refresh knowledge and skills	A, B, C, D
Retaining NTPs		
Monetary incentives	Offer payment during intervention implementation	A, B, C, D
Performance-based incentives	Offer financial reward based on performance	Eichler (2006)
Non-monetary incentives	Provide aides to facilitate delivery of the intervention, e.g., bicycles, umbrellas, backpacks.	Mundeva (2018)
Advancement in role	Provide opportunities to advance in their role, e.g., offer supervisory responsibilities	Murray et al. (2011)
Employment within healthcare	Offer potentially stable employment to NTPs and the chance to develop health careers	South et al. (2014) Greenspan et al. (2013)

Source: Adapted from Perryman (2014)

11.4.1. Pre-training

When developing training, researchers should consider which pre-training planning components are the most relevant. Training should be tailored to the needs of the trainee, which can be identified through pre-training evaluations. Furthermore, the delivery of the training itself should be tailored to the preferred learning styles of the NTPs, which can also be identified from pre-training evaluations. Furthermore, researchers should also consider and plan for any issues that may arise during intervention implementation.

11.4.2. Training delivery

Evidence from this study and the wider literature on task-shifting psychological interventions for CMDs suggests that time within training should be dedicated to providing information on identification and management of mental health conditions. Furthermore, training should also address any implementation issues and barriers to implementation that may arise. The findings from the systematic reviews, qualitative study and current literature suggest that role-play is a

popular and effective method of training NTPs in psychological interventions. Other recommended methods for delivery based on evidence from this current study and the wider literature include group discussions and presentations. Furthermore, the use of online training is increasing in popularity, as it allows training to be accessed by individuals living in remote areas. Moreover, in light of the COVID-19 pandemic, it is a way of ensuring that learning is still occurring whilst still ensuring social distancing. All the recommended training components within this taxonomy can also be implemented via online training. However, it is important to consider that carrying out role-play via online training poses certain challenges (Bennett-Levy & Perry, 2009). The format of online training does not allow trainees to have non-verbal interactions (i.e., body language). Moreover, issues may arise in providing enough structure and information for trainees to assume a role and enact the role-play (Levine, 2013). However, this can be addressed by having specific content which provides information on the topic for the role-play, the duration and expectations for participation by the trainee and the trainer (Levine, 2013). Lastly, the trainer plays a vital role in ensuring the NTPs receive effective training, with evidence highlighting the importance of having skilled and experienced trainers.

11.4.3. Post-training

It is recommended that post-training evaluations are conducted to explore trainees' opinions on the training and whether the learning objectives and trainees' learning needs have been met. Furthermore, competency assessments can evaluate changes in the trainees' knowledge, attitudes and skill, as well as provide insights into how they will deliver the intervention. This will allow researchers to ensure that trainees deliver a high-quality intervention. Furthermore, fidelity to the intervention can also be ensured through ongoing supervision and additional training to maintain their knowledge and skills. Finally, it is important to consider methods of retaining the trainees and keeping them motivated to continue delivering psychological interventions.

11.5. Preferred items for reporting training and supervision of non-traditional providers (PRIMROSE)

Evidence from the systematic reviews and the wider literature have identified several methodological limitations and inconsistencies in reporting training methods in published studies involving NTP-delivered interventions for mental health (Barnett et al., 2018a; Barnett et al., 2018b; Kohrt et al., 2018; Singla et al., 2017). Therefore, the author has developed a checklist (see Table 11.2) that can aid researchers in addressing this issue and fully document their training processes in publications. The development of this checklist was guided by the gaps in information encountered during the data extraction phase of the systematic reviews, as well as taking into consideration the training processes that most commonly occur in task-shifting identified through the systematic review, the qualitative study and the existing literature.

The main motivation for the development of this checklist is to enable researchers to improve the transparency of their research and improve the quality of the documentation of their training within publications, subsequently filling the gaps in the literature and building on the evidence base for effective training for NTPs tasked with psychological interventions. This may lead to the eventual development of high-quality training programmes for NTPs, which may ultimately result in them delivering high-quality interventions for individuals with CMDs. The Enhancing Quality and Transparency of Health Research Network is an initiative that aims to improve the quality of research. It provides an extensive list of reporting guidelines to help authors with reporting their research (Simera et al., 2010). Many journals now require the inclusion of completed guideline checklists as part of their submission progress. For example, almost 200 journals and systematic review organisations have endorsed PRISMA which requires a completed PRISMA checklist and flow diagram as a condition of submission when reporting findings from a systematic review (Page et al., 2021). Compliance with these guidelines demonstrated by a completed checklist provides the editorial offices of journals with an indicator of the thoroughness of the author's submission. Furthermore, it makes the work of reviewers and editors easier when they are assessing submissions, as the use of guidelines provides a consistent and readily recognisable structure (McRae, 2015).

There are, however, some challenges to using this checklist. The number of reporting items may lead to researcher burden, particularly as providing information on each individual item on this checklist may be time-consuming. Furthermore, limitations on word count by journals may hinder full presentation of the information within the main body of the publication, particularly when procedures and outcomes will take priority. Therefore, it is recommended that the information can be submitted within the online appendix or as supplementary material, with the main pertinent points in the main text of the paper.

Table 11.2. Preferred items for reporting training and supervision of non-traditional providers (PRIMROSE)

#	Section/topic	Checklist item	Reported Yes/No
1.0	**TRAINING DEVELOPMENT**		
1.1	Training development	State the process for developing training including, as applicable: theory, background evidence, changes made with explanations	
1.2	Development team	Provide details on the individuals involved in the development of the training (e.g., qualifications, experience)	
2.0	**NON-TRADITIONAL PROVIDERS**		
2.1	Recruitment	State how NTPs were recruited (e.g., advertisements, referrals)	
2.2	Selection	State the process for selecting NTPs (e.g., interviews, written assessments)	
2.3	Selection criteria	Specify NTP characteristics (e.g., education, relevant experience, age, gender) used as a criteria for eligibility	
2.4	Sample size	State the number of NTPs who were trained	
2.5	Education	Provide details on the qualification and job role of the NTPs	
2.6	Age	State the age range of the NTPs	
2.7	Gender	State the gender of the NTPs	
2.8	Incentives	If applicable, provide details on incentives provided to attend training	
2.9	Pre-training evaluation	If applicable, state how pre-training evaluation was conducted, including the use of validated instruments	
3.0	**TRAINING**		
3.1	Duration	State the duration of the training (e.g., hours, days)	
3.2	Venue	Provide details on the training venue (e.g., location, NTP's workplace)	
3.3	Methods	Provide details on the methods used in training (e.g., lectures, role-plays, discussions, exercises, activities)	
3.4	Content	Provide details on the content of the training and, if available, the structure of the training programme	
3.5	Resources	Provide details on the resources used during training (e.g., presentation slides, flipcharts, video/DVD)	

Table 11.2. Preferred items for reporting training and supervision of non-traditional providers (PRIMROSE)

#	Section/topic	Checklist item	Reported Yes/No
3.6	Materials	Provide details on the materials given to the NTPs (e.g., slide handouts, manuals)	
3.7	Post-training evaluation	If applicable, state how post-training evaluation was conducted, including the use of validated instruments	
3.8	Competency assessment	If applicable, state how competency assessments were conducted	
4.0	**TRAINING PROVIDER/FACILITATOR**		
4.1	Number	State the number of trainers who delivered training	
4.2	Selection	If applicable, state the process for selecting trainers	
4.3	Qualification	State the qualification, experience and/or job role of the trainer	
4.4	Training	If applicable, provide details on the process for training the trainers	
5.0	**INTERVENTION**		
5.1	Number	State how many NTPs delivered the intervention	
5.2	Incentives	If applicable, provide details on incentives provided to the NTPs during intervention delivery	
5.3	Barriers	If available, provide details on any challenges encountered by the NTPs during intervention delivery	
5.4	Emergency planning	Provide details of procedures put in place if NTPs identifies risk	
6.0	**SUPERVISION**		
6.1	Frequency	State the frequency of the supervision (e.g., weekly, monthly)	
6.2	Format	State the format of the supervision (e.g., group, individual, face-to-face, via technology)	
6.3	Content	Provide details on the content discussed during supervision	
6.4	Supervisor	Provide details on who provided the supervision and, if applicable, the process for training the supervisors	

Table 11.2. Preferred items for reporting training and supervision of non-traditional providers (PRIMROSE)			
#	**Section/topic**	**Checklist item**	**Reported Yes/No**
6.5	Trainer supervision	If applicable, provide details on the supervision of the trainers/supervisors	
6.6	Fidelity	If applicable, provide details on methods for checking fidelity to the intervention	
6.7	Additional training	If applicable, provide details on any additional training provided to the NTPs	

11.6. Strengths and limitations of the study

Strengths and limitations of the systematic reviews have been presented in their own chapter. This section will focus on the strengths and limitations of the overall thesis and the qualitative study conducted for this PhD.

11.6.1. Strengths

This thesis has a number of strengths. All the studies presented in this thesis share similar aims and address the research questions. The systematic reviews explored the training and supervision of the NTPs in a number of studies that have used a task-shifting approach to deliver psychological treatments for CMDs. Including studies in both HICs and LMICs allowed the ability to explore research in a range of contexts and settings, which identified areas where research is lacking as well as provided the opportunity to learn lessons from areas where a vast amount of research has been conducted. Furthermore, conducting a qualitative review allowed for the exploration of NTPs' experiences in training and intervention delivery, which provided insights into barriers and facilitators and also encouraged the generation of ideas on methods of conducting our own qualitative study.

The qualitative study applied robust, qualitative research methodology. The use of semi-structured interviews to explore the research questions facilitated the acquisition of in-depth understanding of the essential training components for NTPs. Furthermore, the author's ability to speak both Urdu and English and her familiarity with both Pakistani and English culture allowed for flexibility and ease in communication with participants in both countries, which facilitated communication and in-depth understanding.

Interviewing both NTPs and experts from a range of different backgrounds allowed the opportunity to gain different perspectives on training and supervision, in which participants drew upon their own experiences and, in the experts' case, their theoretical knowledge about the essential components of training. Furthermore, conducting interviews in both an LMIC and an HIC allowed for the differences and similarities in training and supervision to be explored. Moreover, it allowed the opportunity to gain understanding into how individuals from LMIC residing in the UK may be effectively trained to deliver psychological interventions. Despite the sample being relatively small, the use of open-ended questions allowed for the generation of data which was rich enough to cover a wide range of perspectives (Ogden & Cornwell, 2010).

The use of framework analysis to manage the data helped to ensure rigour and allowed for a systematic, transparent and robust analysis of the data. The charting stage, in which the data was reduced by summarising sections of the interview into initial themes organised by case, enabled the supervisory team to engage with the data during the analysis process. Moreover, this method of analysis facilitates across- and within-case analysis to aid interpretation of the data, which

includes identifying deviant cases or contradictions within cases and empty cells (Gale et al., 2013).

Although scientific research needs to be handled objectively, the subjective nature of qualitative research makes it difficult for the researcher to separate themselves from the data, therefore making it difficult to maintain objectivity. However, a number of steps can be taken to maintain objectivity and avoid bias including; using multiple people to code the data, having participants review the results, verifying with more data sources, checking for alternative explanations and reviewing findings with peers ("Avoiding bias in qualitative data analysis", 2020). Within this thesis, the author maintained her objectivity by having a multidisciplinary supervisory team consisting of a psychiatrist and a psychologist which allowed for diverse perspectives, particularly during the process of data analysis (Madill et al., 2000). Furthermore, interpretations were supported by findings from the reviews and also wider existing literature. However, it is important to consider the author's previous experiences of being a trainee on a number of postgraduate and researcher training programs that may have influenced personal perceptions about training. Nevertheless, incorporating reflexivity and rigour in data collection and analysis meant that whilst previous experiences may have influenced interpretation of the findings, the author was mindful to return to the data and check to ensure any interpretations were not unduly influenced. Furthermore, consulting the supervisory team through every process allowed for any influences to be minimised. However, objectivity could further be maintained by reviewing findings with experts and NTPs to identify gaps that may need to be addressed and to also provide affirmation that conclusions generated from the data are sound and reasonable.

11.6.2. Limitations

Due to the limited number of studies using a task-shifting approach to deliver psychological interventions within the UK, it was difficult to identify and recruit programmes within the UK. Although previous studies have used this method of delivery, the amount of time that has passed since these studies have ended meant that it was difficult to contact key stakeholders that were involved. Moreover, due to training being so long ago, it would have been difficult for NTPs and experts to recall their training experiences accurately. Consequently, although the initial selection criteria of the NTPs included individuals with no previous training in mental health, the selection criteria had to be widened to be able to recruit NTPs. Therefore, NTPs selected from the UK were all working within a health and well-being service, some of whom had degrees in psychology. However, with the exception of one participant, all the NTPs did not have an accreditation as a mental health professional. Due to the nature of their work within the health and well-being services, all the NTPs in the UK had some form of past experience in receiving training related to mental health, which may have influenced their experiences when receiving training. For these individuals training may have been easier due to their past knowledge of mental health, or harder,

due to any biases or pre-misconceptions they may have already had which they had to disregard. Furthermore, as evidence has shown that individuals with mental health training demonstrate more positive implicit and explicit evaluations of people with mental illness than those without training, when asked about their perceptions about individuals with mental illness, NTPs from the UK may have generated more positive responses (Peris et al., 2008).

In contrast, the majority of NTPs in Pakistan stated how it was their first time participating in training; therefore, it was difficult for them to evaluate the training they received due to the inability to compare with past trainings they may have received. Furthermore, their minimal education and lack of training experience meant that they were unable to identify their preferred style of learning and the effective components of training, making it difficult to draw conclusions about the necessary training methods required for training individuals from LMICs. Moreover, social desirability may have influenced the responses of the NTPs, leading them to respond in a manner they believed the author would expect (Lavrakas, 2008). However, to ensure that answers were as honest as possible, participants were assured that their responses would remain confidential and any information that could be used to identify them would be removed. Furthermore, the author encouraged the participants to be open and honest and took a non-judgemental stance throughout all the interviews. Moreover, to address any language barriers, and to provide familiarity to the NTPs, a trainer of the program was present for all interviews conducted with NTPs in Rawalpindi. This may have resulted in the NTPs painting a more positive picture of their experiences and particularly their positivity when questioned about their views on the trainer due to the trainer being present.

Furthermore, although a strength of this study was the author's ability to travel to a LMIC to conduct this research, it is important to consider that Pakistan does not represent all LMICs, and there will be variations among countries. For example, as previously mentioned in section 8.3.1., in Pakistan, psychiatric illnesses are greater in women than men with factors such as societal norms, attitudes and cultural practices contributing to the high prevalence (Mirza & Jenkins, 2004; Niaz, 2004). Furthermore, the prevalence rate of postpartum depression is among the highest in Asia (Gulamani et al., 2013). Therefore, a greater focus has been placed on developing programmes to address these issues which has led to training Lady Health Workers to deliver psychological interventions (Rahman et al., 2008). In contrast, HIV/AIDS is the leading cause of morbidity and mortality in sub-Saharan Africa (Institute for Health Metrics and Evaluation, 2017), with extensive evidence showing the occurrence of mental health disorders among people living with HIV (Myer et al., 2008). Therefore, initiatives have been developed to train lay individuals to deliver interventions to these HIV-infected individuals (Chibanda et al., 2011; Petersen et al., 2014). Consequently, there would be variation in training between the different countries depending on the target mental health condition and any underlying health conditions. Similar variations will also be present in other countries; therefore, this present study needs to be replicated in other LMICs to be able to fully explore the training and supervision within task-shifting in these countries.

Another limitation of this study was the small sample size that was used. This meant that it was difficult to fully reach saturation; moreover, it led to being unable to identify deviant cases. However, the concept of saturation is problematic, with Nelson (2017) stating that it can be difficult for qualitative researchers who use it as a means to determine sample size. Furthermore, Nelson (2017) suggests that the term 'saturation' is misleading, as it suggests a point beyond which it is not possible to gain additional information, which can lead to a false sense of completeness and an oversimplification of the data. Although it is considered as the gold standard for determining sample size (Morse, 2015), some researchers make the decision to continue sampling beyond saturation to gain a more in-depth understanding (Naegeli et al., 2013; Tutton et al., 2012). This suggests that there may be additional information that is of theoretical importance that cannot be captured by saturation (Saunders et al., 2018). However, samples in qualitative research tend to be small to allow for the in-depth case-orientated analysis that is crucial for this form of inquiry (Sandelowski, 1996). As previously discussed in section 7.4.1.7., a larger sample size can become difficult to manage in terms of the quality of the data and the analysis that would be conducted. Whereas, a smaller sample size can allow for rich data and enable the relevant characteristics to be studied. Furthermore, according to Morse (2000, p. 3) the 'number of participants required to reach saturation depends on a number of factors, including the quality of data, the scope of the study, the nature of the topic, the amount of useful information obtained from each participant, the number of interviews per participant, the use of shadowed data and the qualitative method and study design used'. Moreover, often studies that use a criterion of saturation also propose an a priori sample size at the same time (Niccolai et al., 2016), which may be due to the uncertainty that underlies saturation. Within this study, an a priori sample size was determined due to interviews being conducted abroad. Furthermore, a small sample size was a result of the limitations in the number of participants the author was able to recruit in Pakistan due to the time constraint and lack of resources available. Moreover, within the UK, although a number of NTPs were invited to take part in the study, the uptake to was low. A reason for this may have been that NTPs were LHWs and were not being paid for their work, or some of them may have moved on from their volunteering roles to paid work.

Although the author was mostly able to converse with participants from Pakistan in Urdu, the local language of the participants from Rawalpindi was Punjabi, and similarly, NTPs from Karachi were more familiar with speaking Sindhi. Although in Rawalpindi the language barrier was addressed by having a local trainer present during the interviews who would translate any time the NTP did not understand, with the interviews in Karachi, the author encountered a language barrier, and some questions were lost in translation. However, the author would often rephrase the question or simplify it to ensure understanding of the participants. Furthermore, cross-language research can often affect the trustworthiness of the data, particularly when inconsistent or inappropriate translators are used (Squires, 2009). Therefore, rather than translating whole transcripts into English, data was analysed in the original language, and only quotations that were deemed relevant to themes were translated so as to ensure trustworthiness.

Another limitation was in relation to the gender of the participants in Pakistan. All the NTPs and experts, with the exception of one, were female, which was a result of selecting exemplars that were concerned with maternal mental health conditions. This may have influenced their experiences with training and intervention delivery, particularly with regard to barriers that were encountered. Almost all the women expressed barriers relating to responsibilities at home and gaining permission from their families which may not necessarily be encountered by males. Furthermore, the inability to gain any male perspective from NTPs in Pakistan meant that barriers and facilitators which may have been specifically encountered by them were unexplored. To address this, future studies should have a balance of both male and female NTPs to ensure that all perspectives are explored.

Furthermore, training could have been maximised by exploring patient's views, to identify what they want from their therapist and what they perceive to be important factors contributing to an effective therapist. However, due to time constraints of a PhD study and a lack of resources, this was not viable. Moreover, the study included projects in which patients had completed the interventions and moved on; hence, they would have been difficult to contact. However, a future recommendation would be to investigate their views to ensure that the training delivered to the NTPs incorporates what patients feel makes an effective therapist. This can be carried out by Patient and Public Involvement, where members of the public are actively involved in the development of training for the NTPs. This may be deemed useful as people with lived experiences can contribute additional expertise and give valuable, novel insights. Additionally, patient and public involvement is encouraged on the basis that people affected by a condition, have a right to say in decisions about research that may affect them (Bagley et al., 2016).

Due to logistical challenges and limited time in Pakistan, interviews with participants were conducted back-to-back, with three interviews being conducted every day. This led to exhaustion for the author, which may have caused the inability to absorb key information and potentially miss opportunities for further inquiry. Moreover, whilst for qualitative research, it is recommended that data collection and analysis happen simultaneously and iteratively and that constant comparison of new data with the previously collected data take place throughout (Glaser & Strauss, 2017); this was not possible due to the consecutive nature of the interviews in Pakistan. However, the issue of consecutive interviews was addressed by writing field notes after the interview had ended to ensure that all the author's emerging thoughts during the interview were recorded and that any information from participant's interviews were not mixed.

The gathering and processing of qualitative research data brings important safety considerations for researchers. The data collection process often requires researchers to meet participants face to face and discuss personal aspects of their lives and may also require them to work alone (Given, 2008). Within this study, the author's safety was of important consideration, particularly when

conducting interviews in rural areas of Pakistan. This was ensured by liaising with the research centres in both cities, who were able to arrange transportation and accommodation. Moreover, the author was unable to travel to Gadap town to conduct interviews with the lady health workers in Karachi due to safety concerns over the rough area. Instead, the Pakistan Institute for Living and Learning arranged transportation for the participants to allow the author to interview them at the research centre. Furthermore, when travelling into the field in Rawalpindi to conduct interviews, the author was accompanied by a field co-ordinator who introduced the author to the participants and also acted as a translator. To ensure researcher safety when conducting interviews within the UK, the author arranged interviews to take place at the participant's place of work and in a public setting. However, when this was not possible the interviews were conducted over Skype or telephone.

Research on ethical risks to qualitative researchers describes the emotional nature of qualitative research that deals with sensitive, personal and private topics. Cowles (1988) suggests that for researchers engaged in relational fieldwork with participants, observing emotional, personal and distressing responses can be emotionally difficult and can lead to a range of physical consequences such as guilt, anxiety, exhaustion and burnout (Dickson-Swift et al., 2009). However, as the research topic being studied was not of a sensitive nature it was not anticipated that the participant or the researcher would experience emotional harm. Nevertheless, it was anticipated that there may be disclosure of unethical practice which was addressed by clearly stating on the participation information sheets that any risk to themselves or others disclosed during the interview will be reported to their managing body or supervisor.

A few key learning points can be identified from the author's experience conducting research both in the UK and abroad. Firstly, wherever possible, interviews should be conducted with sufficient time in between. This will allow data analysis to occur simultaneously and iteratively, and will also reduce exhaustion for the interviewer which may occur with back-to-back interviews. Secondly, keeping a diary or writing field notes during all stages of the research process is useful for the researcher to reflect upon different aspects of conducting the research. Thirdly, any concerns regarding safety should be anticipated and addressed prior to travelling to the research site. One method may be by approaching the research centre or the collaborating organisation who may assist in organising accommodation and transportation. Lastly, when dealing with topics of a sensitive nature, emotional harm towards both the participant and the researcher should be anticipated and addressed. For example, if the participant shows signs of emotional distress, the researcher should be able to signpost the participate to or alert the appropriate individual or organisation. Similarly, if the researcher experiences emotional exhaustion they should have formal supervision where they can discuss issues that they may be having.

11.7. Implications of this research

Although there is significant research on task-shifting the delivery of psychological interventions for CMDs, little is known about the essential training components required for training NTPs to deliver these interventions successfully due to inadequate training descriptions and a lack of research that identifies effective training components for non-professionals. The systematic reviews identified poor quality documentation of the training and supervision provided to the NTPs, making it difficult to make conclusions about effective strategies for training these individuals. Therefore, the development of a checklist (Table 11.2) for reporting training and supervision of NTPs can guide authors during the writing stage of their research to ensure that all training is documented and hence improve the quality of their studies. Furthermore, it will allow for fellow researchers to be able to learn from their training processes and replicate their studies, ultimately advancing the science of NTP training.

Additionally, the systematic reviews and in-depth interviews with NTPs and experts provided a detailed investigation of the importance of various training components. Consequently, a wide range of essential training components has been recommended for training NTPs to deliver psychological interventions (Table 11.1). This can be used by researchers when designing their own training programmes for NTPs to improve the quality of their training and ensure its maximum impact. Providing effective training to NTPs is particularly important, as they will ultimately go on to deliver psychological interventions to individuals with mental disorders. Therefore, it is imperative that these NTPs be provided with high-quality training to maximise their chances of delivering high-quality interventions. However, it could be argued that the recommended training components are general, lacking depth and clarification, and not linked to data showing greater outcomes. Therefore, further studies need to be carried out which clearly demonstrate how these components can lead to better outcomes in knowledge and practice post-training. This can be done by carrying out post-training evaluations to assess the effectiveness of the training, discussed in greater detail in section 11.8.

Moreover, this thesis highlights the differences and similarities between training and supervision in the UK and Pakistan. The recommended training components collate evidence from both HIC and LMIC settings and therefore have the potential to be of benefit in a number of different countries. A lack of research has been conducted on the use of NTPs from LMICs residing in HICs, and consequently, little is known about effective strategies to train them. Therefore, the findings from this research add to the database of evidence on the training and supervision of NTPs in LMICs as well as provide insights into effective strategies for training them in HICs. Furthermore, this may offer a potential solution to the barriers in accessing mental health services for ethnic minorities as previously highlighted in section 1.6.2.

11.8. Recommendations for future research

The current study was conducted using individuals with no mental health experience in Pakistan and those with previous mental health experience in the UK. Therefore, to be able to conduct a true comparison of similarities and differences, future research needs to recruit individuals with similar levels of education and experience from both settings. Furthermore, whilst this study was conducted in only two countries, future research should be broadened to include individuals from different countries. Variations in cultures, GDP and geography can allow for the ability to explore the differences of training NTPs in different contexts and cultures.

Furthermore, wider literature on task-shifting has examined the experiences of NTPs delivering psychological interventions, with little evidence available on the experiences of trainers and supervisors involved in the process. Whilst this study explored the perspectives of a handful of experts, future research needs to be conducted examining the views of a number of expert stakeholders including training developers, trainers, supervisors and program managers. There is growing interest in the use of stakeholders within research. This is reflective of the increasing awareness that stakeholder engagement is important for public health research to ensure that it is relevant and allows for the identification of areas that are lacking, prioritising research and providing input into the acceptability of research methods (Laird et al., 2020). Investigating the views of stakeholders prior to the development of training may further add to the evidence on how to train NTPs to successfully deliver psychological interventions as perceived by experts.

Although this thesis offers qualitative insights into the perceived essential components for training NTPs, objective empirical evidence on the effectiveness of training components is also needed. Therefore, future trials on task-shifting psychological interventions using NTPs should also include an assessment of the effectiveness of their training programme to establish effective training components. This could be done by conducting pre- and post-training assessments of the trainee's knowledge, attitudes and practice to examine whether training has had an impact as was conducted in one of the included exemplars within this study. As previously described in section 11.3.1.3., another method of conducting evaluations is by using the Kirkpatrick model of education evaluation (Kirkpatrick, 1996), which was used by Madan et al. (2013) in their evaluation of mental health training for occupational practitioners. In this study, the first three levels of the model were assessed: 1) Satisfaction with the delivery of the workshops (reaction to training); 2) Confidence, knowledge and attitudes relating to screening for and diagnosing specific mental health conditions (Learning outcomes) and, 3) Increased confidence and reported use in clinical practice of the skills learnt in the workshops (changes in performance behaviour). Data was collected immediately prior to the workshop, immediately after the workshop and four months following the workshops, with the results showing an increase in confidence immediately post-training which was maintained after four months. Furthermore, case records or clinical notes can be collected for evaluation which can be compared to the status of the participant receiving the intervention as determined by diagnostic screening tools (Caulfield et al., 2019). Moreover, outcomes from the evaluation could

be compared to the patient mental health outcomes generated from the trials to explore whether there is a correlation between effective training delivered to the NTPs and their effectiveness in delivering the intervention. Garzonis et al. (2015) acknowledges that although a number of training methods have been used to develop skills of a variety of mental health professionals, patient outcomes are rarely used in evaluating the effectiveness of the different training methods, making it difficult to assess its true utility. Therefore, to understand the efficacy of training, it is important to consider both NTP and patient outcomes, especially since training may change knowledge, attitudes and practice in the NTP but have no benefit to the patients.

Future research also needs to be conducted on the applicability of the reporting checklist for documentation of training within research. Whilst the checklist was created from the common gaps in documentation identified from the systematic reviews, further research with experts that aims to develop a consensus is required. A Delphi study could be conducted to explore the views of experts on the perceived usability of the checklist. This method is a structured approach which uses a series of questionnaires and feedback to develop consensus among experts. It is a technique that is used by researchers when existing evidence is incomplete or lacking and other methods that provide knowledge cannot be used (Niederberger & Spranger, 2020). A Delphi study has recently been used by Orkin et al. (2021) to investigate task-shifting, in which 55 prospective panellists who were experts in knowledge synthesis were invited to take part in a series of questionnaires exploring the purpose of task-shifting and the characteristics of task-shifting programmes. Consensus, which was defined as at least 70% of the panel agreeing with an item, was reached after three Delphi rounds among 15 panellists (Orkin et al., 2021). This led to the development of a conceptual framework which offers a refined definition of task-shifting/sharing and provides a general-purpose statement to guide such programmes. Therefore, a similar approach could be used to reach consensus on the applicability of the PRIMROSE checklist.

Alternatively, adopting methods used in the development of previous research guidelines (Boutron et al., 2008), a consensus meeting could be carried out with a panel of experts to discuss items on the checklist and any modifications or additions that need to be made. The refined checklist could be used by researchers alongside CONSORT (Schulz et al., 2010) when reporting training in trials. Improving the quality of scientific research in this area should lead to the development of more effective training programmes for NTPs and consequently improve the delivery of psychological interventions.

Similarly, Moher et al. (2010) provided guidance for developers of health research reporting guidelines, proposing 18 steps which occur in five phases (see Box 11.1). Their strategy involves the use of an expert group to facilitate guideline development, as they acknowledge that the consensus process is a key characteristic of developing reporting guidelines. Therefore, the reporting checklist could be further refined by drawing from the steps of Moher et al. (2010).

Box 11.1 Recommended steps for developing a health research reporting guideline (Moher et al., 2010)

Step	Item Number	Detail
Initial Steps	1	Identify the need for a guideline
	2	Review the literature
	3	Obtain funding for the guideline initiative
Pre-meeting activities	4	Identify experts
	5	Conduct a Delphi study
	6	Generate a list of items for consideration at the face-to-face meeting
	7	Prepare for the face-to-face meeting
The face-to-face consensus meeting itself	8	Present and discuss results of pre-meeting activities and relevant evidence
Post-meeting activities	9	Develop the guidance statement
	10	Develop an explanatory document
	11	Develop a publication strategy
Post-publication activities	12	Seek and deal with feedback and criticism
	13	Encourage guideline endorsement
	14	Support adherence to the guideline
	15	Evaluate the impact of the reporting guideline
	16	Develop website
	17	Translate guideline
	18	Update guideline

11.9. Conclusions

- The high prevalence of CMDs and barriers to accessing treatment has led to psychological interventions being task-shifted by NTPs. For successful task-shifting to occur, the training and supervision provided to these individuals are of utmost importance.
- Little is known about the essential components needed to effectively train these NTPs. Although studies have explored the experiences of NTPs task-shifting these interventions, there is little evidence on their experiences in training. Furthermore, studies using a task-shifting approach often lack detail on their training processes. Moreover, even less is

known about how to effectively train individuals from a more deprived socioeconomic background in HICs.

- This study explored the evidence available on the training and supervision provided to NTPs task-shifting psychological interventions for CMDs in HICs and LMICs. Furthermore, it explored the experiences of NTPs and experts during training and intervention delivery in both resource-rich and resource-poor settings.
- The qualitative research conducted in this thesis led to recommendations of essential training components for NTPs. Factors such as pre-training planning, training delivery and post-training planning are important to consider throughout the training process. These training recommendations can be used by researchers when developing training for NTPs in both HICs and LMICs.
- Improper documentation of training led to the development of a reporting checklist, which can be used by researchers to improve the quality of reporting training within their studies. This will further add to the evidence of effective training for NTPs.
- Improving the quality of NTP training should increase the quality of the interventions they deliver, leading to improved mental health outcomes. Future research should build on the current findings to develop the science of training in task-shifting.

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Appendices

Appendix 1. Systematic Review Search Strategy (example from OVID Medline)

1. Allied Health Personnel/

2. Community Health Aides/

3. Nurses Aides/

4. Psychiatric Aides/

5. Caregivers/

6. Voluntary Workers/

7. Community Networks/

8. Social Support/

9. Health Manpower/

10. "Personnel Staffing and Scheduling"/

11. (lay adj3 (worker? or visitor? or attendant? or aide or aides or support* or person* or helper? or carer? or caregiver? or care giver? or consultant? or advisor? or counselor? or counsellor? or assistant? or staff)).tw.

12. ((voluntary or volunteer?) adj3 (worker? or visitor? or attendant? or aide or aides or support* or person* or helper? or carer? or caregiver? or care giver? or consultant? or advisor? or counselor? or counsellor? or assistant? or staff)).tw.

13. (untrained adj3 (worker? or visitor? or attendant? or aide or aides or support* or person* or helper? or carer? or caregiver? or care giver? or consultant? or advisor? or counselor? or counsellor? or assistant? or staff or nurse? or doctor? or physician? or therapist?)).tw.

14. (trained adj3 (worker? or visitor? or attendant? or aide or aides or support* or person* or helper? or carer? or caregiver? or care giver? or consultant? or advisor? or counselor? or counsellor? or assistant? or staffor nurse? or doctor? or physician? or therapist?)).tw.

15. (unlicensed adj3 (worker? or visitor? or attendant? or aide or aides or support* or person* or helper? or carer? or caregiver? or care giver? or consultant? or advisor? or counselor? or counsellor? or assistant? or staffor nurse? or doctor? or physician? or therapist?)).tw.

16. ((nonprofessional? or non professional?) adj3 (worker? or visitor? or attendant? or aide or aides or support* or person* or helper? or carer? or caregiver? or care giver? or consultant? or advisor? or counselor? or counsellor? or assistant? or staff)).tw.

17. ((non medical or non health or non healthcare or non health care) adj3 (worker? or visitor? or attendant? or aide or aides or support* or person* or helper? or carer? or caregiver? or care giver? or consultant? or advisor? or counselor? or counsellor? or assistant? or staff)).tw.

18. (community adj3 (worker? or visitor? or attendant? or aide or aides or support* or person* or helper? or carer? or caregiver? or care giver? or consultant? or advisor? or counselor? or counsellor? or assistant? or staff)).tw.

19. (paraprofessional? or paramedic or paramedics or paramedical worker? or paramedical personnel or allied health personnel or allied health worker? or support worker? or non specialist?

or specially trained or barefoot doctor? or nurse* aide? or psychiatric aide? or psychiatric attendant? or social worker? or teacher? or school staff or trainer?).tw.

20. (health* adj3 (auxiliary or auxiliaries)).tw.

21. (nurs* adj1 (auxiliary or auxiliaries)).tw.

22. (informal adj (caregiver? or care giver? or carer?)).tw.

23. support group?.tw.

24. ((social or psychosocial) adj (care or support)).tw.

25. (village adj3 worker?).tw.

26. community based.tw.

27. (community adj3 intervention?).tw.

28. community network?.tw.

29. ((health or health care or healthcare) adj manpower).tw.

30. human resources.tw.

31. (task? adj3 shift*).tw.

32. (staff* adj3 chang*).tw.

33. ((common mental or depression or anxiety) adj3 disorder*).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, ui, sy]

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49. 33 and 48

50. adult/

51. 49 and 50

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Appendix 2. Data Extraction Form and Key

Paper No.	
Paper	
Authors	
Year published	
Journal	
Place of Publication	
Location of study	
Study design	
Setting (e.g. community, clinic, academic, hospital)	
Funding	
Sample characteristics	
Total no. of participants	
Age	
Gender (Male, Female)	
Education	
Socio economic	
Marital status (single, divorced, married)	
Mental Health Condition	
Non-traditional provider	
Who was the NTP (e.g. peer, volunteer)?	
Total no. of NTP	
How were NTP selected?	
Previous qualification of NTP	
Who delivered training?	
Training course development details	
Duration of training	
Format of training	
Content of training	
Evaluation of training	
Any training problems?	
Who supervised delivery of intervention?	
How were supervisors selected?	
Supervision frequency	
Supervision format	
Supervision content	

Any supervisor problems?	
Cost	
Was a manual used or created?	
Is a manual available?	
How was quality controlled?	
Intervention	
Type of intervention	
Group or Individual	
Duration of intervention	
No. of sessions	
Duration of sessions	
Content of intervention	
Problems in delivering intervention	
Control Group	
Total no. in control group	
Mental health outcomes	
How were MH outcomes reported?	

Data Extraction Key

Paper no. – The number that was given to the paper.

Paper – The title of the paper.

Authors – The name of the authors that contributed to the paper.

Year published – The year that the paper was published.

Journal – The name of the journal in which the paper was published.

Place of publication – The country of the journal in which the paper was published.

Location of study – The country in which the study was carried out.

Study design – What was the design of the study (i.e. cluster randomised controlled trial, individual randomised controlled trial, before and after evaluation)

Setting – The type of setting in which the study took place (i.e. community, primary care, secondary care, hospital setting, clinical or setting).

Funding – How the study was funded and the name of the organisation that funded the study.

Total no. of participants – The total number of participants that took part in the study and received the intervention.

Age – The mean age and age range of the participants that took part in the study.

Gender – The gender of the participants that took part in the study and the percentage of each gender (male or female)

Education – The highest level of education of the participants taking part in the study. How was literacy recorded?

Socioeconomic status – The socioeconomic background of the participants taking part in the study.

Marital status – The marital status of the participants taking part in the study (i.e. single, married or divorced, widowed).

Mental health condition – The mental health condition that the study is investigating.

Who was the NTP? – Who were the non-traditional providers that delivered the intervention (i.e. peers or volunteers).

Total no. of NTP – The total number of non-traditional providers that delivered the intervention.

How were NTP selected? –What was the procedure for selecting the non-traditional providers (i.e. advert, snowballing, government).

Previous qualifications of NTP – The highest level of education or training received by the non-traditional provider prior to the study.

Who delivered training – Who trained the non-traditional providers prior to them delivering the intervention.

Training course development details – How was the training developed and who developed the training?

Duration of training – How long were the non-traditional providers trained for (i.e. weeks or months) and how often and how many training sessions did the non-traditional providers have? Also, how long was each training session?

Format of training – Were the training sessions delivered in a group or on a one-to-one basis? How was the training delivered and where was it delivered?

Content of training – What content was included in the training sessions.

Evaluation of training – How was the training evaluated and who evaluated it? How was competency of NTPs assessed?

Any training problems? – Were there any problems in training the non-traditional providers and how were they resolved?

Who supervised delivery of intervention? – Who supervised the non-traditional providers as they delivered the intervention?

How were supervisors selected? – On what basis were the supervisors selected to overlook the intervention being delivered by the non-traditional providers.

Supervision frequency – How often were NTPs supervised?

Supervision format – Was the supervision in a group or on a one-to-one basis? What methods were used for supervision?

Supervision content – What was discussed in supervision sessions?

Any supervisor problems? – Were there any problems with the supervision and how were they resolved?

Cost – What was the cost of the training? What was the cost of the therapy?

Was a manual used or created for training? – Was a manual used or created to train the non-traditional providers in delivering the intervention? What other training materials were used?

Is a manual available? – Is the manual used to train the non-traditional provider available online or from the authors?

How was the quality controlled? - How did the authors control the quality of the intervention that was delivered by the non-traditional provider?

Type of intervention – What was the intervention that was delivered by the non-traditional provider? (i.e. CBT, psychosocial, IPT).

Group or individual – Was the intervention delivered in a group or on a one-to-one basis?

Duration of intervention- The total spread of time the intervention was delivered for.

No. of sessions – The total number of sessions that was delivered by the non-traditional provider.

The duration of sessions – The length of time of each intervention session.

Content of intervention – What content was included in the intervention? What did the intervention involve?

Problems in delivering intervention – Were there any problems that the non-traditional provider faced in delivering the intervention and how were they resolved?

Control group – Who were the control group? What was the intervention for the control group?

Total no. in control group – The total number of participants in the control group.

Mental health outcomes – What were the mental health outcomes that the study was investigating?

How were the MH outcomes reported? – How were the mental health outcomes reported (i.e. what assessment criteria was used? Was it qualitative or quantitative?)

Appendix 3. Ten-point Methodological Assessment Scale of Training Reported in HIC studies

Author (year)	*Training sample*			*Training*					*Supervision*		
	Number of trainees given?	Sufficient detail on selection of training sample given?	Education of trainees given?	Sufficient detail on training methods given?	Sufficient detail on content of training given?	Sufficient detail on trainer given?	Is the training evaluated?	Was supervision conducted?	Sufficient detail on supervision given?	Was the fidelity of the intervention checked?	Total score
Armstrong (2010)	1	1	0	1	1	1	1	1	0	1	8
Bright et al. (1999)	1	1	0	1	1	0	0	1	1	1	7
Buck (2015)*	1	1	1	1	1	1	1	N/A	N/A	N/A	7
Burnett-Zeigler et al. (2019)	1	1	0	0	1	1	0	1	0	0	5
Dobkin et al. (2007)	1	1	0	1	1	1	0	1	0	0	6
Hovey et al. (2014)	1	0	0	0	1	1	0	1	0	0	4
Livingston et al. (2014)	1	0	1	1	1	0	0	1	1	1	7
Markle-Reid et al. (2014)	1	0	0	0	0	0	0	1	1	1	4
Mastel-Smith et al. (2006)	1	1	0	0	1	0	0	0	0	0	3
Miyawaki et al. (2020)	1	1	1	1	1	0	0	1	0	1	7

Author (year)	*Training sample*			*Training*					*Supervision*		
	Number of trainees given?	Sufficient detail on selection of training sample given?	Education of trainees given?	Sufficient detail on training methods given?	Sufficient detail on content of training given?	Sufficient detail on trainer given?	Is the training evaluated?	Was supervision conducted?	Sufficient detail on supervision given?	Was the fidelity of the intervention checked?	Total score
Pratt et al. (2017)	1	1	0	0	0	0	0	1	0	0	3
Prosman et al. (2014)	1	1	1	1	1	0	0	1	0	1	7
Quijanao et al. (2007)	1	1	0	1	0	1	1	1	0	1	7
Roman et al. (2009)	0	1	1	0	1	0	0	1	0	0	4
Somer et al. (2005)	1	1	0	0	1	0	0	0	0	1	4
Stanley et al. (2014)	1	1	1	1	1	1	0	1	0	1	8
Tran et al. (2014)	1	1	1	0	1	1	1	1	1	0	8
Wong et al. (2020)*	1	1	1	1	1	1	1	N/A	N/A	N/A	7
Total	17	15	8	10	15	9	5	14	4	9	7[†]

* The study was aimed at delivering a training programme to NTPs and therefore no intervention was delivered.

One point was given for each of the criteria a study satisfied. 0 = no criteria met. [†]Median of total scores = 7

Appendix 4. Characteristics of Included Studies in HICs (n=18)

Author (year)	Location	Design	Intervention sample	Mental health condition	NTP	Intervention
Armstrong (2010)	UK	Pre-post	Clients referred to a voluntary sector counselling agency (n= 118)	Psychological distress	Paraprofessional counsellors	Counselling
Bright et al. (1999)	USA	Pre-post	Depressed patients at a community mental health centre (n= 98)	Depression	Paraprofessional therapists	CBT, MSG
Buck (2015)	USA	Pre-post	N/A	Depression	Community leaders	CBT
Burnett-Zeigler et al. (2019)	USA	Pre-post	African American women at a Federally Qualified Health Centre (n= 41)	Depression	Health educator	MBSR group intervention
Dobkin et al. (2007)	USA	Pre-post	Adults in the community (n = 10)	Depression	Partners	Individual CBT, Adaptive inferential feedback
Hovey et al. (2014)	USA	Pre-post	Female migrant farmworkers of Mexican descent (n = 6)	Depression and stress	Promotora	Cognitive behavioural support group
Livingston et al. (2014)	UK	RCT	Adults with dementia (n = 87)	Anxiety and depression	Psychology graduates	Coping intervention
Markle-Reid et al. (2014)	Canada	Pre-post	Older home care clients (n = 142)	Depression	Home care providers	Evidence-based depression care management strategy
Mastel-Smith et al. (2006)	USA	Quasi-experimental study	Home dwelling older women (n = 14)	Depression	Home care worker	Therapeutic Reminiscence and Life Review Therapy
Miyawaki et al. (2020)	USA	Pre-post	Adults with dementia (n = 19)	Depression	Caregiver	Life Review Therapy
Pratt et al. (2017)	USA	Pre-post	Somali immigrant women (n = 55)	Anxiety	CHWs	CBT
Prosman et al. (2014)	Netherlands	Pre-post	Women exposed to IPV (n = 43)	Depression	Mentor mothers	Mentor Mothers for Support and Advice

Author (year)	Location	Design	Intervention sample	Mental health condition	NTP	Intervention
Quijanao et al. (2007)	USA	Pre-post	Older adults (n = 94)	Depression	Case managers	Healthy IDEAS
Roman et al. (2009)	USA	RCT	Pregnant women (n = 266)	Perinatal depression	CHWs	Behavioural Activation and education
Somer et al. (2005)	Israel	Quasi-experimental controlled pilot study	Mental health emergency hotline callers (n = 17)	Anxiety	Hotline volunteers Paraprofessionals	Cognitive behavioural phone intervention
Stanley et al. (2014)	USA	RCT	Older adults (n = 74)	Anxiety	Bachelor lay providers	CBT
Tran et al. (2014)	USA	Pre-post	Latina Immigrants (n=32)	Depression and stress	Promotoras	ALMA intervention
Wong et al. (2020)	Singapore	Pre-post	N/A	Depression	Foreign domestic workers	CBT

RCT, Randomised controlled trial; IPV, Intimate partner violence; CHWs, Community Health Workers; CBT, Cognitive Behavioural Therapy; MSG, Mutual Support Group; MBSR, Mindfulness Based Stress Reduction; IDEAS, Identifying Depression, Empowering Activities for Seniors; ALMA, Amigas Latinas Motivando el Alma/Latina Friends Motivating the Soul

Appendix 5. Characteristics of Psychological Interventions Delivered by NTPs in HICs

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Armstrong (2010)	Counselling	6-12, brief counselling sessions	Clinical outcome	48% significant improvement	Paraprofessionals in this study were less effective than their professional counterparts
Bright et al. (1999)	CBT, MSG	CBT - active and directive therapy, involving identifying, disputing, and correcting distorted thinking and dysfunctional beliefs. MSG - focused on specific goals, including interpersonal insight, the acquisition of disclosure skills, and sharing of feedback and advice.	Clinical outcome	Significant improvement	Non-professionals were as effective as professionals in reducing depressive symptoms
Buck (2015) *	CBT	N/A	Knowledge, Attitudes	Significant improvement	Training led to greater improvement in depression knowledge and a greater decrease in stigma.
Burnett-Zeigler et al. (2019)	MBSR group intervention	8-week intervention involving simple awareness, attention and perception, noticing thoughts, stress triggers and physiologic responses, responding versus reacting, mindful communication, self-compassion, and developing a personal mindfulness practice.	Clinical outcome	Significant improvement	Change in depressive symptoms, stress, functioning, and well-being was significantly greater in the novice instructor group than the experienced instructor group.
Dobkin et al. (2007)	Individual CBT, Adaptive inferential feedback	10-14, weekly sessions. standard CBT components such as self-monitoring, activity scheduling, relaxation training, identifying cognitive distortions, and cognitive restructuring.	Clinical outcome	Significant improvement	Partner training, as one component of a larger cognitive-behavioural treatment package, was an easy to implement, well-tolerated intervention that may enhance the treatment of depression.

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Hovey et al. (2014)	Cognitive behavioural support group	6, weekly sessions on (1) understanding and coping against stress, anxiety and depression; (2) increasing hopefulness and self-esteem; (3) empowering group members to better individuate, assert themselves, and succeed in society; (4) family issues related to nurturance and childrearing, discipline, family functioning and communication; (5) understanding and recovering from domestic violence and other traumatic experiences	Clinical outcome	Significant improvement	The use of a promotora as a group leader appeared key to the success of the group was especially helpful in decreasing stigma and promoting trust
Livingston et al. (2014)	Coping intervention	8, weekly sessions on (1) psychoeducation about dementia and carer stress; (2–5) discussion of difficult carer situations, incorporating behavioural management techniques; identifying and changing unhelpful thoughts; assertive and effective communication with people with dementia and promoting emotion-focused coping strategies; (6) future needs of the patient, with information about care and legal planning; (7) planning pleasant activities; (8) maintaining the skills learned over time	Clinical outcome	Significant improvement	The intervention was clinically effective and the high-fidelity ratings suggests that the intervention can be delivered consistently

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Markle-Reid et al. (2014)	Evidence-based depression care management strategy	6, monthly visits involving (1) screening for depressive symptoms; (2) assessing modification of depressive symptoms; (3) reviewing medication and supporting antidepressant medication management; (4) psycho-education on depression; (5) providing PST; (6) providing social and behavioural activation; (7) providing intensive support to client and their family caregiver; (8) integrating depression care with ongoing care for other chronic conditions	Clinical outcome	Significant improvement	The findings provide evidence for the feasibility, acceptability, and sustained effects of the nurse-led mental health promotion intervention in improving client outcomes
Mastel-Smith et al. (2006)	Therapeutic Reminiscence and Life Review Therapy	6, weekly sessions, two visits focus on childhood, family, and home; two visits ask the participant to tell stories about adolescence and adulthood; and two visits concentrate on summarizing one's life.	Clinical outcome	Significant improvement	Home care workers can deliver a community-based psychosocial intervention that decreases depression in their home-dwelling clients.
Miyawaki et al. (2020)	Life Review Therapy	6, weekly sessions involving reviewing the older adults' life events, recalling and revaluating earlier events and their implications regarding how they feel about their life.	Clinical outcome	No significant improvement	The feasibility of the intervention is high and promising among dyads of caregivers and care recipients with mild to moderate dementia.
Pratt et al. (2017)	CBT	8, weekly sessions, focused on building skills for positive mental wellbeing in the context of facing a wide range of stressors faced in life	Clinical outcome, Satisfaction	Significant improvement	Intervention led to significant improvements in mood. Intervention was well received, particularly because it was delivered by a fellow community member

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Prosman et al. (2014)	Mentor Mothers for Support and Advice	16, weekly sessions on (1) dealing with IPV; (2) coping with depressive symptoms using CBT; (3) strengthening social network; (4) accepting professional mental health assistance and parenting support	Clinical outcome	Significant improvement	An intervention by trained mentor mothers is promising method to decrease exposure to IPV and symptoms of depression.
Quijanao et al. (2007)	Healthy IDEAS	6-month intervention involving screening and assessment of depression, education, referral and linkage and BA	Clinical outcome	Significant improvement	NTPs can be trained to successfully implement a self-management intervention for depression with frail, high-risk older adults
Roman et al. (2009)	BA and education	Weekly or fortnightly sessions for 6 months involving (1) relationship-based support; (2) increasing self-esteem through positive regard; (3) promoting positive health behaviours; (4) developing self-awareness of stressors, it's causes and active problem solving; (5) increasing self-determination through the development of personal life goals; (6) using community resources.	Clinical outcome	Significant improvement	Nurse-CHW team resulted in significantly fewer depressive symptoms, which were most pronounced for women with low psychosocial resources, high stress, or both.
Somer et al. (2005)	Cognitive behavioural phone intervention	One phone call in which callers were taught deep and slow diaphragmatic breathing to reduce stress and help them cope. CBT intervention involving specific instructions related to modified cognitive-restructuring and psychoeducation.	Clinical outcome	Significant improvement	Brief CBT provided by paraprofessionals via the phone can assist people with worry and associated functional impairment resulting from potential threat.

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Stanley et al. (2014)	CBT	10 sessions over 3 months on education, awareness training, motivational interviewing; deep breathing; coping self-statements, BA, exposure, sleep management, problem solving, progressive muscle relaxation, thought stopping and cognitive restructuring. Following sessions involved patients calling weekly for 4 weeks and then biweekly for 8 weeks.	Clinical outcome	Significant improvement	Lay providers, working under the supervision of licensed providers, can deliver effective CBT.
Tran et al. (2014)	ALMA intervention	Provided with mental health promotion resources, information and support on a regular basis to prevent and reducing negative mental health outcomes	Clinical outcome	Significant improvement	The intervention demonstrated the potential impact of a lay health educator model in improving depressive symptoms and stress for Latinas.
Wong et al. (2020) *	CBT	N/A	Knowledge, Satisfaction	Significant improvement	Training led to improved depression literacy, CBT knowledge, and attitudes towards seeking professional help. All participants indicated a high level of satisfaction with the training program.

* The study was aimed at delivering a training programme to NTPs and therefore no intervention was delivered or described. The outcomes detailed in this table are the outcomes of the trainees' that were measured and reported in the study.

BA, Behavioural Activation; IPV, Intimate partner violence; CHWs, Community Health Workers; CBT, Cognitive Behavioural Therapy; MSG, Mutual Support Group

Appendix 6. Ten-point Methodological Assessment Scale of Training Reported in LMIC Studies

		Training sample			Training				Supervision		
Author (year)	**Number of trainees given?**	**Sufficient detail on selection of training sample given?**	**Education of trainees given?**	**Sufficient detail on training methods given?**	**Sufficient detail on content of training given?**	**Sufficient detail on trainer given?**	**Is the training evaluated?**	**Was supervision conducted?**	**Sufficient detail on supervision given?**	**Was the fidelity of the intervention checked?**	**Total score**
Ali et al. 2003	1	1	0	0	1	1	0	1	0	0	5
Ali et al. 2010	1	1	0	0	1	1	0	1	1	0	6
Bass et al. 2012	0	1	0	0	1	1	0	1	0	0	4
Bolton et al. 2003	1	1	1	1	1	1	0	1	0	0	7
Bolton et al. 2014	1	1	1	0	0	1	0	1	1	1	7
Bryant et al. 2017	1	0	1	1	1	1	1	1	0	1	8
Chibanda et al. 2011	0	1	1	1	1	1	1	1	0	0	7
Chibanda et al. 2016	1	1	1	1	0	1	0	1	0	1	7
Dawson et al. 2016	1	0	1	0	1	1	1	1	0	1	7
Edelblute et al. 2014	1	1	0	0	1	0	0	1	1	0	5
Fuhr et al. 2019	1	1	1	1	1	1	1	1	1	1	10
Hirani et al. 2010	0	0	0	0	1	0	0	0	0	0	1

Author (year)	Training sample			Training					Supervision		Total score
	Number of trainees given?	Sufficient detail on selection of training sample given?	Education of trainees given?	Sufficient detail on training methods given?	Sufficient detail on content of training given?	Sufficient detail on trainer given?	Is the training evaluated?	Was supervision conducted?	Sufficient detail on supervision given?	Was the fidelity of the intervention checked?	
Joag et al. 2020	1	1	0	1	1	1	0	1	1	1	8
Jordans et al. 2019	1	0	1	1	1	1	1	1	0	1	8
Khan et al. 2017	1	0	1	0	1	1	1	1	1	1	8
Lund et al. 2019	1	1	1	0	0	1	1	1	1	1	8
Murphy et al. 2020	0	1	1	0	1	1	0	1	0	1	6
Musyimi et al. 2017	0	1	0	1	1	0	1	1	0	0	5
Myers et al. 2019	1	0	1	0	0	0	1	1	1	1	6
Patel et al. 2010	0	1	0	0	1	0	0	1	0	0	3
Patel et al. 2017	1	1	1	1	1	1	1	1	1	1	10
Petersen et al. 2014	1	0	1	0	1	1	0	1	0	0	5
Pokhrel et al. 2018	1	0	0	0	0	1	0	0	0	0	2
Rahman et al. 2008	1	0	1	0	0	1	0	1	1	0	5
Rahman et al. 2016	1	0	1	1	1	1	1	1	1	1	9
Rahman et al. 2019	1	0	1	1	1	1	0	1	1	1	8

Author (year)	Training sample			Training				Supervision			
	Number of trainees given?	Sufficient detail on selection of training sample given?	Education of trainees given?	Sufficient detail on training methods given?	Sufficient detail on content of training given?	Sufficient detail on trainer given?	Is the training evaluated?	Was supervision conducted?	Sufficient detail on supervision given?	Was the fidelity of the intervention checked?	Total score
Rotheram-Borus et al. 2015	1	1	0	1	1	0	0	1	1	0	6
Shidhaye et al. 2017	1	0	1	0	0	0	0	1	1	0	4
Sikander et al. 2019	1	1	1	1	1	1	1	1	1	1	10
Tripathy et al. 2010	0	1	0	0	0	0	0	1	0	0	2
Total	23	18	19	13	22	22	12	28	15	15	6.5*

One point was given for each of the criteria a study satisfied. 0 = no criteria met. *Median of total scores = 6

Appendix 7. Characteristics of Included Studies in LMICs (n=30)

Author (year)	Location	Income classification	Design	Intervention sample	Mental health condition	NTP	Intervention
Ali et al. 2003	Pakistan	L	RCT	Women in community-based settings (n = 70)	CMD	Counsellors	Counselling
Ali et al. 2010	Pakistan	LM	pre-post	Women during first 2.5 years after childbirth (n = 59)	Anxiety and depression	CHWs	Counselling
Bass et al. 2012	Indonesia	LM	pre-post	War affected adults (n = 214)	Anxiety and depression	RATA counsellors	Problem Solving Counselling
Bolton et al. 2003	Uganda	L	cRCT	Adults in community-based settings (n = 163)	Depression	Group leader	Group Interpersonal Therapy
Bolton et al. 2014	Thailand	UM	RCT	Burmese refugees (n = 182)	Depression	Counsellors	Common Elements Treatment Approach
Bryant et al. 2017	Kenya	LM	RCT	Women with a history of gender-based violence (n = 209)	Psychological distress	CHWs	Problem Management Plus
Chibanda et al. 2011	Zimbabwe	L	Randomised Non-Controlled Trial	Adults living with HIV, attending primary healthcare clinics (n = 320)	CMD	LHWs	Problem Solving Therapy
Chibanda et al. 2016	Zimbabwe	L	cRCT	Adults attending primary healthcare clinics (n = 286)	CMD	LHWs	Problem Solving Therapy + peer led group
Dawson et al. 2016	Kenya	LM	RCT	Women affected by urban adversity and gender-based violence (n = 35)	Psychological distress	CHWs	Problem Management Plus
Edelblute et al. 2014	Mexico	UM	pre-post	Women affected by migration (n = 39)	Depression	Promotoras	MESA
Fuhr et al. 2019	India	LM	RCT	Women attending antenatal clinics (n = 140)	Perinatal depression	Sakhis	Thinking Healthy Programme Peer-delivered

Author (year)	Location	Income classification	Design	Intervention sample	Mental health condition	NTP	Intervention
Hirani et al. 2010	Pakistan	LM	cRCT	Women attending adult literacy centres (n = 16)	Depression	CHWs	Economic skill building, Counselling
Joag et al. 2020	India	LM	Mixed Methods, pre-post	Adults in community-based settings (n = 215)	CMD	Atmiyata Champions, Mitras	Atmiyata intervention
Jordans et al. 2019	Nepal	L	RCT	Adults attending primary healthcare clinics (n= 162)	Depression	Community-based counsellors	Healthy Activity Programme
Khan et al. 2017	Pakistan	LM	cRCT	Women in community-based settings (n = 59)	Anxiety and depression	Lay Helpers	Group Problem Management Plus
Lund et al. 2019	South Africa	UM	RCT	Women attending antenatal clinics (n = 184)	Perinatal depression	CHWs	Counselling
Murphy et al. 2020	Vietnam	LM	cRCT	Adults in community-based settings (n = 190)	Depression	Social Collaborators	Supported self-management
Musiyimi et al. 2017	Kenya	L	pre-post	Adults seeking care from Traditional Health Practitioners (n = 377)	Depression	Traditional Health Practitioner	mhGAP-IG Psychosocial interventions
Myers et al. 2019	South Africa	UM	Mixed methods	Adults with chronic disease, attending primary healthcare clinic (n = 40)	Depression	CHWs	Counselling
Patel et al. 2010	India	LM	cRCT	Adults attending primary healthcare clinics (n= 1360)	CMD	LHCs	MANAS
Patel et al. 2017	India	LM	RCT	Adults attending primary healthcare clinics (n= 245)	Depression	Lay Counsellor	Healthy Activity Programme
Petersen et al. 2014	South Africa	UM	RCT	Adults living with HIV, attending primary healthcare clinics (n = 17)	Depression	Lay HIV Counsellors	Interpersonal Therapy
Pokhrel et al. 2018	Nepal	L	pre-post	Adults living with HIV (n = 344)	Depression	CHWs HIV-Positive Person, Social Worker	Community home-based care
Rahman et al. 2008	Pakistan	L	cRCT	Pregnant women (n = 412)	Perinatal depression	Lady Health Workers	Thinking Healthy Programme
Rahman et al. 2016	Pakistan	LM	RCT	Adults attending primary healthcare clinics (n = 146)	Psychological distress	Lady Health Workers	Problem Management Plus

Author (year)	Location	Income classification	Design	Intervention sample	Mental health condition	NTP	Intervention
Rahman et al. 2019	Pakistan	LM	cRCT	Women in community-based settings (n = 288)	Psychological distress	Facilitators	Problem Management Plus
Rotheram-Borus et al. 2015	South Africa	UM	cRCT	Pregnant women (n = 456)	Perinatal depression	CHWs	Home-based intervention
Shidhaye et al. 2017	India	LM	Cross-Sectional, Population-Based, Follow-Up	Adults in community-based settings (n = 58)	Depression	CHWs, Counsellors	VISHRAM
Sikander et al. 2019	Pakistan	LM	cRCT	Pregnant women (n = 226)	Perinatal depression	Razakaars	Thinking Healthy Programme Peer-delivered
Tripathy et al. 2010	India	LM	cRCT	Women who had just given birth (n = 6452)	Perinatal depression	Local Women	Women's group

L, Low-income; LM, Low-middle-income; RCT, Randomised controlled trial, cRCT, cluster randomised controlled trial; CMD, Common Mental Disorder; CHWs, Community Health Workers; LHWs, Lay Health Workers, LHCs, Lay Health Counsellors; MESA; Mujeres en Solidaridad Apoyandose; mhGAP-IG, Mental Health Gap Action Programme-Intervention Guide; VISHRAM, Vidarbha Stress and Health ProgRAM

Appendix 8. Characteristics of Psychological Interventions Delivery by NTPs in LMICs

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Ali et al. 2003	Counselling	8, weekly sessions. Counsellors provided supportive, cognitive and problem-solving counselling.	Clinical outcomes	Significant reduction	Counselling by minimally trained community counsellors reduced levels of anxiety and/or depression in women of their own community
Ali et al. 2010	Counselling	8, weekly sessions. Very basic cognitive behavioural therapy, supportive and problem-solving counselling.	Clinical outcomes	Significant reduction	The intervention led to a significant decline, with the counselled group faring better than the not counselled.
Bass et al. 2012	Counselling	8, weekly group sessions. (1-2) Introduction, expectations and current problems related to distress; (3-6) Discussions and sharing of individual experiences how different members employed strategies to cope; (7) Self-evaluation of how participants were doing since they joined the group and discussions on positive and negative changes; (8) Looking toward the future, with participants encouraged to talk about their next plans.	Clinical outcomes	No effect for reducing the burden of depression and anxiety	The intervention had some limited success in improving functioning, but not in improving mental health symptoms.
Bolton et al. 2003	Group Interpersonal Therapy	16, 90-minute, weekly, sessions. Identify problem areas associated with current symptoms and the 4 areas of interpersonal difficulties that served as triggers for the depression; weekly review of mood and encouragement of participant's description of events that could link to the mood; facilitation of support and solutions from group members.	Clinical outcomes	Significant reduction	Group IPT was highly efficacious in reducing depression and dysfunction.

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Bolton et al. 2014	Common Elements Treatment Approach	Weekly, 1-hour sessions on; engagement, attention to perceived obstacles to engagement, psychoeducation, program information, normalisation of symptoms, anxiety management, strategies to reduce physiological stress, BA, identifying and engaging in pleasurable, mood-boosting activities, cognitive coping, identifying and connecting thoughts, feelings, and behaviours, evaluating and restructuring thoughts to be more accurate and helpful, imaginal gradual exposure, facing feared and/or avoided traumatic memories, in vivo exposure, facing innocuous triggers in the environment, safety, assessing risk for suicide, homicide, and domestic violence, developing a safety plan.	Clinical outcomes	Significant reduction	CETA provided by LHCs was highly effective across disorders among trauma survivors.
Bryant et al. 2017	Problem Management Plus	5, 90-minute, weekly, sessions. (1) Introduction to the program, motivational interviewing, psychoeducation, and stress management; (2) Problem-solving strategies focused on specific problems nominated by the participant and review of stress management strategies; (3) BA and review of problem-solving and stress management; (4) strengthening social supports and review of stress management, problem-solving, behavioural activation, and social supports; (5) Reinforcement of all strategies and relapse prevention education	Clinical outcomes	Medium-term reductions	A brief, lay administered behavioural intervention resulted in moderate reductions in psychological distress at 3-month follow-up.
Chibanda et al. 2011	Problem Solving Therapy	6, 30-45-minute, weekly sessions. (1) Assessment and problem identification; (2) Home visit before next session/prayer with family; (3) Summary of session 1, prioritise problems, identification of solutions, information provided on referral where necessary, action plan, identifying activities the person used to find rewarding and which matter to them; (4) Brief review of session, implementation, motivation, referral; (5) Home visit, follow up; (6) Reinforce sessions 3, 4 and 5, and reassessment.	Clinical outcomes	Significant reduction	There was a clinically meaningful improvement in CMD associated with locally adapted PST delivered by LHWs through routine primary healthcare. Furthermore, nine of the ten lay workers rated themselves as very able to deliver the PST intervention.

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Chibanda et al. 2016	Problem Solving Therapy + peer led group	6, 30-45-minute, weekly sessions. (1) 3 components: Opening the Mind, uplifting, and strengthening; (2-6) Building on opening the mind. After 4 individual sessions, group participants joined a weekly peer-led group which provided group support and consisted of sharing personal experiences while crocheting a bag from recycled plastic materials to develop a skill for generating income through making and selling the bags.	Clinical outcomes	Significant reduction	LHW-administered, primary care–based PST with education and support resulted in improved symptoms at 6 months.
Dawson et al. 2016	Problem Management Plus	5, 90-minute, weekly sessions. Evidence-based strategies of problem-solving counselling with selected behavioural strategies including stress management, behavioural activation, in vivo exposure and strengthening social support.	Clinical outcomes	No significant effect	The findings revealed that PM+ had the potential to improve mental health for women affected by adversity, including gender-based violence.
Edelblute et al. 2014	MESA	5, 1.5 hrs, weekly sessions. (1) Establishing group norms, such as confidentiality and courtesy, and sharing migration stories; (2) CBT techniques such as recognizing stress and negative thoughts; (3) Discussion on depression and anxiety with a local psychologist; (4) ‘‘Listen, Advise, Support’’ model for providing peer support to others; (5) Coping skills and applying concepts learned in daily life.	Clinical outcomes	Depression scores declined modestly	Addressing mental health for a vulnerable population through a community-based approach has the potential to improve depression and social support in communities of migration, and a lay health provider model may be the most feasible approach in low-resource settings.
Fuhr et al. 2019	Thinking Healthy Programme Peer-delivered	6-14, 30-45-minute sessions in 4 phases over 7-12 months. The four phases were: (1) Prenatal phase; (2) Early infancy; (3) Middle infancy; (4) Late infancy. Intervention based on CBT and includes strategies that incorporate behavioural activation, active listening, collaboration with the family, guided discovery, and homework.	Clinical outcomes	No significant effect in reducing symptom severity	Laywomen in the community can be trained and empowered to deliver first-line psychological care to depressed mothers in the setting of a relatively low-resource country.

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Hirani et al. 2010	Economic skill building, Counselling	8, weekly sessions. ESB: skills for employment attainment and retention such as, effective communication, balancing personal and work life and time management, conflict resolution, dealing with abuse and harassment, enhancing self-efficacy, effective parenting, and personal hygiene and grooming. Group counselling: Components included stress and anger management, effective communication, active listening and supportive problem-solving.	Clinical outcomes	Significant effect of ESB, No significant effect of counselling	ESB is a potentially effective intervention to improve mental health and decrease violence among urban poor women compared to counselling.
Joag et al. 2020	Atmiyata intervention (counselling)	6, 20-40-minute sessions. Integrated care approach addressing both social and healthcare needs and consists of identification of community members with mental distress and CMD followed by counselling sessions. Counselling techniques include active listening, BA, problem solving, and social support.	Clinical outcomes	Significant reduction	Community-led interventions using volunteers can serve as a locally feasible and acceptable approach to facilitating access social welfare benefits, as well as reducing distress and symptoms of depression and anxiety in a LMIC context.
Jordans et al. 2019	Healthy Activity Programme	6-8 weekly sessions. BA, psychoeducation, behavioural assessment, activity monitoring, activity structuring, problem solving and activation of social networks.	Clinical outcomes	Significant reduction	Psychological treatment for depression delivered by community-based counsellors confers additional short- and long-term benefit.
Khan et al. 2017	Group Problem Management Plus	5, 2-hour, weekly sessions. Group intervention on problem solving, counselling and behavioural techniques.	Clinical outcomes	Significant reduction	The findings show encouraging results regarding the feasibility and acceptability of the group PM+ intervention delivered by lay-helpers.
Lund et al. 2019	Counselling	6, 45-60-minute sessions on psycho-education, problem solving, BA, healthy thinking, relaxation training, and birth preparation.	Clinical outcomes	No significant reduction	The task-sharing psychological intervention was neither effective nor cost-effective in treating perinatal depression in an adverse low-resource South African setting.

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Murphy et al. 2020	Supported self-management	Based on CBT principles, where a patient works through a structured workbook, with coaching support by a non-specialist provider. Patient is provided with ASW which introduces them to depression symptoms, describes options for treatment and includes guidance in three antidepressant skills. Social collaborators provided one-on-one coaching on the use of the ASW every 2 weeks, in which they consult with the patient on progress, reviewed the concepts in the ASW, and helped to create a plan for the subsequent 2-week period.	Clinical outcomes	Significant reduction	The effectiveness of the SSM intervention, delivered in community-based settings by minimally trained lay social workers, employing principles of task-sharing, has important implications for improving availability of and access to depression care in the Vietnamese context.
Musiyimi et al. 2017	mhGAP-IG Psychosocial interventions	The intervention consisted of psychosocial interventions such as cognitive behaviour therapy or problem solving, describing in detail what to do as listed under mhGAP-IG in the depression component.	Clinical outcomes	Significant reduction	It is crucial to engage THPs in the care of patients with depression and the need for inclusion of training packages; and other mental disorders in order to establish and maintain collaboration between THPs and conventional health workers and promote evidence-based care among marginalised populations
Myers et al. 2019 *	Problem solving Therapy, MI	3 sessions of MI and PST. The CHW and participant collaborated to identify and explore problems within the participant's life while the CHW taught the participant a structured PST approach to resolving these concerns. Participants learnt strategies for addressing problems that are important and resolvable, for dealing with negative and intrusive worries that are unrelated to their life goals and for coping with important problems that are unresolvable.	Confidence, Acceptability	N/A	Both dedicated and designated CHWs viewed the counselling package as highly acceptable but requested additional training and support to facilitate implementation.

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Patel et al. 2010	MANAS	6-12 sessions. A Collaborative Stepped Care Intervention involving psychoeducation and interpersonal therapy. Psycho-education taught patients simple strategies for symptom alleviation, for example breathing exercises for anxiety symptoms. Encouraging adherence to CMD treatments and providing information about social/welfare agencies when required were other key components of psycho-education.	Clinical outcomes	Modest effect	Findings demonstrated that an intervention led by a trained LHC improves recovery from CMD, in particular among those attending primary healthcare facilities.
Patel et al. 2017	Healthy Activity Programme	6-8, 30-40 minutes sessions. Psychological treatment based on BA that includes: psychoeducation, behavioural assessment, activity monitoring, activity structuring and scheduling, activation of social networks, and problem solving. Additional strategies used in response to specific needs included behavioural strategies to improve interpersonal communication skills and decrease rumination, advice regarding sleep problems and tobacco cessation, and relaxation training.	Clinical outcomes	Significant reduction	HAP delivered by LHCs plus enhanced usual care was better than enhanced usual care alone was for patients with moderately severe to severe depression.
Petersen et al. 2014	Interpersonal Therapy	16 sessions over 8 weeks. Each session comprised a number of steps: (1) Introducing a common trigger or exacerbating factor using a vignette; (2) Asking participants who identify with the story to share their problem; (3) Problem management to address the triggers of depression and cognitive behavioural techniques for exacerbating factors, promoting healthy thinking in the case of negative intrusive thoughts and BA for social isolation; (4) Participants identifying problems that they were going to work on in the next week.	Clinical outcomes	Significant improvement	These preliminary findings suggest that group-based counselling for depression in HIV positive patients can potentially be effectively delivered by appropriately trained and supported lay HIV counsellors

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Pokhrel et al. 2018	Community home-based care	Monthly 2-hour home visits involving psychosocial support and peer counselling, antiretroviral therapy adherence support and counselling, basic healthcare, and referral for further care. Counselling involved coping skills for the side effects of treatment, stress management, and self-care skills for physical symptoms.	Clinical outcomes	Significant reduction	The community home-based care program was effective in reducing the prevalence depressive symptoms, anxiety and stress levels. Home-based family counselling may have also improved their interpersonal relationship in family leading to their psychosocial wellbeing.
Rahman et al. 2008	Thinking Healthy Programme	16 total sessions. 1, weekly session for 4 weeks in the last month of pregnancy, 3 sessions in the first postnatal month, and 9, 1-monthly sessions thereafter. CBT techniques of active listening, collaboration with the family, guided discovery, and homework.	Clinical outcomes	Significant improvements	In a poor rural community with little access to mental healthcare, integration of a CBT-based intervention into the routine work of CHWs more than halved the rate of depression in prenatally depressed women.
Rahman et al. 2016	Problem Management Plus	5, 90-minute, weekly sessions. (1) Introduction, MI techniques to improve engagement, information about common reactions to adversity, and a basic stress management strategy; (2) Problem-solving techniques and BA; (3-4) support in continued application of problem solving, BA, and stress management and introduced strategies to strengthen social support networks; (5) Education about retaining treatment gains.	Clinical outcomes	Significant improvements	The results show that the lay workers can be successfully trained and supervised to effectively deliver the psychological intervention in primary care settings
Rahman et al. 2019	Problem Management Plus	5, 2 hours, weekly group sessions. (1) Psychoeducation, goal setting, and brief MI; (1-4) Strategies for stress management, problem solving, BA, and strengthening social support; (5) Revision of learning, education on preventing relapse, and a closing ceremony	Clinical outcomes	Significant improvements	The results showed the feasibility of employing local non-specialist graduates to deliver a transdiagnostic psychological intervention in this post-conflict setting.

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Rotheram-Borus et al. 2015	Home-based intervention	Home visits before and after birth. Intervention involved providing and applying health information about general maternal and child health, HIV/TB, alcohol use, and nutrition.	Clinical outcomes	Significant improvements	The intervention was associated with improved maternal emotional health 36 months after their children were born, though the intervention did not initially target reductions in maternal depression or improved maternal emotional health.
Shidhaye et al. 2017 †	VISHRAM	CHWs conducted small group meetings and household visits to increase awareness about mental disorders and to inform people about availability of mental health services. CHWs identified individuals with depression and provided them mental health first aid and referred individuals who had greater needs to the next tier of workers, health counsellors. Counsellors offered the HAP, a brief structured psychosocial intervention for depression.	Contact coverage	N/A	A grass-roots programme led by a team of CHWs and LHCs working in collaboration with primary care physicians and visiting psychiatrists can contribute to reducing the huge treatment gap for depression.
Sikander et al. 2019	Thinking Healthy Programme Peer-delivered	10 individuals and 4 group sessions of 30-45-minutes. 10 sessions during pregnancy and in the first 3 months after childbirth. The core psychological strategies included BA; narratives and pictures to gently challenge unhelpful thinking and behaviour and to encourage alternative helpful ones; and simple, everyday language to which both the peers and the mothers could relate.	Clinical outcomes	Significant reduction in symptom severity at 3 months	Findings showed that the intervention, which focused primarily on BA, was acceptable to participants and feasible to deliver by lay volunteer women in the community who had no previous health training.

Author (year)	Intervention	Intervention description	Outcome measure	Significance	Key findings
Tripathy et al. 2010	Women's group	20 monthly, group meetings. Groups took part in a participatory learning and action cycle. Information about clean delivery practices and care-seeking behaviour was shared through stories and games. By discussion of case studies imparted through stories, group members identified and prioritised maternal and new-born health problems in the community, collectively selected relevant strategies to address these problems, implemented the strategies, and assessed the results.	Clinical outcomes	No significant effect	Women's groups led by peer facilitators reduced neonatal mortality rate and moderate maternal depression at low cost in largely tribal, rural populations of eastern India

* A feasibility study examining the proportion of patients who completed counselling and were retained, and acceptability of intervention assessed through qualitative interviews. Therefore, no mental health outcomes were reported.

† A study examining healthcare coverage and therefore no mental health outcomes were reported.

CMD, Common mental disorder; CHWs, Community Health Workers; LHWs, Lay Health Workers; LHCs, Lay Health Counsellors; CETA, Common Elements Treatment Approach; PM+, Problem Management Plus; PST, Problem Solving Therapy; MESA; Mujeres en Solidaridad Apoyandose; ESB, Economic skill building; HAP, Healthy Activity Programme; mhGAP-IG, Mental Health Gap Action Programme-Intervention Guide; IPT, Interpersonal Therapy; VISHRAM, Vidarbha Stress and Health ProgRAM; ASW, Antidepressant Skills Workbook; BA, Behavioural Activation; MI, Motivational Interviewing; CBT, Cognitive Behavioural Therapy.

Appendix 9. Qualitative Review Published in 'International Journal of Mental Health Systems'

The Experiences of Lay Health Workers Trained in Task-Shifting Psychological Interventions: A Qualitative Systematic Review

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ABSTRACT

Introduction: The prevalence of common mental disorders, such as depression and anxiety, is high and the demand for psychological interventions and talking therapies is increasing. In order to meet this need, it is necessary to explore alternative methods to deliver talking therapies. Training lay health workers (LHWs) to deliver psychological interventions might be one possible solution to address current gaps in service provision. A number of studies have successfully used this approach to deliver psychological interventions in order to meet the demand for mental health care. Despite increased interest in this area, the evidence has not been synthesised or systematically reviewed.

Methods: Electronic databases (MEDLINE, EMBBASE, PsycINFO and CINHAL) were systematically searched to specifically capture studies on task-shifting psychological interventions for common mental disorders. Data were extracted on the experiences of the lay-workers on training and therapy delivery. Thematic analysis was used to analyse the data. Themes and subthemes of LHWs views on receiving training, barriers and facilitators to therapy delivery, factors required to become a successful therapist and the impact of training and therapy delivery on the therapists are described.

Results: 10 studies were eligible for inclusion. Key messages were: LHWs were satisfied with training but wanted more robust supervision; not enough time was given to training on understanding mental health problems; LHWs grew in confidence and this impacted on their personal relationships with others.

Conclusion: This is the first review to explore LHWs experiences in training and therapy delivery by synthesising existing qualitative research. A number of key messages derived out of this review can help in further improving the quality of the training programmes and highlighting the benefits that are available for the LHW in delivering psychological interventions.

Keywords: Task-shifting; Psychological Intervention; Lay Health Worker; Training; Experiences; Qualitative Review

INTRODUCTION

Common mental disorders (CMDs) refer to depression and a range of anxiety disorders which lead to significant decline in health and functioning (1). Depression is the leading cause of disability worldwide, and is a major contributor to the overall global burden of disease (2). In 2015, the proportion of the global population who had depression was estimated to be 4.4% (322 million) (2). Depression is associated with a range of negative outcomes, including decreased physical and social functioning (3, 4), high health care utilisation (5), poor quality of life (6), and increased risk of mortality (7).

A number of psychological interventions such as Cognitive Behaviour Therapy (CBT) have been found to be effective in reducing symptoms of depression (8-10) and anxiety (11, 12). In 2006, the Increasing Access to Psychological Therapies (IAPT) service was developed in the United Kingdom (UK) to increase access to psychological treatments, and in particular CBT, for people with CMDs. The NHS long term plan now aims to increase the number of people with depression and anxiety disorders who can access talking therapies through IAPT to 1.9 million by 2023/24 (13). However, IAPT services are already under immense pressure with approximately 1.4 million new referrals to IAPT care providers between 2017-18 (14). Between 2017-18 a total of 23,686 mental health staff left the NHS (15), and estimated levels of burnout in IAPT workers are among the highest seen in the mental health workforce (16) resulting in growing waiting lists and increased unmet needs.

Considering the increase in demand for treatments and raised prevalence targets, it is necessary to explore alternative methods for delivering psychological interventions. Task-shifting to lay health workers (LHWs) is one such alternative. It is a process of delegation which involves shifting tasks, such as the delivery of psychological interventions for CMDs, from highly qualified health workers to workers with fewer qualifications and minimum training, in order to increase the coverage of health care and to use resources more efficiently (17). LHWs are individuals carrying out functions related to health care delivery; trained in some way in the context of the intervention; and usually have no formal professional or paraprofessional certificated or degreed tertiary education (18).

Global recommendations and guidelines on task-shifting suggest the implementation of this approach as a way to strengthen and expand the healthcare workforce to increase access to services (19). A number of studies have shown the effectiveness of task-shifting for a range of conditions such as, the delivery of antiretroviral therapy for HIV (20), with the approach now being used in the psychiatric field (21, 22). Several trials have successfully used task-shifting to deliver psychological interventions for a variety of mental illnesses. A Cochrane review investigating the effect of non-specialist health workers on people with mental health conditions found that compared with usual care, interventions delivered by non-specialist health workers may increase the number of adults recovering from depression or anxiety two to six months after treatment (risk ratio (RR) 0.30, 95% confidence interval (CI) 0.14 to 0.64) (23).

Studies that have adopted a task-shifting approach have used a range of LHWs, from paraprofessionals already working within health systems, such as nurses, to lay women from within the community (24). Furthermore, laypersons have been used in studies in low- and middle-income countries (LMICs) to deliver psychological interventions (25-27), as a solution to the shortage of fully trained health workers. Qualitative data have shown that participants prefer LHWs from the same community who share common socio-demographic characteristics as they are more accessible (28) and less intimidating than a formal service (29). Furthermore, it avoids a formal mental health label and diagnosis, a reason that often leads people to avoid mental health services due to the stigma attached (30).

In LMICs, laypersons often come from more deprived socioeconomic backgrounds and have minimal formal education. Therefore, in-depth training, supervision and support from mental health professionals is required for task-shifting to be successful and to ensure high quality care (31). Systematic reviews of qualitative studies have previously been conducted on task-shifting of psychological therapies (32, 33). However, to date no review has been conducted on lay workers' experiences on training. Qualitative research methods such as in-depth interviews and focus groups are used to answer questions about experience and meaning to gain a deeper understanding of a participant's perspective in interventions such as task-shifting (34). Therefore, the aim of our review is to systematically review the qualitative literature on the impact of training and delivery of psychological therapies by lay health workers (LHWs). This systematic review is

important to help us understand the existing knowledge in this area and to direct future training and delivery of task-shifting programmes.

Objectives

The aims of this review were to answer two primary questions:

3. How have studies explored the experiences of LHWs who have received training and delivered psychological therapies for CMD?
    d. What are the types of studies?
    e. What are the characteristics of the LHWs described in the papers?
    f. What are the characteristics of training?

4. What does the evidence say about the LHWs' experiences in training and delivering psychological therapies?
    e. What were the LHWs own experiences of receiving training?
    f. What were the barriers and facilitators to therapy delivery?
    g. What factors are required to effectively train LHWS to deliver psychological interventions?
    h. What was the impact of training and therapy delivery on the LHWs?

METHODS

Eligibility Criteria

This review aimed to identify all papers that explored the experiences of LHWs delivering psychological interventions for CMDs. Therefore, we did not restrict the search to one type of qualitative methodology or to articles published during a particular period of time. A 'lay health worker' was defined as any health worker carrying out functions related to health care delivery; trained in some way in the context of the intervention; and having no formal professional or paraprofessional certificated or degreed tertiary education (18).

The inclusion criteria for studies were: (a) available in English, (b) used qualitative data, (c) studies in which the LHW was a lay person with no mental health experience and (d) studies describing LHWs' experiences of training and therapy delivery.

The exclusion criteria were: (a) studies evaluating the effectiveness of training LHWs that did not include any qualitative data, (b) studies focusing on the experiences of those receiving therapy and (c) studies involving participants with serious mental illnesses such as schizophrenia, bipolar disorder and other psychoses.

Literature search strategy

We searched databases (CINAHL, Medline, Embase, PsycINFO) from inception until 13th March 2018. All the searches were exported to EndNote and duplicate references were reviewed and removed. Searches were conducted to specifically capture studies on task-shifting psychological interventions for CMDs. The search was adapted from another systematic review investigating non-specialist health worker interventions for the care of mental, neurological and substance abuse disorders (23). Key terms including: lay, voluntary, untrained, non-professional, task shift, were combined with terms for CMDs, including: stress, common mental, anxiety and depression. To further limit the search to meet the aims of this review, we then combined the results of this search with criteria to specify qualitative methods . These included: qualitative, interview, focus group, content analysis, discourse, grounded theory, ethnograph. The full search strategy can be seen in Additional file 1.

Data Extraction

Titles and abstracts were screened by one researcher (US) and full papers of potentially relevant abstracts were obtained. A second researcher cross-checked and agreed the included and excluded papers (WW) and a final decision was made. Data were independently extracted by two reviewers (US and MWW) onto a standardised Excel spreadsheet. Data was collected on study details including intervention and participants, design and methods, as well as the author's interpretations of their data. Data extraction followed the guidelines for meta-ethnography outlined by Noblit and Hare (35), whereby first order constructs defined as direct participant quotes were extracted. Therefore where possible we extracted data on LHWs self-reported experiences of training, supervision, and therapy delivery. However, in many cases there was insufficient primary

data; in this instance we extracted second order constructs, defined as the authors' interpretations of participants' quotes expressed as themes, extracted from both the results and discussion sections of papers in order to capture all constructs. Therefore, here the second order constructs referred to the authors' interpretations of the LHWs' experiences of training. Data extraction rigour was enhanced by continuous discussion within the review team, as US and MWW independently extracted the data, whilst WW reviewed both sets of extraction for consistency. CASP (Critical Appraisal Skills Programme) tool was used for assessing the quality of included studies (36). However, the quality of studies was not an inclusion criterion in this review. The decision to avoid quality as an inclusion criterion was in consideration of the different context in which qualitative studies are conducted (37).

Thematic analysis

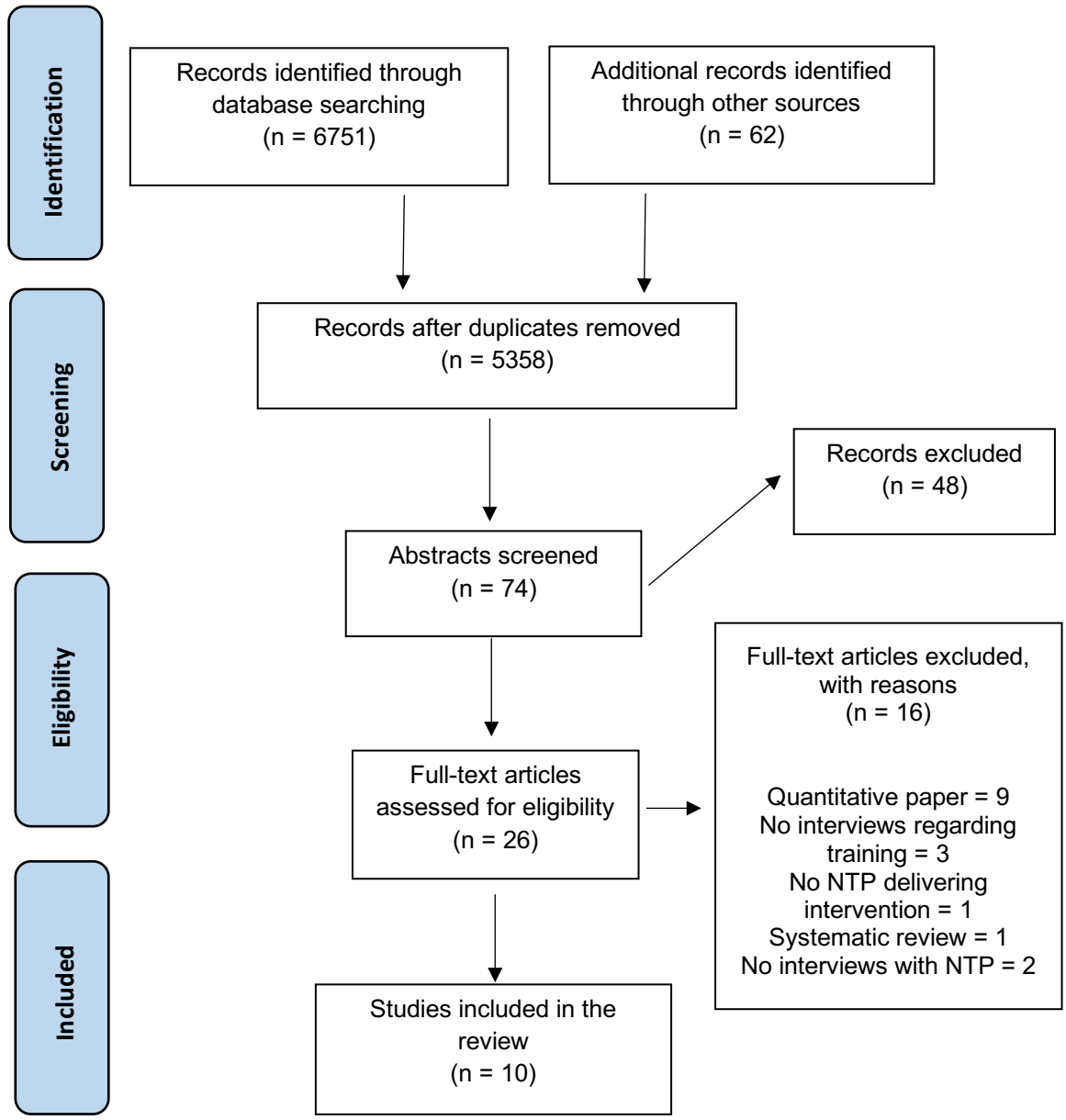
The thematic analysis approach to analysing qualitative data by Braun and Clarke (38) was used to aid thematic identification and summarisation of data from included studies. The aim of this review was to descriptively summarise evidence from qualitative studies exploring the impact of training and delivery of therapy on LHWs, therefore thematic analysis was appropriate.

In utilising the thematic analysis approach, we conducted, all six phases described by Braun and Clarke (38): (1) becoming familiar with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining themes and, (6) the write-up process. All included studies were read multiple times to facilitate understanding of the key concepts published in the studies. The analysis was undertaken in a multidisciplinary team (PhD student (US), Medical student (MWW) and a Psychiatrist (WW)). Papers were read and re-read by two reviewers (US and MWW) and the extracted data was then grouped into broad themes by the reviewers (US, MWW and WW).

Broad themes and subthemes were then refined though discussion between (US, MWW and WW) until consensus was reached. Once the themes had been broadly agreed, one reviewer (WW) read through the data in each of the themes checking that the interpretation of the data was correct and suggesting changes based on the original context of the studies.

The results are reported in line with PRISMA guidelines for systematic reviews. Our themes are presented in accordance with our review objectives as listed above.

Figure 1. PRISMA flowchart representing the process of identifying relevant papers (39)



RESULTS

In summary, a total of 6751 papers were identified through the electronic search and a further 62 papers were identified through an electronic search which was conducted to find any systematic reviews that had investigated task-shifting. After duplicates were removed, 5358 were excluded after reading the title and a further 48 after reading the abstracts. 26 full text articles were screened for inclusion: 16 were excluded, resulting in a total of 10 articles to be included in this review. The flow diagram for the included papers can be seen in Figure. 1.

Characteristics of included studies. The 10 included studies were conducted in two high income countries (HICs) which were UK (n=1) and Scotland (n=1) and the remaining were conducted in LMICs, Pakistan (n=4), India (n=2), Nepal (n=1) and Zimbabwe (n=1). Six studies employed mixed methods and four studies were qualitative. Half of the studies used semi-structured interviews to collect data; two studies used focus groups, whereas one used both interviews and focus groups and another used open-ended questionnaires. A description of included studies is presented in Table 1.

Two studies investigated the experiences of the LHWs in delivering the intervention (40, 41), whereas one study examined the barriers and facilitators of delivering the intervention through LHWs (42) and another examined the role of the voluntary sector in supporting women with perinatal mental health problems (43). Two studies were conducted to investigate the perspective of stakeholders involved in the intervention (44, 45), whilst another study was a cluster randomised controlled trial evaluating the feasibility and acceptability of the intervention (46). A study by Armstrong (47) evaluated the impact of a common factors approach in training the LHWs. Rahman (48) conducted a multi-method study to investigate the challenges and opportunities in developing an intervention for perinatal depression. Finally, Maulik et al. (49) conducted a study to develop and test a tool for referral and treatment as well as gather research to understand perceptions about mental health in rural India.

As per inclusion criteria, studies only included participants with anxiety, depression or CMDs, however one study included participants with mild to severe psychosocial problems and in one study the mental health condition was unknown.

In three studies the intervention being delivered was counselling, two used the Thinking Healthy Programme based on CBT techniques, one study focused on psychoeducation and another used a form of social support. One study used Problem Solving Therapy (PST) whilst another used a combination of PST and Behavioural Activation (BA) which was given the term Problem Management Plus (PM+). Lastly, another study trained LHWs in an intervention that utilised a mobile technology based electronic decision support system (EDSS) to improve the identification and management of individuals.

Table 1. Table of characteristics of studies (n = 10)

First Author/ Year	Participant type (No.)	Study design	Psychological intervention	Mental health condition	Data collection method	Method of analysis
Armstrong, J., 2003	Paraprofessional counsellors (12)	Mixed methods	Counselling	Unknown	Open-ended questionnaires	Content analysis
Naeem, S., 2003	Lay women (11)	Mixed methods	Counselling	Anxiety and depression	Focus groups and open-ended feedback	Unknown
Jordans, M.J., 2007	Paraprofessional counsellors (26)	Qualitative study	Counselling	Mild to severe psychosocial problems	Semi-structured interviews	Content analysis
Rahman, A., 2007	Lady Health Workers (24)	Mixed methods	Thinking Healthy Programme (CBT)	Perinatal depression	Focus groups	Systematic triangulation process
Pereira, B., 2011	Lay health counsellor (17)	Qualitative study	Psychoeducation	CMD	Qualitative semi-structured interviews	Thematic framework analysis
Coe, C., 2013	Volunteers befrienders (14)	Mixed methods	Perinatal support	Maternal anxiety and depression	Qualitative interviews	Unknown
Atif, N., 2016	Peer volunteers (8)	Qualitative study	Thinking Healthy Programme (CBT)	Perinatal depression	Interviews and focus groups	Thematic framework analysis
Maulik, P.K., 2016	Accredited social health activists (4)	Mixed methods	Mobile technology based electronic decision support system (EDSS)	CMD	Focus groups	Thematic analysis
Chibanda, D., 2017	Lay health workers (7)	Qualitative study	Problem solving therapy	CMD	Semi-structured interviews	Thematic content analysis
Khan, M.N., 2017	Lay helpers (2)	Mixed methods	Problem solving and behavioural activation	Anxiety and depression	Semi-structured interviews	Thematic content analysis

1

Characteristics of LHWs and the training received

A description of the characteristics of the LHWs is presented in Table 2. LHWs trained to deliver the interventions included two studies using paraprofessional counsellors, one study using lady health workers and the remaining four studies using lay persons. Two studies used volunteers, one in the form of volunteer befrienders and the other in the form of peer volunteers (PVs). Finally, one study used Accredited Social Health Activists (ASHAs) to deliver the psychological intervention.

Half of the studies did not report on the previous qualifications of the LHWs, whereas the other half of the studies reported that LHWs had minimal education ranging from 8 to 16 years or had completed high school. Three studies used LHWs that were already working within the community. This included one study in which LHWs had been trained to provide preventative mother and child health care and education and similarly in another study, where LHWs were responsible for providing basic maternal and child care through government funded schemes. In one study LHWs had previous training in home-based care for people living with HIV/AIDS, in community follow-up of persons on TB treatment and in delivering community health education and promotion. In another study using twelve paraprofessional counsellors whilst five had no counselling experience, seven had previously attended some form of training. In four studies, LHWs had no previous training, whilst in two; previous training or role within the community was not documented.

In two studies, a member of the research team delivered the training to the LHWs, whereas in one study the training was delivered by a team of experienced mental health professionals including two clinical psychologists, a general nurse trained in systemic counselling and a psychiatrist. Two studies used a train the trainer approach in which the trainer received training and supervision themselves before training LHWs. However, half of the studies did not document who delivered the training to the LHWs.

Training ranged from two days to months and consisted of a variation of lectures, role play and field work. The content of the training in almost all studies mostly focused on understanding the relevant mental health disorder, its management, counselling and communication skills. In three studies, supervision was conducted by a member of the research team, two studies used non-specialist supervisors whilst three studies used mental health professionals. However,

supervision was poorly documented with two studies not detailing who conducted supervision and almost all studies not reporting on the format and content of the supervision. Of the two studies that did, supervision involved LHWs sharing their experiences and receiving guidance and support in difficult cases.

Table 2. Table of characteristics of LHWs

First Author/ Year	LHW	Total No. of LHWs	Previous qualifications of LHW	Previous training/Role within the community
Armstrong, J., 2003	Paraprofessional counsellors	12	Unknown	Five people had no previous counselling training while seven had some form of training experience.
Naeem, S., 2003	Lay women	19	Unknown	No previous training
Jordans, M.J., 2007	Paraprofessionals	26	Minimal educational background (i.e., mainly high school level, with a few college-level participants.	Unknown
Rahman, A., 2007	Lady health workers	24	Completed secondary school	Trained to provide mainly preventative mother and child health care and education.
Pereira, B., 2011	Lay health counsellor	17	Unknown	Unknown
Coe, C., 2013	Volunteer befrienders	14	Unknown	No previous training
Atif, N., 2016	Peer volunteers	8	They had an education of at least 10 years	No previous training
Maulik, P.K., 2016	Accredited Social Health Activist (ASHA)	4	Unknown	Responsible for providing basic maternal and child care through government funded schemes.
Chibanda, D., 2017	Lay Health Workers	7	Mean of 8 years of education.	Previous training in home based care for people living with HIV and AIDS, in community follow-up of persons on TB treatment and in delivering community health education and promotion.
Khan, M.N., 2017	Lay helpers	2	Lay helpers had 16 years of education	No previous training

1

LHWs' own experiences of receiving training

LHWs' views on training and supervision

Generally, LHWs felt that there was insufficient information given during training and not enough time allowed for training regarding mental health issues (47). With one LHW also stating that training days were too long, making it difficult to take in all the information provided.

> *"There was too much going on – I felt I wanted to go and sort it out before the next point."* (Paraprofessional counsellor) (47, p.275)

Others expressed a need for more advanced training, with authors commenting that LHWs voiced a need for more opportunities to share and network with other counsellors (44). Similarly, Atif et al. (42) found that LHWs expressed satisfaction with their training, however believed that more detailed training would be required for dealing with a population with a range of health issues.

> *"While most PVs [peer volunteer] found the training sufficient to prepare them for the volunteering role, some felt that a longer and comprehensive training would have equipped them better to deal with the diverse health issues of their target population."* (42, p.8)

Satisfaction in training and support was also reported in Maulik et al. (49) and by Coe and Barlow (43). Armstrong (47) found that participation and engagement in training was facilitated by the LHWs' views of the learning environment as 'supportive' and 'encouraging'. Furthermore, Pereira et al. (45) found that the LHWs cited *"a comprehensive training program focusing on skills-based learning"* as critically important for successful delivery of the intervention (45, p.8)

> *"I liked the training… the trainers were friendly… the way they explained the content was very good. I didn't experience any problems in understanding it."* (PV) (42, p.6)

Most authors found that LHWs felt that supervision enhanced their skills and prepared them for any challenges and issues they faced in delivering the therapy (42, 45), which in one study also included managing their emotional well-being (46).

> *"The majority of LHCs [lay health counsellor] reported that experience in the clinics, training before the program and monthly peer group supervision during the program…gave them confidence to overcome the challenges they faced."* (45, p.5)

Atif et al. (2016) described how field supervision, in which supervisors accompanied the LHWs in therapy delivery, improved the LHWs' credibility within the community and their trustworthiness.

> *"When xx (supervisor) accompanied me, mothers took me more seriously and shared their concerns more openly knowing that I have been properly trained and supervised."* (PV) (42, p.6)

Furthermore, in Chibanda et al.'s study (40), increase in skills and confidence led to decreases in the rate of referral to the supervisor. Similarly, Maulik et al. (49) described how with increasing confidence the LHWs required less support from the staff after becoming more comfortable using the screening tool.

> *"They indicated that over the years the rate of referral to the supervisor had reduced significantly because they now felt confident with difficult clients."* (40, p.148)

Pereira et al. (2011) also commented on the LHWs' emphasis on supervision as a critically important element for successful delivery of the intervention, specifically on the use of a structured on the job supervision protocol involving both on site supervision and once a month group supervision. This emphasis on supervision was also highlighted in two other papers (40, 44). Finally, only Coe and Barlow (43) reported on the satisfaction of the LHWs' regarding supervision.

> *"The training and guidance they received, coupled with ongoing support from the project co-ordinator, was valued and praised by the volunteer befrienders."* (43, p.26)

Barriers and facilitators to therapy delivery

Barriers to therapy delivery

A few authors reported on barriers faced by the LHWs in delivering the intervention which affected them in their roles as therapists and hindered therapy delivery. In one study, in which LHWs were peer volunteers often from the same village as the participants, the author commented on how the LHWs experienced difficulties, as the participants were hesitant to reveal personal information possibly fearing a breach of confidentiality or judgement from the LHW especially if

they were from the same village (42). Confidentiality issues were also discussed by Khan et al. (46) who observed that participants were reluctant to disclose their problems when the intervention sessions were made up of participants from the same household.

> *"If in any session there were two or three participants from the same house that made it difficult to let the participants share their problems."* (Lay helper) (46, p.8)

> *"One of the challenges that the PVs experienced was some mothers' reluctance to disclose personal information, especially when both the PV and the mother belonged to the same village."* (42, p.8)

Furthermore, barriers to therapy delivery also included a hesitance to seek help due to the stigma attached to mental illness which influenced the LHW's level of acceptability.

> *"She got upset when I told her that the assessment indicated that she has depression. She said that she is not mad and stopped me from coming in when I went for my next visit."* (PV) (42, p.6)

Jordans et al. (44) noted that factors such as training, difficult clients and organisational difficulties limited the LHWs' abilities and affected their competency in delivering the interventions. Furthermore, the author addressed how for some LHWs the extra responsibilities were difficult to carry out with their current duties due to a lack of time and conflicts of interest. Other roles and responsibilities were also reported by Maulik et al. (49) who discussed LHWs' concerns of the harvest season *"as both ASHAs [accredited social health activists] and many villagers work as season labourers in the fields during harvest."* (49, p.7)

> *"For some multiple responsibilities were compatible with the counselling activities, but for others they were distracting or even incompatible…due to time restraints or confusing due to conflicts of interest, and generally reflective of a lack of management's prioritization of psychosocial services."* (44, p.63)

Use of aids in facilitating therapy delivery

Physical aids. The use of materials to aid in the delivery of the intervention was briefly described in Armstrong (47), in which the usefulness of handouts and video demonstrations of counselling sessions was emphasised by the LHW. Similarly, in Pereira et al.'s study (45), as well as using a flip chart to aid in the delivery of the therapy, a patient card was also used to facilitate the LHWs in planning the intervention for the patient.

> *"The flip chart was observed to facilitate the psychoeducation by helping the patients understand the content better and acting as a guide to the LHC."* (45, p.4)

> *"LHC's reported that the patient card with the screening results aided them in planning the intervention for the patient."* (45, p.4)

Abstract aids. Some studies also reported on the use of abstract aids such as being local to the community and current roles as health workers that facilitated the LHW in delivering the intervention. For example, Rahman (48) commented on how the LHWs were already providing preventative mother and child health care and education and therefore found it easier to understand the intervention. Furthermore, infant care was viewed as a 'mutually agreed agenda' and so facilitated the therapists when they met challenges within the therapeutic process.

> *"Infant care, on the other hand, was seen as a shared responsibility… It also helped [Lady Health Workers] negotiate difficult situations within the therapeutic process by referring back to this common mutually agreed agenda."* (48, p.7)

Chibanda et al. (40) noted how being local to the community was also found to facilitate therapy delivery as this increased the LHWs' level of trustworthiness.

> *"So, because we are known as Ambuya Utano (Lady Health Workers) there is a certain level of trust we get from PLWH [people living with HIV]. We have lived here for more than 20 years so we are known because with most of them we see each other at the market, we have helped them in the past…"* (LHW) (40, p.147)

The LHWs' own experiences were also seen as a facilitator due to a mutual understanding between the therapist and client which aided in therapy delivery.

"because I (LHW) also live with HIV when I show understanding (empathy), they are grateful and when I share my own experience this helps to further open up their mind." (LHW) (40, p.147)

Motivations for training to become a therapist

The motivation of the LHWs was also important in facilitating successful delivery of the intervention. Atif et al. (42) noted how the LHWs' perceived personal gains which were described as being altruistic, opportunistic or linked to their well-being as factors contributing to their motivation.

"Several factors were identified which contributed to their motivation such as their own families endorsement to their role and approval from mothers' families." (42, p.8-9)

Furthermore, family and community endorsement also motivated LHWs to receive training and deliver the intervention.

"My family is supportive, without their encouragement, I would not have done this work. It would have been really difficult to leave housework and children." (PV) (42, p.6)

2c. The factors required to effectively train LHWs to deliver psychological interventions

Acceptability

Confidentiality. A common theme found by authors was that the level of acceptability and successful delivery of the intervention was dependent on the LHWs' ability to maintain confidentiality. Naeem et al. (41) commented on how initial reluctance from the clients disappeared as trust in the LHW developed. Similarly, Pereira et al. (45) reported how the LHWs learnt to emphasise confidentiality over time which helped the patients become more comfortable in disclosing personal information.

"In time the LHCs were accepted by the patients and appreciated by the primary care staff due to their polite and friendly nature and also for maintaining confidentiality." (45, p.8)

"I stressed to every patient that whatever they would confide in me would remain confidential. I felt these would make the patient feel more comfortable with me and they would ventilate their feelings more easily." (LHC) (45, p.9)

Local and trustworthy. Khan et al. (46) found that level of acceptability was also closely linked with the trustworthiness of the LHW, further suggesting that being local and known in the community might be one factor which contributed to the LHWs being trusted compared to a health professional who would be an outsider and unfamiliar to the participants. . Atif et al. (42) observed how being local and trustworthy was an advantage to the LHWs, benefitting them in delivering the intervention, which was also found by Chibanda et al. (40).

"The PVs level of acceptability was dependent upon a number of key factors, including their personal characteristics (e.g. empathy and trustworthiness), being local and linked to the health system, and the intervention perceived as beneficial." (42, p.7)

"LHWs successfully facilitated the introduction of lay-helpers to the community and invited participants to the sessions. They were ideal hosts for Group PM+ as they are trusted and respected in the communities, overcoming a barrier to accessing women in need." (46, p.9)

Furthermore, as a relationship built between the LHWs and clients overtime, the LHWs became more trusted and accepted, leading to the clients disclosing personal information (41, 42).

Developing a therapeutic relationship

Chibanda et al. (40) observed that the LHWs used their own life experiences to help build a relationship with the clients, as well as using physical gestures to connect with them.

"because I (LHW) also live with HIV when I show understanding (empathy), they are grateful and when I share my own experience this helps to further open up their mind." (LHW) (40, p.147)

"Connecting with clients came in several forms from touching the hand and other culturally appropriate parts of the body, offering a tissue paper to a crying client, and praying. It was

not unusual for the LHWs to use their own life experiences to help create rapport." (40, p.146)

Empathy was also described by two authors as an important factor in building a relationship between the LHWs and the client and was also linked to their level of acceptability (41, 42).

"Initial resistance from the clients that gradually disappeared as empathy, trust and confidentiality developed." (41, p.2)

Collaborative working with other healthcare professionals

Collaborative working can also be regarded as an important component to becoming a successful therapist as it can provide the therapist with more guidance and support from more experienced professionals. Only two authors discussed this collaborative working with Atif et al. describing the LHWs *"good links with the local health system"* (42, p.5) and Jordans et al. observing that the counsellors expressed a desire for more *"opportunities to share and network with other counsellors"* (44, p.3)

"Nobody knows about us whereas, LHWs (Lay Health Workers) are working for the last 18-19 years. It would be really difficult for the PVs to work without their involvement." (PV) (42, p.6)

LHWs' expected skills

Through analysis of the papers it was found that specific skills are required for the intervention to be successful. Chibanda et al. (40) commented on how the LHWs found it difficult to only deal with one problem at a time and that they often felt pressured from the clients to provide solutions. Therefore, it is important for LHWs to be able to learn the skills to manage more than one issue and have the ability to prioritise the more serious concerns.

"because we are LHWs they think we have answers and we should tell them which problem to start with, so it can take going forward and backward before they identify one problem on their own…" (LHW) (40, p.147)

Furthermore, it is necessary for the therapists to have the ability to be able to adapt the intervention to the patient's needs. Chibanda et al. (40) discussed how the therapists felt that the first session of the intervention required greater emphasis and the subsequent sessions could be shorter. Furthermore, the author noted that as the LHWs realised that clients were not able to attend sessions regularly, adjustments were made to the intervention to ensure that the clients took home a solution that was *"specific, measurable and achievable after the first visit"* (40, p.149).

> *"Ensuring that the bulk of the work was done in the first session was critical because sometimes clients were unable to come back for subsequent sessions. Furthermore, LHWs felt that waiting a week before a problem was reviewed was discouraging for clients."* (40, p.146)

Pereira et al. (45) also found that the LHWs were able to find solutions to involve those who were reluctant about the intervention. In contrast, Khan et al. (46) observed that LHWs had difficulties motivating the participants to attend the intervention due to a lack of monetary incentive, therefore it is necessary to provide training to the LHWs to be able to encourage the participants to attend intervention sessions.

> *"Participants wanted some monetary incentives and when it was not provided they lost interest and they were not punctual."* (Lay helper) (45, p.8)

> *"The LHCs observed that providing explanations about the importance of treatment and explaining the mind-body link also helped engage patients who were sceptical about the program's effectiveness."* (45, p.5)

It is also important for the therapists to be able to deal with social issues that may arise during the intervention, as often task-shifting approaches are used in LMICs where factors such as financial problems may be a large concern of the patients. Chibanda et al. (40) commented on how problems related to finance were difficult for the LHWs, however over the years and with experience they were able to find solutions by focusing on the reason for needing the money.

> *"Some (patients faced) social difficulties like financial problem which is mainly due to seasonal work, daily wages and alcoholism. Another problem was patients not having proper documentation to apply for social schemes e.g. unregistered marriage… But I tried to give*

them information about various available schemes and how to follow the procedure and some even applied for it." (LHC) (45, p.5)

"One woman needed $30 for school fees. After we talked about ways of making $30 she came up with several solutions…" (LHW) (40, p.148)

The impact of training and therapy delivery on the LHW

LHWs' gains

Impact of training. Some authors commented on the positive benefits that the training had on the LHW. Armstrong (47) noted that the LHW valued the training, emphasising that the stimulating learning environment and working within a group allowed them to share their personal thoughts and feelings and gave them the opportunity to meet new people. Furthermore, the author noted that training led to personal development and a way of enhancing their skills (47), this was a common theme which was also observed by Naeem et al. (41) and Jordans et al. (44).

"Participants used the training experience as an opportunity to facilitate their development as counsellors, to learn more about themselves, and to increase their personal effectiveness in their day-to-day lives." (47, p.275)

The training was also found to have a positive impact on the confidence of the LHW (41, 44, 47), with Naeem et al. (41) noting that the training led to a positive approach towards life for the LHWs.

"I am more self-confident in my ability, more self-aware and… more open to others views…" (Paraprofessional counsellor) (47, p.274)

"…the training taught us to look for solutions for our problems rather than allowing them to get on our nerves." (Lay women) (41, p.2)

Impact of therapy delivery. Most of the authors described the positive impact of delivering the therapy on the LHWs themselves. A common theme that emerged from most papers was that the LHWs developed new skills, which included enhanced listening skills and empathy in Armstrong (47) and learning tolerance and maintaining confidentiality in Naeem et al. (41). In

Maulik et al.'s (49) study, the new skills led to the LHW feeling empowered to talk to the community about mental health, whereas Rahman (48) noted how the skills made them more effective health workers. This benefit to existing duties of the LHWs was also mentioned by Armstrong (47) who suggested that the development of interpersonal skills appeared to be *"helpful in relation to existing human service work."* (47, p.274-275)

> *"(It) feels like I have opened a part of myself finally, having struggled to find a means to do it for some time*." (Paraprofessional counsellor) (47, p.274)

> *"It's just really… I just found it really rewarding. I wanted to give something back to the community really and I feel that I have done that. Um. It's kind of made me feel accepted in a way."* (Volunteer befriender) (43, p.26)

Furthermore, LHWs also gained personal benefit from therapy delivery which involved an improvement in their relationship with others, with Pereira et al. (45) stating that the LHWs used intervention components in handling interpersonal problems. Coe and Barlow (43) also found that LHWs reported an increasing sense of acceptance from therapy delivery, and Naeem et al. (41) found that the LHWs described having an increase in sensitivity and becoming more accepting towards others, as well as understanding the importance of working together and helping each other solve problems.

> *"…this training taught us to live our life in a new and different way."* (Lay women) (41, p.2)

> *"I have gained insight and knowledge on how to approach people sensitively, allow them time… remembering that it is their experience, making no assumptions… that your solution is necessarily theirs."* (Paraprofessional counsellor) (47, p.273)

DISCUSSION

Summary of the findings

This is the first review of LHWs' experiences of receiving training to deliver low-intensity psychological interventions. The findings of this review provide support for the feasibility of training non-professionals to deliver psychological interventions as well as highlighting a number of areas that have not been adequately addressed in the published literature, such as how to successfully train and support non-professionals in delivering psychological interventions.

Ten studies were included and ten themes emerged under four overarching areas which were the LHWs' own experiences of receiving training, barriers and facilitators to therapy delivery, factors required to become a successful therapist and impact of training and therapy delivery on the LHWs were explored in this synthesis.

There are limitations to drawing conclusions about LHWs' views on training. Limited data about views on the content of training exist and even less on whether the delivery of the training was acceptable. Our findings demonstrate that whilst training is positively received by LHWs, generally it is felt that there is a lack of focus on mental health problems, with more comprehensive training required to support a population with mental health issues. Mental healthcare professionals, in all probability will have existing knowledge about mental illnesses and therapy delivery. In contrast, lay therapists will have little to no knowledge in this area, making delivery of therapy difficult. Despite this, emphasis is placed upon training the therapists in delivering the intervention which although is an important element would be more successful if the therapist had a greater knowledge and broader understanding of the nature and context of mental health issues.

A number of barriers and facilitators to therapy delivery were identified in this review, which researchers should be aware of when planning their own training. A critical barrier highlighted in this review is participants' hesitance to reveal personal information, fearing a breach of confidentiality. Whilst this barrier is more likely to arise in LMICs where the patient and LHW will often come from the same village (27), and where there is a greater stigma attached to mental health (50); it is also important to be aware of this when task-shifting interventions in HICs. Given that interventions will often be delivered by a volunteer from within the local area there is a probability that the therapist and patient may know each other or when the intervention is delivered in a group, know fellow group members. Within the wider literature confidentiality and disclosure

concerns are a known barrier to accessing mental health services (51, 52). Loss of confidentiality is closely related to the stigma often surrounding mental health problems within the communities, for example fear of a breach in confidentiality can stem from the fear of stigma and embarrassment of others finding out (53). The basis of any therapeutic relationship is confidentiality (54) and building trust between individuals, communities and mental health services is important when ensuring access to mental health services (55). Therefore, those developing and delivering mental health training should carefully consider how best to create a confidential environment which allows patients to safely make personal disclosures. Training should focus on the importance and boundaries of confidentiality, as well as incorporating solutions for when a patient is reluctant to disclose information, or for when disclosure is necessary, for example due to risk of harm to self or others.

Another barrier that was noted in this review was the LHWs' difficulty in balancing the extra responsibilities of delivering their respective interventions with their current roles and duties. This should be considered when selecting LHWs, particularly in HICs where LHWs will most likely be volunteers who have other work commitments, leading to a lack of time, conflicts of interest and hence affect their competency in delivering the intervention. Moreover, numerous roles and responsibilities may lead to burnout, a phenomenon that is common among the mental health service workforce due to higher workloads and can impact the quality of care provided to mental health consumers (56, 57). Therefore, preventing burnout through management of workloads and increasing supervision is essential in order to maintain therapists' satisfaction and a high quality of care (16).

Numerous facilitators were also described in this review, with aids such as training materials guiding the LHWs during intervention delivery. Use of physical materials such as flip charts and handouts not only support the training but can also act as a guide or a point of information for the therapist to refer back to when faced with a challenge. Moreover, abstract factors such as the previous life experiences of LHWs can aid in delivering interventions, as by having similar experiences to the patients they may be more able to empathise with them as well as understand the intervention better (58). This is a crucial element when selecting LHWs to train, for example, past service users can use their own past experiences and offer guidance through experiential knowledge of mental illness (59), acting as role-models and restoring hope for the

patient (60). Therapist self-disclosure in which the therapist discloses personal information regarding the therapist's life outside the therapeutic encounter can have facilitating effects on the therapeutic relationship, by building rapport and adding to client comfort (61). This past experience may also play as motivation for helping others, with the review identifying motivation as a facilitating factor for successful delivery of the intervention. However, qualitative data by Atif et al. (42) shows that despite having well-trained and motivated therapists, it is possible an intervention may not be accepted by the community if the therapists selected are not desirable, or unmatched to the community they are serving. Therefore, in addition to similar experiences of mental health problems it may be useful to recruit LHWs who are peers from the same socio-demographic area as those that they will work with, to ensure they are not perceived as 'foreign' by the community. Peers who are persons who share socio-demographic characteristics with the target population, have been used to perform a variety of tasks including counselling, coaching and advocacy (62), with evidence suggesting that peers may have a small additional impact on patient outcomes compared to standard psychiatric care (58).

Training and therapy delivery can lead to multiple gains for LHWs as outlined by this review, which can be used as an incentive by researchers when recruiting people to deliver the intervention. Training can lead to a positive impact in terms of confidence, development of new skills, and provides the opportunity to meet new people. Furthermore, delivery of the intervention can develop the LHWs' communication skills and lead to an improvement in their relationship with others. In addition, the skills learnt can benefit the individuals in their existing work, especially if they are involved in healthcare and human services work. The benefits of delivering therapy is supported by McLeod (63) who suggests that this type of work is greatly satisfying and individuals feel a privilege to be a part of a process in which someone turns their life around. Moreover, evidence has supported the benefits of incorporating self-practice into training, in which trainees practice therapy techniques on themselves and reflect on their experiences (64). Therefore, training should include aspects of self-reflection as this can lead to increased empathy for the client and enhance therapeutic understanding and therapist skills (64, 65).

Supervision data is relatively absent from the literature. However, the data available highlights the importance of supervision for successful task-shifting. Supervision is an essential factor for increasing the confidence of the LHW which in turn can lead to less support required as

skills are developed. Furthermore, supervision can improve the trustworthiness of the therapist within the community which is of particular importance in LMICs where there is a greater reluctance to seek help for mental health issues and disclose personal information. Clinical supervision is an integral part of psychotherapy training and continuous development, and its importance is supported through empirical evidence suggesting that supervision has positive effects on the trainees' therapeutic development and competencies (66). Furthermore, specific supervision formats such as video monitoring and feedback may be effective in improving both therapist competence and treatment outcomes (67).

A number of key messages have been derived out of this review which can help in further improving the quality of training programmes and highlighting the benefits that are available for the therapists. Firstly, duration and skill development should be reconsidered in training programmes to include sufficient time for learning about the nature and context of CMDs. Secondly, it should be explained to LHWs that as this is a new role, expectations of their performance are realistic and it is with supervision and time, that they would be able to improve their skills. A reassuring supervisory role by a senior member of the team can help in building therapists' confidence and trust within the community, thereby facilitating the learning and therapy-delivering process. Moreover, LHWs should be given the opportunity to collaborate with other healthcare professionals as they can offer further guidance and support through their own experiences. Lastly, it is necessary to ensure that LHWs understand the nature and boundaries of therapeutic relationships and that they have the practical knowledge of how to develop them.

Strengths and limitations

To our knowledge this review is the first of its kind to focus on the experiences of LHWs trained in delivering psychological interventions. Our literature searches were systematic and transparent, but searching for qualitative studies is complex and requires further investigation (Flemming & Briggs, 2007).

Whilst the main objective of this review was to explore the experiences of LHWs on training and therapy delivery, the papers included in this review were mostly focused on the intervention itself with training only encompassing a small aspect of the papers. Therefore, it was not possible to gain in depth information on each element of training such as format, content and

delivery methods. Furthermore, direct quotes of patient experience were limited for extraction and therefore, much of our findings are based on authors' interpretations of LHWs experiences. Whilst this has provided interesting data which adds considerably to the literature on the training of LHWs, a greater depth of data direct from LHWs would have been desirable.

In order to maximise data available, a range of psychological interventions and mental health conditions were included. While this facilitated increased data for inclusion, it also created limitations for transferability of the findings. Firstly, the content of training for various types of interventions will differ. Interventions such as CBT and PST are more likely to focus on the delivery components of structured interventions, whereas; counselling interventions will focus on the development of therapeutic relationships, engagement of the patient and person-centred approaches. Secondly, studies investigating CMDs would have to include training on a range of mental health conditions compared to those only investigating a single condition such as perinatal depression, leading to information on the mental illnesses being condensed which could likely influence experiences.

It should be noted that eight out of ten papers meeting the inclusion criteria are from LMICs, where LHWs are commonly used as a solution to the health worker shortage. Although differences can be seen between HICs and LMICs in terms of barriers faced by the LHWs in therapy delivery, there are also factors such as confidentiality that were common across all studies, and the themes that arose are universal themes that would be applicable elsewhere.

Implications for future research

Key lessons learned from this review should be incorporated into a training framework so that future developers of LHW training interventions are aware of the important factors that need to be incorporated in the training plan. Future research should focus on identifying barriers and facilitators to training LHWs. We should seek to identify in-depth accounts of LHWs experience of training, supervision, and therapy delivery. A further review should also be conducted to explore the experiences of trainers and supervisors. Synthesis of the experience of LHWs, trainers, and supervisors can then inform the future development and delivery of training programmes for lay workers. Furthermore, whilst a review investigating the effectiveness of LHWs delivering psychological interventions has been conducted, the authors have noted that the quality of the

studies used was low (23). Therefore, further high-quality research needs to be conducted to better estimate the effect of LHW delivered interventions for the treatment of depression and anxiety.

Conclusions

Task-shifting psychological interventions to LHWs has been found to be an effective solution to address the health worker shortage and is often seen as less intimidating and stigmatizing than a formal service. Training is an essential component for successful task-shifting and therefore, to be able to develop effective training programmes for these LHWs, their experiences in training and therapy delivery should be considered. This review highlights the important elements that researchers should be aware of when developing their own training programmes. The findings of this review have added to the evidence base of existing knowledge which should assist researchers to develop high quality training based on clinical and research experience.

List of Abbreviations

LHWs – Lay Health Workers

CMD – Common Mental Disorders

CBT – Cognitive Behaviour Therapy

IAPT – Increasing Access to Psychological Therapies

LMICs – Low- and Middle-income Countries

CASP – Critical Appraisal Skills Programme

HICs - High-income Countries

PST – Problem Solving Therapy

BA – Behavioural Activation

PM+ - Problem Management Plus

EDSS – Electronic Decision Support System

PVs – Peer Volunteers

ASHAs – Accredited Social Health Activists

LHCs – Lay Health Counsellors

DECLARATIONS

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not Applicable.

Availability of data and materials

The data used and analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

US and WW designed the research. US and MWW conducted the literature search and data extraction. All authors contributed to data analysis. US wrote the first draft under the supervision of WW and AB. The paper was edited and revised for critical content by all authors and all authors have approved the final manuscript.

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Appendix 10. COnsolidated Criteria for REporting Qualitative Research Checklist

Topic	No.	Description	Page no.
Domain 1: Research team and reflexivity			
Personal Characteristics			
Interviewer/facilitator	1.	Which author/s conducted the interview or focus group?	169
Credentials	2.	What were the researcher's credentials? E.g., PhD, MD	172
Occupation	3.	What was their occupation at the time of the study?	172
Gender	4.	Was the researcher male or female?	172
Experience and training	5.	What experience or training did the researcher have?	163, 170
Relationship with the participants			
Relationship established	6.	Was a relationship established prior to study commencement?	n/a
Participant knowledge of the interviewer	7.	What did the participants know about the researcher? E.g., Personal goals, reasons for doing the research	167
Interviewer characteristics	8.	What characteristics were reported about the interviewer/facilitator? E.g., Bias, assumptions, reasons and interests in the research topic	172
Domain 2: Study design			
Theoretical framework			
Methodological orientation and theory	9.	What methodological orientation was stated to underpin the study? E.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis	171
Participant selection			
Sampling	10.	How were participants selected? E.g., purposive, convenience, consecutive, snowball	166
Method of approach	11.	How were participants approached? E.g., face to-face, telephone, mail, email	167
Sample size	12.	How many participants were in the study?	191, 213
Non-participation	13.	How many people refused to participate or dropped out? What were the reasons for this?	191
Setting			
Setting of data collection	14.	Where was the data collected? E.g., home, clinic, workplace	170

Presence of non-participants	15.	Was anyone else present besides the participants and researchers?	170
Description of sample	16.	What are the important characteristics of the sample? E.g., demographic data, date	192, 213
Data collection			
Interview guide	17.	Were questions, prompts, guides provided by the authors? Was it pilot tested?	169
Repeat interviews	18.	Were repeat interviews carried out? If yes, how many?	n/a
Audio/visual recording	19.	Did the research use audio or visual recording to collect the data?	170
Field notes	20.	Were field notes made during and/or after the interview or focus group?	173
Duration	21.	What was the duration of the interviews or focus group?	191
Data saturation	22.	Was data saturation discussed?	288
Transcripts returned	23.	Were transcripts returned to participants for comment and/or correction?	171
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24.	How many data coders coded the data?	171
Description of the coding tree	25.	Did authors provide a description of the coding tree?	n/a
Derivation of themes	26.	Were themes identified in advance or derived from the data?	171
Software	27.	What software, if applicable, was used to manage the data?	171
Participant checking	28.	Did participants provide feedback on the findings?	172
Reporting			
Quotations presented	29.	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? E.g., Participant number	Chapter 9
Data and findings consistent	30.	Was there consistency between the data presented and the findings?	Chapter 11
Clarity of major themes	31.	Were major themes clearly presented in the findings?	Chapter 11
Clarity of minor themes	32.	Is there a description of diverse cases or discussion of minor themes?	n/a

Appendix 11. Approval Letter from Human Development Research Foundation

Human Development Research Foundation

NPO SEAL OF GOOD PRACTICES
HDRF has been certified by the Pakistan Centre for Philanthropy (PCP) on September 11, 2015, for meeting certification standards in the areas of Internal Governance, Financial Management, and Programme Delivery

Ref. No: HDRF/0129/2019 Date: 29.03.19

Dear Ujala,

Thank you for approaching us with regards to your PhD, I confirm that we are conducting research which involves training non-traditional providers. I am pleased to inform you that we are interested in your PhD project and approve your request to access training materials and documents, as well as allow you to conduct interviews with TTHP trainers and peer volunteers once you have received ethical approval.

You will have to make your own travel and accommodation arrangements and we will facilitate you in conducting these interviews, as well as provide you with local liaison and support during your data collection.

If you need any further assistance, please do not hesitate to ask me.

Sincerely,

Irum Iftikhar

Irum Iftikhar
Manager Human Resource
Human Development Research Foundation

Appendix 12. Approval Letter from the Big Life Group

The Big Life group
463 Stretford Road
Manchester M16 9AB
Telephone: 0161 848 2420
Fax: 0161 848 8072
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www.thebiglifegroup.com

31st May 2019

Dear Ujala,

Thanks you again for approaching us with regards to your PhD. I can confirm that Big Life Company will grant you access to any training materials or resources you may require, and that we will facilitate your access to trainees for the purpose of conducting interviews, and recording that consent has been given by all participants.

Sincerely,

Paul Cookson
Business Development and Programme Lead

Appendix 13. Approval Letter from Pakistan Institute for Living and Learning

26th March 2019

Dear Ujala,

Thank you for approaching us with regards to your PhD, I confirm that we are conducting research which involves training non-traditional providers. I am pleased to inform you that we are interested in your PhD project and approve your request to access training materials and documents, as well as allow you to conduct interviews with experts and non-traditional providers once you have received ethical approval.

We are happy to host you in Pakistan, as well as provide you with local liaison and support during your data collection as we have extensive experience hosting students and University of Manchester researchers.

If you need any further assistance, please do not hesitate to contact me.

Yours Sincerely

Professor Nusrat Hussain

Appendix 14. Participant Information Sheet for NTPs

A qualitative study exploring the experiences in training and supervision of non-traditional providers trained in delivering psychological interventions

Participant Information Sheet (PIS)

You are being invited to take part in a research study as part of a PhD student project investigating the content and delivery of training for non-traditional providers delivering psychological interventions. Before you decide whether to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully before deciding whether to take part and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Thank you for taking the time to read this.

About the research

Who will conduct the research?

Ujala Shahmalak, PhD Student, Suite 5.23, 5th Floor, Williamson Building, The University of Manchester, Oxford Road, Manchester, M13 9PL.

What is the purpose of the research?

To identify effective training techniques and theories as perceived by lay providers who have received training in delivering psychological interventions with regards to implementing research into practice and with the aim of finding out more information than what is available in published research.

Why have I been chosen?

You have been chosen because you are a lay provider who has taken part in training to deliver psychological interventions.

Where will the research be conducted?

The interview will be conducted face to face or Skype/Phone if face to face is not possible.

Will the outcomes of the research be published?

The outcomes of the research will form part of a PhD thesis, and will be submitted for publication in peer reviewed scientific journals.

Who has reviewed the research project?

The project has been reviewed by the University of Manchester Research Ethics Committee.

What would my involvement be?

What would I be asked to do if I took part?

If you agree to take part you will spend 30 minutes to one hour with the researcher who will ask you questions about your experiences on training and supervision that you have received. The interview will be audio recorded, and will take place face to face.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form or will be asked for verbal consent. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself. However, it will not be possible to remove your data from the project once it has been anonymised as we will not be able to identify your specific data. Furthermore, if you withdraw your consent after the research has been published, it will not be possible to remove your quotes. This does not affect your data protection rights. If you decide not to take part you do not need to do anything further.

Audio recordings are essential for the study; therefore if you decide to take part the interview will be audio-recorded. However should you become uncomfortable with the recording process you are free to stop the recording at any time.

Data Protection and Confidentiality

- **What information will you collect about me?**

In order to participate in this research project we will need to collect information that could identify you, called "personal identifiable information". Specifically we will need to collect:

- Professional background
- Voice only audio recording of the interview. The audio recorded data will be stored electronically and transcribed by the researcher that conducted the interview. The interview transcripts will be made anonymous as each participant will be given a unique ID number which will be used on the interview transcripts.

Under what legal basis are you collecting this information?

We are collecting and storing this personal identifiable information in accordance with data protection law which protect your rights. These state that we must have a legal basis (specific reason) for collecting your data. For this study, the specific reason is that it is a public interest task and a process necessary for research purposes.

What are my rights in relation to the information you will collect about me?

You have a number of rights under data protection law regarding your personal information. For example you can request a copy of the information we hold about you, including audio recordings.

If you would like to know more about your different rights or the way we use your personal information to ensure we follow the law, please consult our Privacy Notice for Research.

Will my participation in the study be confidential and my personal identifiable information be protected?

In accordance with data protection law, The University of Manchester is the Data Controller for this project. This means that we are responsible for making sure your personal information is kept secure, confidential and used only in the way you have been told it will be used. All researchers are trained with this in mind, and your data will be looked after in the following way:

Only the study team at the University of Manchester will have access to your personal identifiable information, that is data which could identify you, but they will anonymise it as soon as practical. Your participation in the study will be kept confidential to the study team. The University of Manchester policy on storage of personal data is 5 years after the last publication of the study or for 10 years, whichever is the greater. Consent forms will be retained as essential documents, but items such as contact details will be deleted as soon as they are no longer needed. All participant data will be stored in locked filing cabinets in locked rooms at the university. Identifiable and personal information will be stored separately from research data and linked by a unique ID number.

The audio recorded data will be stored electronically and transcribed by the researcher that conducted the interview. The interview transcripts will be made anonymous as each participant will be given a unique ID number which will be used on the interview transcripts. All information will be kept strictly confidential. Your name will not appear in any publication or shown to anyone outside the research team. Any information including the interview data will have your name and address removed so that you cannot be recognised from it. We may use quotations from you in publications or presentations arising from this research: all such quotations will be anonymised. The audio files will be deleted immediately after transcription. The transcribed data will be stored in a secure electronic file and in a locked filing cabinet and will only be accessible by the research team. In line with the university regulations and good research practice, at the end of a project all confidential or important paper/digital data is sent into secure storage for a period of 10 years. The University has a contract with Iron Mountain off-site archiving facility.

When you agree to take part in a research study, the information about you may be provided to researchers running other research studies in this organisation. The future research will be of a similar nature to this research project and will concern the training of non-professionals to deliver psychological interventions. Your information will only be used by this organisation and researchers to conduct research in accordance with The University of Manchester's Research Privacy Notice.

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of research into task-shifting, and cannot be used to contact you regarding any other matter.

If, during the study, you disclose information about unethical practice, we have a professional obligation to report this and will therefore need to inform your supervisor.

Individuals from the University, the site where the research is taking place and regulatory authorities may need to review the study information for auditing and monitoring purposes or in the event of an incident.

Please also note that individuals from The University of Manchester or regulatory authorities may need to look at the data collected for this study to make sure the project is being carried out as planned. This may involve looking at identifiable data. All individuals involved in auditing and monitoring the study will have a strict duty of confidentiality to you as a research participant.

What if I have a complaint?

If you have a concern about any aspect of the study, you should contact the researcher who will do their best to answer your questions.

If you have a minor complaint then you need to contact Waquas Waheed in the first instance by emailing: waquas.waheed@manchester.ac.uk
If you wish to make a formal complaint to someone independent of the research team or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact

The Research Governance and Integrity Officer, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674.

If you wish to contact us about your data protection rights, please email dataprotection@manchester.ac.uk or write to The Information Governance Office, Christie Building, The University of Manchester, Oxford Road, M13 9PL at the University and we will guide you through the process of exercising your rights.

You also have a right to complain to the Information Commissioner's Office about complaints relating to your personal identifiable information Tel 0303 123 1113

Contact Details

Contact for further information

If you have any queries about the study then please contact the researcher:
Ujala Shahmalak, PhD Student, Suite 5.23, 5th Floor, Williamson Building, The University of Manchester, Oxford Road, Manchester, M13 9PL. Email: ujala.shahmalak@postgrad.manchester.ac.uk.

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [2019-6468-10957].

Appendix 15. Participant Information Sheet for Experts

A qualitative study exploring the experiences of experts involved in the training and supervision of non-traditional providers delivering psychological interventions

Participant Information Sheet (PIS)

You are being invited to take part in a research study as part of a PhD student project because you have expertise in the design and or delivery of complex training interventions. Before you decide whether to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully before deciding whether to take part and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Thank you for taking the time to read this.

About the research

Who will conduct the research?

Ujala Shahmalak, PhD Student, Suite 5.23, 5th Floor, Williamson Building, The University of Manchester, Oxford Road, Manchester, M13 9PL.

What is the purpose of the research?

To identify effective training techniques and theories as perceived by lay providers who have received training in delivering psychological interventions with regards to implementing research into practice and with the aim of finding out more information than what is available in published research.

Why have I been chosen?

You have been chosen to take part because of your experience and expertise in training non-traditional providers as evidenced by published literature. You may have been identified by another participant as being a suitable person to approach to participate.

Where will the research be conducted?

The interview will be conducted face to face or over Skype/phone if face to face is not possible.

Will the outcomes of the research be published?

The outcomes of the research will form part of a PhD thesis, and will be submitted for publication in peer reviewed scientific journals.

Who has reviewed the research project?

The project has been reviewed by the University of Manchester Research Ethics Committee.

What would my involvement be?

What would I be asked to do if I took part?

If you decide to take part in the research you will be interviewed by the researcher on the above topic. The interview is expected to take 30 minutes to one hour. The interviews will be audio recorded and will take place face to face.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form or will be asked for verbal consent. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself. However, it will not be possible to remove your data from the project once it has been anonymised as we will not be able to identify your specific data. Furthermore, if you withdraw your consent after the research has been published, it will not be possible to remove your quotes. This does not affect your data protection rights. If you decide not to take part you do not need to do anything further.

Audio recordings are essential for the study; therefore if you decide to take part the interview will be audio-recorded. However should you become uncomfortable with the recording process you are free to stop the recording at any time.

Data Protection and Confidentiality

- **What information will you collect about me?**

In order to participate in this research project we will need to collect information that could identify you, called "personal identifiable information". Specifically we will need to collect:

- Professional background
- Voice only audio recording of the interview. The audio recorded data will be stored electronically and transcribed by the researcher that conducted the interview. The interview transcripts will be made anonymous as each participant will be given a unique ID number which will be used on the interview transcripts.

Under what legal basis are you collecting this information?

We are collecting and storing this personal identifiable information in accordance with data protection law which protect your rights. These state that we must have a legal basis (specific reason) for collecting your data. For this study, the specific reason is that it is a public interest task and a process necessary for research purposes.

What are my rights in relation to the information you will collect about me?

You have a number of rights under data protection law regarding your personal information. For example you can request a copy of the information we hold about you, including audio recordings.

If you would like to know more about your different rights or the way we use your personal information to ensure we follow the law, please consult our Privacy Notice for Research.

Will my participation in the study be confidential and my personal identifiable information be protected?

In accordance with data protection law, The University of Manchester is the Data Controller for this project. This means that we are responsible for making sure your personal information is kept secure, confidential and used only in the way you have been told it will be used. All researchers are trained with this in mind, and your data will be looked after in the following way:

Only the study team at the University of Manchester will have access to your personal identifiable information, that is data which could identify you, but they will anonymise it as soon as practical. Your participation in the study will be kept confidential to the study team. The University of Manchester policy on storage of personal data is 5 years after the last publication of the study or for 10 years, whichever is the greater. Consent forms will be retained as essential documents, but items such as contact details will be deleted as soon as they are no longer needed. All participant data will be stored in locked filing cabinets in locked rooms at the university. Identifiable and personal information will be stored separately from research data and linked by a unique ID number.

The audio recorded data will be stored electronically and transcribed by the researcher that conducted the interview. The interview transcripts will be made anonymous as each participant will be given a unique ID number which will be used on the interview transcripts. All information will be kept strictly confidential. Your name will not appear in any publication or shown to anyone outside the research team. Any information including the interview data will have your name and address removed so that you cannot be recognised from it. We may use quotations from you in publications or presentations arising from this research: all such quotations will be anonymised. The audio files will be deleted immediately after transcription. The transcribed data will be stored in a secure electronic file and in a locked filing cabinet and will only be accessible by the research team. In line with the university regulations and good research practice, at the end of a project all confidential or important paper/digital data is sent into secure storage for a period of 10 years. The University has a contract with Iron Mountain off-site archiving facility.

When you agree to take part in a research study, the information about you may be provided to researchers running other research studies in this organisation. The future research will be of a similar nature to this research project and will concern the training of non-professionals to deliver psychological interventions. Your information will only be used by this organisation and researchers to conduct research in accordance with The University of Manchester's Research Privacy Notice.

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of research into task-shifting, and cannot be used to contact you regarding any other matter.

If, during the study, you disclose information about unethical practice, we have a professional obligation to report this and will therefore need to inform your managing body.

Individuals from the University, the site where the research is taking place and regulatory authorities may need to review the study information for auditing and monitoring purposes or in the event of an incident.

Please also note that individuals from The University of Manchester or regulatory authorities may need to look at the data collected for this study to make sure the project is being carried out as planned. This may involve looking at identifiable data. All individuals involved in auditing and monitoring the study will have a strict duty of confidentiality to you as a research participant.

What if I have a complaint?

If you have a concern about any aspect of the study, you should contact the researcher who will do their best to answer your questions.

If you have a minor complaint then you need to contact Waquas Waheed in the first instance by emailing: **waquas.waheed@manchester.ac.uk**
If you wish to make a formal complaint to someone independent of the research team or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact

The Research Governance and Integrity Officer, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674.

If you wish to contact us about your data protection rights, please email dataprotection@manchester.ac.uk or write to The Information Governance Office, Christie Building, The University of Manchester, Oxford Road, M13 9PL at the University and we will guide you through the process of exercising your rights.

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Contact Details

Contact for further information

If you have any queries about the study then please contact the researcher:
Ujala Shahmalak, PhD Student, Suite 5.23, 5th Floor, Williamson Building, The University of Manchester, Oxford Road, Manchester, M13 9PL. Email: ujala.shahmalak@postgrad.manchester.ac.uk.

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [2019-6468-10957].

Appendix 16. Consent Forms for NTPs

MANCHESTER 1824
The University of Manchester

A qualitative study exploring the experiences in training and supervision of non-traditional providers trained in delivering psychological interventions

Consent Form

If you are happy to participate please complete and sign the consent form below

	Activities	Initials
1	I confirm that I have read the attached information sheet (Version 2.0, 19/02/19) for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
2	I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set. I agree to take part on this basis.	
3	I agree to the interviews being audio recorded.	
4	I agree that any data collected may be published in anonymous form in academic books, reports or journals.	
5	I understand that data collected during the study may be looked at by individuals from The University of Manchester or regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
6	I agree that any anonymised data collected may be shared with researchers.	
7	I understand that there may be instances where during the course of the interview information is revealed which means that the researchers will be obliged to break confidentiality and this has been explained in more detail in the information sheet.	
8	I agree to take part in this study.	

Data Protection

The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the Privacy Notice for Research Participants.

_____	_____	_____
Name of Participant	Signature	Date

_____	_____	_____
Name of the person taking consent	Signature	Date

A copy of this consent form will be given to you and the original will be kept by the research team. Consent forms will be retained as essential documents, but items such as contact details will be deleted as soon as they are no longer needed. All participant data will be stored in locked filing cabinets in locked rooms at the university.

Appendix 17. Consent Forms for Experts

MANCHESTER 1824
The University of Manchester

A qualitative study exploring the experiences of experts involved in the training and supervision of non-traditional providers delivering psychological interventions

Consent Form

If you are happy to participate please complete and sign the consent form below

	Activities	Initials
1	I confirm that I have read the attached information sheet (Version 2.0, 19/02/19) for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
2	I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set. I agree to take part on this basis.	
3	I agree to the interviews being audio recorded.	
4	I agree that any data collected may be published in anonymous form in academic books, reports or journals.	
5	I understand that data collected during the study may be looked at by individuals from The University of Manchester or regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
6	I agree that any anonymised data collected may be shared with researchers.	
7	I understand that there may be instances where during the course of the interview information is revealed which means that the researchers will be obliged to break confidentiality and this has been explained in more detail in the information sheet.	
8	I agree to take part in this study.	

Data Protection

The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the Privacy Notice for Research Participants.

_____	_____	_____
Name of Participant	Signature	Date

_____	_____	_____
Name of the person taking consent	Signature	Date

A copy of this consent form will be given to you and the original will be kept by the research team. Consent forms will be retained as essential documents, but items such as contact details will be deleted as soon as they are no longer needed. All participant data will be stored in locked filing cabinets in

Appendix 18. Participation Information Sheet for NTPs - Urdu version

شرکاء کے لیے معلوماتی کتابچہ

آپ کو اس تحقیق میں حصہ لینے کی دعوت دی جا رہی ہے، جو کہ پی ایچ ڈی کے طالب علم کے پروجیکٹ کا حصہ ہے جس کا مقصد غیر ماہرِنفسیات کی مدد سے سائیکلوجیکل انٹروینشنز کے لیے مواد اور تربیت کی فراہمی کے بارے میں تحقیقات کر نا ہے۔اس سے پہلے کہ آپ اس تحقیق میں حصہ لیں آپ کے لیے یہ جاننا ضروری ہے کہ یہ پروگرام کیوں ہورہا ہے اور اس میں کیا شامل ہے۔ برائے مہربانی اس تحقیق میں شامل ہونے سے پہلے تمام معلومات کو پوری توجہ سے پڑھیں اور اگر آپ چاہیں تو دوسروں کے ساتھ اس کے متعلق بات چیت کر سکتے ہیں۔اگر آپ اس کے بارے میں مزید کچھ جاننا چاہتے ہیں یا کچھ واضح نہیں ہے تو براہ مہربانی ہم سے پوچھیں۔ آپ کے وقت دینے کا بہت شکریہ۔

<u>تحقیق کے متعلق</u>

یہ تحقیق کون کرے گا؟

اُجالا شاملاک پی ایچ ڈی سٹوڈنٹ ،سوٹ5.23, 5th فلور، ولیمسن بلڈنگ، یونیورسٹی آف مانچسٹر آکسفورڈ روڈ، مانچسٹر M13 9PL۔

اس تحقیق کا مقصد کیا ہے؟

ایک پُراثر ٹریننگ کے طریقوں کی شناخت کرنےاور تحقیق کو عملی شکل میں لانے کے لئےغیرماہرِ نفسیات نے سائکلوجیکل انٹروینشن پر ٹریننگ لی ہےتاکہ وہ پہلے سے موجود ریسرچ میں کیا چیز موجود ہے اور کیا نہیں ،اس حوالے سے زیادہ سے زیادہ معلومات اکٹھی کر سکیں ۔

مجھے کیوں چنا گیا؟

آپ کو اس لیے چنا گیا کیونکہ آپ ایک غیرماہرِ نفسیات ہیں جس نے نفسیاتی انٹرنیشنز فراہم کرنے کی ٹریننگ میں حصہ لیا ہے ۔

یہ تحقیق کہاں کی جائے گی؟

یہ انٹرویو ٹیلی فون ، سکائپ یا اگر ممکن ہوا تو آمنے سامنے کیا جائے گا ۔

کیا اس تحقیق کے نتائج شائع کیے جائیں گے؟

اس تحقیق کے نتائج پی ایچ ڈی کے تھیسزکاایک حصہ ہوں گے اور شائع ہونے کے لئے پیر ریویوڈ تحقیقی جرنل کو بھیجے جائیں گے۔

اس تحقیق کا جائزہ کس نے لیا؟

اس تحقیق کا جائزہ یونیورسٹی آف مانچسٹر کی ریسرچ ایتھیکس کمیٹی نے لیا۔

<u>میری شمولیت کیوں ضروری ہے؟</u>

اگر میں نے اس تحقیق میں حصہ لیا تو مجھے کیا کرنا ہو گا؟

اگر آپ اس تحقیق میں حصہ لیں گے تو ریسرچر کے ساتھ آپ کو کچھ سوالات کے جوابات دینے ہونگے جس کا دورانیہ30منٹ سے ایک گھنٹے کا ہو گا، جس کا مقصد لی گئی ٹریننگ اور سپر ویژن کے تجربے کے متعلق جاننا ہے۔ انٹرویو کی ریکارڈنگ کی جائے گی۔ یہ انٹرویو ٹیلی فون ، سکائپ یا اگر ممکن ہوا تو آمنے سامنے کیا جائے گا ۔

کیا ہوگا اگر میں اس تحقیق میں حصہ نہ لینا چاہوں یا میں اپنا ارادہ بدل لوں؟

یہ آپ پر منحصر ہے کہ آپ اس تحقیق میں حصہ لیں یا نہیں۔ اگر آپ اس تحقیق میں شامل ہونے کا فیصلہ کر لیتے ہیں تو یہ معلوماتی کتابچہ آپ کو فراہم کیاجائے گا۔آپ کی

رضامندی اجا زت نامے پر دستخط کی صورت میں لی جائے گی یا پھر زبانی لی جائے گی۔ اگر آپ نےاس تحقیق میں شامل ہونے کا فیصلہ کر لیاہے تو بھی آپ کسی بھی وقت اس تحقیق سے بغیر کسی وجہ کے دستبردار ہونے کا فیصلہ کرسکتے ہیں۔لیکن، تحقیق سے آپ کے متعلق فراہم کی گئی معلومات خارج نہیں کی جا سکتی، کیونکہ لی گئی معلومات میں آپ کا نام شامل نہیں ہو گا جس سے آپ کی شناخت کی جا سکے۔ اس کے علاوہ اگر آپ تحقیق کے شائع ہونے کے بعداس سے دستبردار ہونا چاہیں تو آپ کی کہی گئی باتوں کو ختم کرنا ممکن نہیں ہوگا اور نہ ہی اس سے آپ کی فراہم کی گئی معلومات پر کوئی اثر ہوگا۔ اگر آپ نے اس تحقیق میں حصہ نہ لینے کا فیصلہ کیا تو آپ کو مزید کچھ نہیں کرنا پڑے گا۔

اس تحقیق کے لئے انٹرویو کو ریکارڈ کرنا ضروری ہے،اس لیے اگر اپ نے انٹرویو میں شامل ہونے کا فیصلہ کیا تو اس کو ریکارڈ کیا جائے گا۔ پھر بھی اگر آپ ریکارڈنگ کے دوران آرام دہ محسوس نہ کریں تو آپ کو یہ حق حاصل ہوگا کہ آپ کسی بھی وقت ریکارڈنگ رکوا سکتے ہیں۔

<u>ڈیٹا کی حفاظت اور رازداری کو قائم رکھنا</u>

میرے متعلق آپ کیا معلومات حاصل کریں گے؟

اس تحقیقی پروجیکٹ میں شامل ہونے کے لئے ہمیں ایسی معلومات کی ضرورت ہوگی جس کے ذریعے آپ کی شناخت کی جا سکے،جیساکہ خاص طور پر:

- آپ کا نام۔
- پیشہ۔
- انٹرویو کے لئے آپ کی آواز کی ریکارڈنگ ۔ ریکارڈنگ کے ڈیٹا کو الیکٹرانک طریقے سے محفوظ کیا جائے گا اور جس ریسرچرنے انٹرویو لیا ہوگا وہی اس ریکارڈنگ کو سننے کے بعد پیپر پر لکھے گا۔ پیپر پر انٹرویو نام کے بغیر لکھے جائیں گے اور ہر انٹرویو کو ایک خاص ای -ڈی نمبر دیا جائے گا جن کا نمبر انٹرویو ز کے لیے استعمال کیا جائے گا۔

کیا قانونی طور پر آپ یہ معلومات حاصل کرنے کا حق رکھتے ہیں؟

ہم یہ معلومات ڈیٹا کے حفاظتی قانون(جو کہ آپ کے حقوق کی حفاظت کرتا ہے) کے تحت حاصل اور محفوظ کر رہے کریں ہیں ۔اس میں لکھا ہے کہ معلومات حاصل کرنے کے لئے قانونی بنیاد(خاص وجہ) ہونی چاہیے۔ اس کی سب سے خاص وجہ عوامی دلچسپی اور تحقیق میں شامل عمل سے آگاہ ہونا ہے ۔

مجھ سے حاصل کی گئی معلومات سے متعلق میرے کیا حقوق ہیں؟

آپ کی ذاتی معلومات کےلیے حفاظتی قانون کے مطابق آپ کے بے شمار حقوق ہیں۔ مثال کے طور پرآپ کی جو معلومات ہمارے پاس موجود ہیں آپ ان کی ایک کاپی ریکارڈنگز کے ساتھ حاصل کر سکتے ہیں۔اگر آپ مزید اپنے حقوق کے متعلق جاننا چاہتے ہیں یا اس بات کو یقینی بنانے کے لیے کہ ہم کس طرح سے آپ کی ذاتی معلومات کو استعمال کریں گے اس حوالے سے آگاہ ہونا چاہتے ہیں تو برائے مہربانی ریسرچ کے متعلق ہمارے پرائیویسی نوٹس کو پڑھیں۔

کیا تحقیق سے متعلق میری معلومات کو صیغہ راز میں رکھا جائے گا اور اس کی حفاظت کی جائے گی ؟

ڈیٹا کے حفاظتی قانون کے مطابق ڈیٹا کی حفاظت کرنے کی زمہ داری یونیورسٹی آف مانچسٹر کی ہے، اس کا مطلب یہ ہے کہ اس با ت کو یقینی بنانے کی زمہ داری ہماری ہے کہ آپ کی ذاتی معلومات کو رازداری میں رکھا جائے،اور صرف اسی لئے استعمال کیا جائے جس کے متعلق آپ کو پہلے آگاہ کیا جاچکا ہے ۔ تحقیق میں شامل تمام

لوگوں کو اس کی ٹریننگ دی گئی ہےاور آپ سے لی گئی معلومات کی مندرجہ ذیل طریقوں سے حفاظت کی جائے گی :
صرف مانچسٹر یونیورسٹی کی تحقیقاتی ٹیم کو آپ کی ذاتی معلومات تک رسائی حاصل ہوگی، یہ وہ معلومات ہوں گی جس سے آپ کی شناخت کی جا سکتی ہے لیکن جب اس معلومات کو استعمال کیا جائے گا تو جلد از جلد آپ کی شناخت وہاں سے ہٹا دی جائے گی ۔آپ کی شمولیت تحقیقاتی ٹیم سے رازداری میں رکھی جائے گی۔ مانچسٹر یونیورسٹی کی، ڈیٹا کو اپنے پاس محفوظ رکھنے کی پالیسی ،تحقیق کی آخری اشاعت کے بعد پانچ یا 10 سال کے لئے ہے۔اجازت نامہ کے فارم کو لازمی دستاویزات کی طرح رکھا جائے گا، لیکن رابطے کی دوسری تفصیلات کوجیسے ہی مزید ضرورت نہیں ہو گی ختم کر دیا جائے گا۔ تمام شرکاءسے لی گئی معلومات کو یونیورسٹی کے محفوظ کمرے میں رکھا جائے گا۔ انفرادی ID نمبرسے تمام شرکاء کی شناختی اور ذاتی معلومات کو تحقیقاتی معلومات سےالگ کیا جائے گا۔
انٹرویو کے لئے آپ کی آواز کی ریکارڈنگ ۔ ریکارڈنگ کے ڈیٹا کو الیکٹرانک طریقے سے محفوظ کیا جائے گا اور جس ریسرچرنے انٹرویو لیا ہوگا وہی اس ریکارڈنگ کو سننے کے بعد پیپر پر لکھے گا۔ پیپر پر انٹرویو نام کے بغیر لکھے جائیں گے اور ہر انٹرویو کو ایک خاص ای -ڈی نمبر دیا جائے گا جوانٹرویو ز پر لکھنے کے لیے استعمال کیا جائے گا۔ تمام معلومات کو خفیہ رکھا جائے گا۔آپ کا نام کسی بھی اشاعت میں نہیں دکھایا جائے گا یا تحقیقی ٹیم سے باہر کسی کونہیں دکھایا جائے گا۔ تمام معلومات یاانٹرویو ز میں سے آپ کا نام اور پتہ ہٹا دیا جائے گا تاکہ اس سے آپ کی پہچان نہ ہو سکےہم اس تحقیق میں اشاعتوں یا نمائش کے لیےآپ سےحاصل کیے گئے محاوروں کو استعمال کر سکتے ہیں: تمام محاوروں کی شناخت نہیں کی جا سکے گی۔
ریکارڈنگ کی تحریر کرنے کے فوری بعد ان کو مٹا دیا جائے گا۔ڈیٹا کو محفوظ الیکٹرونک فائل اور ایک لاک شدہ الماری میں رکھا جائے گا اور صرف تحقیقاتی ٹیم کو اِس تک رسائی حاصل ہوگی۔ یونیورسٹی کے قواعد و ضوابط اور اچھی تحقیق کی بنیاد پر اور ایک پراجیکٹ کے اختتام پر تمام خفیہ یا اہم کاغذ / ڈیجیٹل ڈیٹا 10 سال کی مدت کے لئے محفوظ جگہ پر رکھے جاتے ہیں ۔یونیورسٹی کا آئرن ماؤنٹین آف سائٹ آرچیونگ کے ساتھ معاہدہ طے ہوا ہے۔
جب آپ ایک تحقیقی مطالعہ میں شامل ہونے کی رضامندی ظاہر کریں تو آپ کے متعلق معلومات اُن ریسرچر کو مہیا کی جا سکتی ہیں جو کہ اسی طرح کے تحقیقاتی مطالعوں پر اِسی آرگنائزیشن میں کر رہے ہیں۔ مستقبل میں کی جانے والی تحقیق بھی اسی تحقیقی پروجیکٹ کی طر ح ہو گی اور اُس میں بھی غیر ماہرِ نفسیات کو سائکلوجیکل انٹرویشنز پہنچانے پر ٹریننگ دی جائے گی۔ آپ کی معلومات تک رسائی صرف اس آرگنائزیشن اور ریسر چر کو حاصل ہو گی جو یونیورسٹی آف مانچسٹر کے ریسرچ پرائیویسی نوٹس کے مطابق تحقیق کرتی ہے۔
یہ معلومات آپ کی شناخت نہیں کرے گی اور نہ ہی دوسری معلومات کے ساتھ ملائی جاسکیں گی جس سے آپ کی شناخت ہو سکے۔ یہ معلومات صرف کام میں ردوبدل کرنے کے لیے صرف تحقیقی مقصد میں استعمال کی جائینگی اور کسی بھی دوسرے کام کے متعلق آپ سے رابطہ کرنے کے لئے استعمال نہیں کی جا سکیں گی ۔
اگر،تحقیق کے دوران، آپ اس کے حوالے سے کو ئی بھی معلومات رازداری میں نہیں رکھتی تو یہ ہماری ذمہ داری ہے کہ اس کے متعلق آپ کے سپر وائزر کو مطلع کیا جائے ۔

یونیورسٹی سےتعلق رکھنے والے افراد،وہ جگہ جہاں ریسرچ کی جا رہی ہے اور ریگولیٹری حکام ،آڈیٹنگ, نگرانی کرنے کے لئے یا کسی حادثے کی صورت میں آپ سے لی گئی معلومات کا جائزہ لے سکتی ہے۔
براہ مہربانی یہ بھی یاد رکھیں کہ مانچسٹر یونیورسٹی یا ریگولیٹری اتھارٹی کے افراد اس بات کو یقینی بنانے کے لیے کہ پراجیکٹ منصوبے کے عین مطابق چل رہا ہےجمع کیے گئے ڈیٹا کو دیکھ سکتے ہیں۔ اس میں وہ ڈیٹا بھی شامل ہوسکتا ہے جس سے آپ کی شناخت کی جاسکے۔آڈیٹنگ اور نگرانی میں شامل تمام افراد پر ایک تحقیقاتی شرکاء ہونےکے ناطے یہ زمہ داری عائد ہو گی کہ وہ تمام معلومات کو راز داری میں رکھیں۔

اگر مجھے شکایت ہو تو؟

اگر آپ کوتحقیق کے کسی بھی پہلو کے بارے میں کو ئی بھی تشویش ہے توآپ کو ریسر چر سے بات کرنی چاہیے جو کہ آپ کے سوالوں کے تسلی بخش جو اب دیں گے۔
اگر آپ کوکو ئی معمولی سی شکایت ہے تو آپ ریسر چر.
ujala.shahmalak@postgrad.manchester.ac.uk سے ای میل کے زریعے رابطہ کر سکتے ہیں۔
اگر آپ تحقیقاتی ٹیم سے آزادانہ طور پر شکایت کرنا چاہتے ہیں یا اگر آپ ان کے جوابات سے مطمئن نہیں ہیں جو آپ نے پہلےریسرچر سے حاصل کیے ہیں تو براہِ مہربانی مندرجہ ذیل پتہ پر رابطہ کریں۔
ریسرچ گورننس اور انٹیگریٹی آفیسر، ریسرچ آفس، کرسٹی بلڈنگ، یونیورسٹی آف مانچسٹر، آکسفورڈ روڈ، مانچسٹر، M13 9PL۔
ای میل: research.complaints@manchester.ac.uk
یا 01612752674 پر ٹیلی فون کرکےرابطہ کریں ۔
اگر آپ اپنے ڈیٹا کے تحفظ کے حقوق کے بارے میں ہم سے رابطہ کرنا چاہتے ہیں تو براہ مہربانی dataprotection@manchester.ac.uk کو ای میل کریں یا انفارمیشن گورننس آفس، کرسٹی بلڈنگ، یونیورسٹی آف مانچسٹر، آکسفورڈ روڈ، M13 9PL
یونیورسٹی میں لکھیں اور ہم آپ کو آپ کے حقوق کو استعمال کرنے کے حوالے سے آگاہ کر یں گے۔
آپ کو اپنی ذاتی شناختی معلومات سے متعلق شکایتوں کے بارے میں کمشنر آفس سے شکایت کرنے کا بھی حق حاصل ہے
فون نمبر: 03031231113

<u>رابطہ کی تفصیلات:</u>

مزید معلومات کے لئے رابطہ کریں۔
اگر آپ کے تحقیق کےحوالے سے مزید کو ئی سوالات ہیں تو براہ مہربانی ریسرچرز سے رابطہ کریں:
اجالا شاملا ک، پی ایچ ڈی طالب علم، سوٹ 5.23، 5th فلور، ولیمسن بلڈنگ ،یونیورسٹی آف مانچسٹر، آکسفورڈ روڈ، مانچسٹر، M13 9PL
ای میل:
ujala.shahmalak@postgrad.manchester.ac.uk.
اس پراجیکٹ کو مانچسٹر کی تحقیقی اخلاقی کمیٹی (UREC حوالہ نمبر) نے منظور کیا ہے ۔

Appendix 19. Consent Forms for NTPs - Urdu Version
اجازت نامہ

اگر آپ اس تحقیق میں حصہ لینے کے لئے رضامند ہیں تو براہِ مہربانی نیچے دیے گئے فارم کو پُر کریں اور اس پر
اپنے دستخط کریں .

1	میں اس بات کی تصدیق کرتی / کرتا ہوں کہ میں نےاس تحقیق سے متعلق تمام معلومات پڑھ لی ہیں۔ اور ان کو پڑھنے کے بعد مجھے سوالات پوچھنے کا پورا موقع دیا گیا جس کےمجھےتسلی بخش جوابات دیئے گئے ۔	
2	میں سمجھتا ہوں /سمجھتی ہوں کہ اس تحقیق میں میر ی شر کت رضاکارانہ ہے اور میں کسی بھی وقت بغیر کسی وجہ کے کسی بھی موقع پر اس سے دستبردار ہو سکتی ہوں۔میں سمجھتا ہوں /سمجھتی ہوں کہ اگر ایک بار میری فراہم کردہ معلومات کو محفوظ کردیا گیا تو اس کو اس تحقیق سے نہیں نکالا جا سکتا ۔ لیکن پھر بھی اس بنیادپر میں اس میں حصہ لینے کے لئے رضامند ہوں ۔	
3	میں جانتا/جانتی ہو ں کہ میرے انٹرویوز کو ریکار ڈ کیا جائےگا۔	
4	میں جانتا/جانتی ہو ں کہ مجھ سے لی گئی معلومات بغیر میرا نام شامل کیے کسی تعلیمی کتابچہ، رپورٹ یا جرنل میں چھاپی جا سکتی ہے۔	
5	میں سمجھتا ہوں /سمجھتی ہوں کہ اس تحقیق سے حاصل کیے گئے ڈیٹا کو یونیورسٹی آف مانچسٹراور ریگولیٹری اتھارٹیز تک رسائی حاصل ہو سکتی ہے۔ میں اُن افراد کو اپنے ڈیٹا تک رسائی کی اجازت دیتی ہوں ۔	
6	میں جانتا/جانتی ہو ں کہ بغیر شناخت کے حاصل کئےگئےڈیٹا کو ریسرچرزکے ساتھ شئیر کیا جائے گا۔	
7	میں سمجھتا ہوں /سمجھتی ہوں کہ پر وگر ام میں آگے چل کر ایسی صورت حال پیش آ سکتی ہے جہاں میری فراہم کر دہ کچھ معلومات ریسرچرز رازداری میں نہ رکھ سکیں اور اس حوالے سے معلوماتی کتابچے میں تفصیلاً بات کی گئی ہے۔	
8	میں اس تحقیق میں حصہ لینے پر رضامند ہوں۔	

ڈیٹا کی حفاظت
اس تحقیق کو تر تیب دینے اور اس میں استعمال کرنے کے لیے جو ذاتی معلومات ہم حاصل کریں گے اُس پر ڈیٹا کےحفاظتی قانون کے مطابق عملدرآمد کیا جائے گا ، جس کی و ضاحت شرکاء کی معلوماتی شیٹ، اورپرائیویسی نوٹس برائے شرکاء میں کی گئی ہے۔

_____ _____ _____

حصہ لینے والےکا نام دستخط تاریخ

_____ _____ _____

رضامندی لینے والے کا نام دستخط تاریخ

اس اجازت نامے کی اصل کاپی تحقیقاتی ٹیم کے پاس ہو گی اور ایک کاپی آپ کو دی جائے گی ۔ اجازت نامے کوضروری دستاویزات کی طرح رکھاجائےگا، لیکن کچھ معلومات کو ضرورت ختم ہونے کے بعد ختم کر دیا جائیگا جیساکہ رابطے کی معلومات وغیرہ ۔ تمام شرکاء کا ڈیٹا یونیورسٹی کےلاک شدہ کمروں میں محفوظ کیا جائے گا۔

Appendix 20. Topic Guide for NTP Interviews

My name is Ujala Shahmalak, I'm a PhD student from the University of Manchester. Thank you for letting me interview today, I appreciate you giving your time. Your participation is entirely voluntary and you are free to withdraw at any time, and the data derived from this interview will be confidential, and you will not be identified in any documents or reports containing the data. I will be audio recording this interview - Is that ok? The audio recorded data will be stored electronically and transcribed by the researcher that conducted the interview. The audio files will be deleted immediately after transcription. The transcribed data will be stored in a secure electronic file and in a locked filing cabinet and will only be accessible by the research team.

Just to give you a bit more information in regards to this interview, my PhD is looking at the effective characteristics of training for non-professionals with the aim to create a framework to train non-traditional providers (e.g. peers and volunteers) to be able to deliver psychological interventions for common mental health disorders. I am conducting these interviews to explore your experiences of the training you attended and also to find out more information about what people feel are effective types of training in general. Do you have any questions?

- To begin with, can you tell me what your position/job/role is and what your professional background is? Was this your first time receiving training of this type?
- Are you currently delivering a psychological intervention/ working with people with common mental health disorders? If so, what type of intervention is it?

Format of training

- What did you think about the format of the training? Are there any other formats that you would prefer or recommend e.g. on site educational visits, online?
- What did you think about the structure of the training? Did you think that the training was outlined clearly?
- What did you think about learning through lectures in which the facilitator used a presentation? Do you think this is the best way to learn? Did you feel that you needed this part of the training? Why?
- What did you think about the interactive parts of the training?

- Which did you prefer, the lecture based way of presenting information or the interactive way of presenting information involving the whole group? Would you prefer training to be made up of a mixture of both or only one?
- What did you think of the materials given out during the training? Did you find them helpful? Did you use them after to assist you in delivering the intervention or are you currently using them?
- What did you think about the group size, would you have preferred larger or smaller group?
- What did you think about the length of the training? Do you prefer longer, intense sessions or shorter, more numerous sessions.
- What did you think about the location of the training? What do you think is the ideal setting to have training? (i.e. workplace, at a community centre)
- What did you think about the time of the training? Do you mind taking time off work to have training? Would you prefer training over several evenings or on a weekend?

Content of training

- Did you feel the training was presented to you clearly? How well did you understand your role after the training?
- Did you feel you learnt enough about depression/anxiety in people? What do you think helped improved or did not help improve your knowledge? Did you need more/less education on this?
- Has the training changed your attitudes about people with depression/anxiety in any way? How have they changed?
- Did you think the different treatment techniques were covered in enough detail? (e.g. behavioural activation, goal setting, cognitive restructuring, coping strategies). Would you like to have received more or less training on any of these?
- Do you think you will use any of these treatment techniques on yourself?
- Did the training help your confidence to be able to work with people with depression/anxiety? Why/How?
- Do you feel it is important for training to include theory and/or evidence to support the content of the training? Would you feel more convinced about the content if is supported by evidence or if it has a theory behind it?

Facilitator and Supervision

- What did you think about the facilitators who delivered the training? Do you think the expertise/qualifications of the facilitator are important?
- Is it important for facilitators to be experienced in the skills they are teaching? Do you think it is important for the facilitator to be senior/well known?
- (If currently delivering a psychological intervention) Do you receive any supervision whilst delivering the intervention? If not, what do you think about having regular supervision whilst delivering the intervention? Would it make you feel more confident?
- What format of supervision would you prefer? (i.e. group format or one to one?) How often would you like to be supervised? (i.e. fortnightly, once a month)

Thank you for participating in this interview, I reiterate the data derived from this interview will be confidential, and you will not be identified in any documents or reports containing the data.

Appendix 21. Topic Guide for Expert Interviews

My name is Ujala Shahmalak, I'm a PhD student from the University of Manchester. Thank you for agreeing to let me interview today, I appreciate you giving your time. I just want to reiterate that your participation is entirely voluntary and you are free to withdraw at any time, and the data derived from this interview will be confidential, and you will not be identified in any documents or reports containing the data. I will be audio recording this interview - Is that ok? The audio recorded data will be stored electronically and transcribed by the researcher that conducted the interview. The audio files will be deleted immediately after transcription. The transcribed data will be stored in a secure electronic file and in a locked filing cabinet and will only be accessible by the research team.

Just to give you some background to the interview, my PhD is looking at the effective characteristics of training for non-professionals to deliver psychological interventions for common mental health disorders. I have done a systematic review of studies investigating the content and delivery of the training of non-traditional providers, task shifting interventions for common mental health disorders. My next aim is to create a framework to train non-traditional providers (e.g. peers and volunteers) in delivering psychological interventions. As the studies I reviewed did not report much detail about the training, I am conducting these interviews in order to supplement the findings of the review with more information about what experts feel are effective types of training. Do you have any questions?

- To start with, can you tell me what your professional background is?
- Can you tell me what training programmes to train non-professionals in psychological interventions you have been involved in (or are aware of)?

Content of training

- What training techniques do you think are the most useful in teaching non-professionals about common mental health disorders and psychological interventions?
- Do you think training time should be equally divided to cover information regarding the mental health condition and treatment techniques/skills? Or should most of the time be devoted to teaching trainees how to deliver the intervention and only briefly cover the MHC?

- Is practicing skills an essential part of the learning process? Are there any types of skills practice that you have used or know of? (i.e role-playing)
- How do you find trainees react to skills practice? How do you get around a negative reaction?
- Do you think it is important to adapt the training to individual/organisational?

Delivery of training

- Can you tell me what your ideal training programme to train NTP in delivering psychological interventions would be?
- What do you think are the best modes of delivery of training? E.g. interactive vs. didactic, case based discussions, workshops, online
- Who do you think is the best type of person to deliver the training? How important is expertise/credibility/professional background?
- Where do you think is the best place for training to be delivered? (i.e. trainees' workplace, community centre). Do you think the setting/location of the training makes any difference?
- What do you think the optimal length of training should be? Should there be shorter, more numerous sessions or longer, intense sessions?
- Is group size important in training? What do you think the ideal number of trainees is?
- Do you think supervision is important when trainees are delivering the intervention?
- What do you think is the best mode of supervision? How often should supervision occur? What should the format of supervision be?
- How do you think competence of the trainees should be assessed?

Organisational factors

- How do you think fidelity/quality of the intervention delivered by the NTP should be assured?
- Do you think incentives are important to encourage people to attend training programmes? What is the best way to motivate people to attend training programmes?

- Do you have any further comments regarding the most effective ways to train non-professionals?

Theoretical frameworks for training

- What theories are most useful to use in designing training programmes?
- Which theories do/would you use?
- Do you think it is important for training content to be evidence based?
- There is a lack of evidence on what constitutes effective training, why do you think that is?
- Reporting of the training of NTPs in research papers is often brief, incomplete or lacking, why do you think that is?
- Do you think a checklist for researchers when reporting training would be a useful tool? How would you use it?
- Do you think a toolkit for researchers delivering training would be useful? How would you use it?

Thank you for participating in this interview, I reiterate the data derived from this interview will be confidential, and you will not be identified in any documents or reports containing the data

Appendix 22. Topic guide for NTP Interviews - Urdu Version

Mera nam Ujala hai. Mein Manchester University mein PhD ki Tailibe-ilm hoon. Aaap ka shukria ke aap ne mujhe interview ke liye waqat dia, mein aap ki mamnoon hoon.
Aap aapni marzi se is tahqeeq mein shamil ho sakte hain aur jab chahain nikal sakte hain. Aap ki zatee maloomat ki poori razdari ho gee aur us se aap ki shanakat nahee ho sakti. Mein interview ko tape bhi karoon gee, kya aap ki ejaazat hai? Tape ki saree maloomat bhi poori razdaari ke sath mahfooz ki jaye gee aur sirf tehqeeqi team ki pohnch mein ho gee.
Mein aap ko batana chahon gi ke meri tehqeeq ye dekhi gee ke ghar tarbiat yafta afrad ke zarye nafsiyati tariqa elaj ki training me kaun kaun se juz hain jo inhe mausar banate hain, ta ke ye ghair tarbiat yafte afrad aam zehni bemari ke nafsiyati elaj kar saken.
Mein aap ka interview kar rahi hoon ta ke ye jan sakoon ke ye kam ke liye aap ka tajreba kesa tha, aur aap ke khiyal mein kis taraha ke training madad gar hui. Kya aap koi sawal karna chatey hain?

Can you tell me what your position/job/role is and what your professional background is? Was this your first time receiving training of this type?
Aap ka kya pesha hai aur aap kya kam karte hain? Kya is qism ki training aap ne pehli bar lee hai?

Are you currently delivering a psychological intervention/working with people with CMDs? If so, what type of intervention is it?
Kya aap aaj kal nasfsiyati elaj kar rahe hain ya aam zehni bemar logon ke saath kam kar rahe hain. (if yes,) yeh nafsiyati elaj kis tarah ka hai?

Format of training
What did you think about the format of the training? Are there any other formats that you would prefer or recommend e.g. on site educational visits, online?
Aap ka training ke tarike bare mein kya khayal hai? Kya aap kisi muktalaf training ko tarjeeh den gain, jese ki computer pe ya phir khud idare pe ja kar taleem laina.

What did you think about the structure of the training? Did you think that the training was outlined clearly?
Aap ka training ki tafseel ke bare mein kya khayal hai? Aap ke khayal mein training sahee taur par biyan ki gahee thee?

What did you think about learning through lectures in which the facilitator used a presentation? Do you think this is the best way to learn? Did you feel that you needed this part of the training? Why?

Wo lectures jis mein presentation ka istamal hua tha, us ke bare mein aap ka kya khayal hai? Aap ke khayal mein, aap ko is tarah ki training ki zaroorat hai?

What did you think about the interactive parts of the training?
Aap ke khayal mein miljul kar ya ek dusre see baat kar ke training karna kaisa hai?

Which did you prefer, the lecture based way of presenting information or the interactive way of presenting information involving the whole group? Would you prefer training to be made up of a mixture of both or only one?
Aap kis qism ki training ko ziyada tarjeel dete hain, maloomati lecture ko ya pore group ko miljul kar aur baat cheet se maloomat daine ko? Kiya dono tareeqo ko mila kar ya koi ek?

What did you think of the materials given out during the training? Did you find them helpful? Did you use them after to assist you in delivering the intervention or are you currently using them?
Aap ke khayal mein training ke doraan jo parche (Materials) diya gaya tha wo kaise the? Kya wo madadgar hua? Kya aap ne phir us ko istemal kiya jab ap zehni bemar logon ke saath kam kar rahi thi.

What did you think about the group size, would you have preferred larger or smaller group?
Aap ka group ke size ke bare mein kya khayal hai? Kya chota group ya bara group ziyada behtar hai?

What did you think about the length of the training? Do you prefer longer, intense sessions or shorter, more numerous sessions.
Aap ka training ke dauraniye ke bare mein kya khayal hai? Kya aap ke khayal mein training lamba aur sakat hona chahiye ya chote chote aur bohot se dino mein hona chahiye.

What did you think about the location of the training? What do you think is the ideal setting to have training? (i.e. workplace, at a community centre)
Aap ka training ki jagha ke bare mein kya khayal hai? Yeh kam ki jagha pe ho ya mohaley mein?

What did you think about the time of the training? Do you mind taking time off work to have training? Would you prefer training over several evenings or on a weekend?
Aap ko training ke time ke bare mein kya khayal hai? Aap ko chuthi kar ke training karna pe koi eitraz hain? Aap training sham ke waqat ya chutti wale din karna pasand karte hain?

Content of training

Did you feel the training was presented to you clearly? How well did you understand your role after the training?

Kiya aap ko training ke bare mein sahee samjhya gaya tha? Training ke baad, aap kitna samjeh aap ki zimedari kya thee?

Did you feel you learnt enough about depression/anxiety in people? What do you think helped improved or did not help improve your knowledge? Did you need more/less education on this?

Kiya aap samajteh hain ke aap ne anxiety aur depression ke bare mein kaafi seekha? Kiya cheez aap ki maloomat barhane mein madadgar ya kam madadgar hui? Kya aap ko aur zaada taleem ki zaroorat hai?

Has the training changed your attitudes about people with depression/anxiety in any way? How have they changed?

Kya is training me aam zehni bemar logon ke bare mein aap ka rawyah tabdeel kiya? Kis tarha ki tabdeeli aayee?

Did you think the different treatment techniques were covered in enough detail? Would you like to have received more or less training on any of these?

Kiya aap ke khayal mein mukhtalif elaj ke tareeqay sahee bataya gaye tha, ya aur training ke zaroorat hai?

Do you think you will use any of these treatment techniques on yourself?

Kaya aap is mein se koi tareeqa elaj apne par istemal kar rahe hai?

Did the training help your confidence to be able to work with people with depression/anxiety? Why/How?

Is training se aap ki madad hui ke ab aap aam zehni bemar logon ke saath kam kar sakte hein? Kis tarha aap ke etemad mein izafa hua?

Do you feel it is important for training to include theory and/or evidence to support the content of the training? Would you feel more convinced about the content if is supported by evidence or if it has a theory behind it?

Aap ke kyal mein kya cheez training mein ziyada zaroori hai? Elaj ka tareeqke ya zehni amraz ke bare mein maloomat?

Facilitator and Supervision

What did you think about the facilitators who delivered the training? Do you think the expertise/qualifications of the facilitator are important?

Jin logon ne aap ko training di thee, un ke bare mein aap ka kiya khayal hai? Un ki qaabliyaat aur tajruba kitna zaroori hai?

Is it important for facilitators to be experienced in the skills they are teaching? Do you think it is important for the facilitator to be senior/well known?
Kya un ka qabil aur mashoor hona zaroori hain? Kya un ko us training ka tajurba hona chaiye?

(If currently delivering a psychological intervention) Do you receive any supervision whilst delivering the intervention? If not, what do you think about having regular supervision whilst delivering the intervention? Would it make you feel more confident?
Aap nafsiyati elaj kisi ki nigrani mein kar rahe hain? (if not) Aap ko zere nigrani nafsiyati elaj ke bare mein kya khayal hai? Kya is se aap ziyade khud etamad hon gain?

What format of supervision would you prefer? (i.e. group format or one to one?) How often would you like to be supervised? (i.e. fortnightly, once a month)
Kaisi negrani behtar hai group mein ya akele akele? Kitni bar honi chaiye?

Aap ke waqat dena ke shukriya. Mein phir aap ko batana chati hoon ke yeh sara interview bilkul khofiyah rakha jaye ga aur kisi bhi maloomat se aap ki pehchan nahi ho sakti.

Appendix 23. University Research Ethics Committee Approval Letter

Research Governance, Ethics and Integrity
2nd Floor Christie Building
The University of Manchester
Oxford Road
Manchester
M13 9PL
Tel: 0161 275 2206/2674
Email: research.ethics@manchester.ac.uk

Ref: 2019-6468-10957

11/06/2019

Dear Miss Ujala Shahmalak, Dr Waquas Waheed, Dr Amy Blakemore

Study Title: Task-shifting psychological interventions for mental health disorders

University Research Ethics Committee 1

I write to thank you for submitting the final version of your documents for your project to the Committee on 07/06/2019 20:24 . I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

Please see below for a table of the title, version numbers and dates of all the final approved documents for your project:

Document Type	File Name	Date	Version
Advertisement	Email for NTPs v 1.0 13.11.18 (1)	13/11/2018	1.0
Advertisement	Email for experts v 1.0 13.11.18 (1)	13/11/2018	1.0
Consent Form	Consent form experts v 2.0 19.02.19	19/02/2019	2.0
Consent Form	Consent form NTPs v 2.0 19.02.19	19/02/2019	2.0
Additional docs	PIS_NTPs_ Translation doc	19/03/2019	1.0
Additional docs	Consent Form translation	19/03/2019	2.0
Additional docs	Email for researchers v 3.0	19/03/2019	3.0
Additional docs	Pakistan Ethical Approval Letter pg.1	21/03/2019	1.0
Additional docs	Pakistan Ethical Approval Letter pg. 2	21/03/2019	1.0
Lone Worker Policy/Procedure	Lone Working Policy 09.04.19	09/04/2019	2.0
Lone Worker Policy/Procedure	Pre Travel Self Checklist_	09/04/2019	1.0
Additional docs	Approval Letter PhD v2-Ujala	09/04/2019	2.0
Additional docs	Letter of Approval ROSHNI	09/04/2019	1.0
Data Management Plan	DMP v2	17/04/2019	2.0
Additional docs	Big Life letter	30/04/2019	1.0
Default	Draft Topic Guide for NTP Interviews v 2.0 13.03.19	13/05/2019	2.0
Default	Draft Topic Guide for Experts Interview v 2.0 13.05.19	13/05/2019	2.0
Participant Information Sheet	PIS experts v3.0 13.05.19	13/05/2019	3.0
Participant Information Sheet	PIS NTPs v3.0 13.05.19	13/05/2019	3.0
Distress Protocol/Debrief Sheet	risk_distress protocol v2.0 13.05.19	13/05/2019	2.0
Lone Worker Policy/Procedure	risk assessment 13.05.19	13/05/2019	3.0
Advertisement	NTP email translation	17/05/2019	1.0
Additional docs	NTP email translation	17/05/2019	1.0
Additional docs	Approval Letter_Ujala	24/05/2019	2.0
Additional docs	ROSHNI-Pakistan approval letter	30/05/2019	2.0
Additional docs	Approval letter Big Life	31/05/2019	2.0
Additional docs	Ethics amendments	04/06/2019	2.0

This approval is effective for a period of five years however please note that it is only valid for the specifications of the research project as outlined in the approved documentation set. If the project continues beyond the 5 year period or if you wish to propose any changes to the methodology or any other specifics within the project, an application to seek an amendment must be submitted for review. Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or

kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

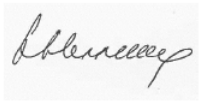
1. Amendments: Guidance on what constitutes an amendment
2. Amendments: How to submit an amendment in the ERM system
3. Ethics Breaches and adverse events
4. Data breaches
5. Notification of progress/end of the study

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a **UREC Feedback Form**. Instructions for completing this can be found in your approval email.

We wish you every success with the research.

Yours sincerely,



Ms Kate Hennessy

Secretary to University Research Ethics Committee 1

Appendix 24. Pakistan Ethical Approval Letter

Human Development Research Foundation

NPO SEAL OF GOOD PRACTICES
HDRF has been certified by the Pakistan Centre for Philanthropy (PCP) on September 11, 2015, for meeting certification standards in the areas of Internal Governance, Financial Management, and Programme Delivery

Institutional Review Board-HDRF

Ujala Shamalak
March 21, 2019

Dear Ms. Shamalak,

Submission Title: Task-shifting psychological interventions for common mental disorders through non-traditional providers: A qualitative study exploring the views of stakeholders

HDRF IRB Ref: IRB/006/2019

Thank you for submitting your protocol for ethical approval on Feb 26, 2019.

The board has reviewed your application and the relevant documents.

The board also reviewed the subsequent changes you made to your ethical approval application and submitted on March 20, 2019, after the board's comments.

Confirmation of Ethical Approval

On behalf of the board, I am pleased to confirm a favourable ethical opinion for the above titled research on the basis described in the application form, protocol and supporting documentation, as specified below.

Approved Documents

The final list of documents reviewed and approved by the board are as follows:

Document Type	File Name	No. of Version	Date
Appendix 1	Participant information sheet (PIS)	02	19.02.19
Appendix 2	Consent Form	02	26.02.19
HDRF Ethical Approval Application			26.02.19
Study Protocol			26.02.19

HDRF Human Development Research Foundation

House 06, Street 55, F-7/4, Islamabad. Tel: 051-2656172-3 Po Box No. 516. Reg # 617, NTN # 1552649-6
Website: www.hdrfoundation.org Email: info@hdrfoundation.org

Human Development Research Foundation

NPO SEAL OF GOOD PRACTICES
HDRF has been certified by the Pakistan Centre for Philanthropy (PCP) on September 11, 2015, for meeting certification standards in the areas of Internal Governance, Financial Management, and Programme Delivery

After Ethical Review

The IRB must be updated on any subsequent changes to the application/protocol/consent and information forms during the lifetime of the study.

Sincerely,

Shamsa Zafar
Chair IRB- HDRF
Human Development Research Foundation

HDRF Human Development Research Foundation

Appendix 25. Additional Quotes from NTP Interviews

Sub-Themes	HIC	LMIC
1.0 Who are the NTPs?		
1.1 Shared characteristics	Services like or projects like PERSUADE benefit from a normalising of those ideas and the benefit of those ideas being real world possible, accessible in an easy way or a simple way and I think that benefits also from its delivery being uh from kind of a peer or lay because it does normalise or level out what the content is in that sense, that somebody can go, 'yeh well he's given me a real world context about that, he's a guy like me or she's a woman like I am, she's come from this background, I understand, they live their lives in a way that I would understand and like being lived and they've had the same pressures and stresses'. (NTP05HIC)	We knew the mothers because they were from our village so it was easy to deliver it to them (NTP09LMIC) They (the mothers) were Sindhi so I would explain it to them in Sindhi) (NTP14LMIC) They knew that I was already working in the area so this work wouldn't be difficult for me (NTP16LMIC) If it's someone from their own village then she can use her own language and words to explain things (NTP13LMIC) The benefit of being from the same village, is that they know what the atmosphere is like in the home. Like how I know my area, if someone dies, I go for condolences, if someone is ill I will go or if there is a wedding at someone's house then I will go... I know what the people in my area are like and what the situation is in their homes. (NTP10LMIC) If she's from the village it's better because she knows about the home, she knows about the mother, the husband, the children. It should be someone the she (the mother) trust, because she's telling her about everything (NTP09LMIC) I could tell when a mother would start hesitating or changing the topic that there would be something inside of her that she would be hiding... it would take a bit of time for them to build trust but then they would start sharing with us (NTP11LMIC) If the mothers are scared by us we tell them the reason why we're there, and only if they agree will we give them advice, it will benefit them (NTP19LMIC)

Sub-Themes	HIC	LMIC
1.2 Knowledge in mental health	I didn't do any qualifications but in terms of working with people on the front-line with poor mental health, I guess that gave me a bit of experience. And I'd work quite closely with self-help services uh when I was on Working Well, so we'd do a lot of referrals, then if we had any questions, I could just give them a call, or drop them an email and they'd be able to answer my questions. (NTP01HIC) I've always worked in community organisations or charities uh and I've worked with, always worked with people who have, I don't know, it's either been a well-being project or mental health or getting people into work. (NTP02HIC) I do have a training qualification in mindfulness and I also had a five day course that I attended for online CBT (NTP06HIC)	We didn't know anything about how our mood is and how it should be... only when we got training did we realised that this is good mood and that's bad (NTP10LMIC) Even though some of us were educated, this work was still new for us. I had a little bit of an idea about health but most people didn't (NTP11LMIC) We have knowledge around the child and mother, we give vaccinations, we measure weights, we give women advice about food and rest but we were learning about why someone can become mentally ill for the first time (NTP14LMIC) I didn't know anything about mental illness. I used to think that those people were crazy and they don't understand anything so there's not point speaking to them (NTP17LMIC)
1.3 Capacity to deliver intervention (confidence)	I always think preparation is important because you need to know it, not inside out necessarily.... We need to respect the fact that somebody has walked in, to a room of people they've never met before and the action of opening that door is saying something about them or something they believe about them or some help that they want. So, we need to respect that and I think that is one of the ways we need to do it, by being prepared. We should never be unprepared (NTP05HIC) I genuinely believe that if you can empathise and you have the capacity, the confidence perhaps or find that confidence in yourself to deliver you can, if the training is right, you can learn as much as you need and no more, and you can still be full of high quality and effective. Bogging someone down with a load of stuff which is interesting, but what does that mean for the person that is doing something for two hours? (NTP05HIC) The person delivering something like PERSUADE needs to be confident to do so, and how you would assess that is a different matter (NTP05HIC)	I would read the book the night before and I revise everything (NTP15LMIC) I would tell them (mothers) that this is going to benefit you and your children... in 3 months you are going to have learnt so much that you will be telling other mothers about this too. Just come at least once and see, if you don't like it then you don't need to come again (NTP14LMIC) They would give us homework which I would do before going, I used to write it down on a diary… and we were told to read the job aid before going to deliver a session (NTP13LMIC)
1.3 Capacity to deliver intervention (assessments)	I personally think it (assessment) is important but I understand why in some contexts people don't do it, or maybe why some people don't think it's	After the training we did role-plays which was our test to see how we are delivering the intervention (NTP09LMIC)

Sub-Themes	HIC	LMIC
	necessary. Because obviously for something like PERSUADE it's kind of psychoeducation rather than therapy and that being quite a big difference because obviously with things like therapy like counselling and CNT, like literally you're not allowed to do it until you've got a competency based assessment that you've passed and you've got a diploma. But I think for psychoeducation because it's not therapy, it's not really done, it's not really assessed. (NTP06HIC)	The only assessment we had was the first time we went to deliver the group session; it was a practice and our supervisor came with us (NTP12LMIC) It was a long training. They went through each and everything in detail and then they gave us a form to see how much we knew. They gave us a form at the start to see how much we did or didn't know and then after the training they gave us another form to see how much we had learnt (NTP14LMIC)
2.0 Elements of training		
2.1 Accessible training venue	for people that drive they would offer lifts to people that couldn't drive, so people would car share anyway (NTP01HIC) I wouldn't really want to travel. The thing is I don't mind if it's near to my office or not because I'm barely there and I was coming from home so the location was good, but the surrounding area is really good. Limelight is a beautiful place (NTP03HIC) If you are recruiting specifically from, for example for the sake of our conversation, umm the Big Life; clearly it's going to work better if you go there because you can have somebody who's going to have time to come down from the office, you are widening a pool from that group and you will likely get a better sort of take up I would have thought. It would be hard to convince, wouldn't it? If you've got a community room in a building or the people going to the training are from that building and you bring them here. It would be hard to do that; it wouldn't make any sense. (NTP05HIC) I think it was very convenient and Manchester University is accessible. If you say, 'do I want training at the place that I am working?', then yes of course that's better and I would want that, but I think the question is about what can be available. (NTP07HIC)	For the last few days I've hurt my back from sweeping the floor and it's been so bad that I've been unable to walk, and I've been so worried about what I'm going to do. I wasn't worried about anything else only how am i going to walk. One of the mothers lives far away and I have to walk a lot so I was thinking a lot about how I'm going to get there (NTP10LMIC) It was really good, they would message us one day before as to what time they are going to come and pick us up for training. They would pick us up and drop us off at a fixed time (NTP13LMIC) A car would come to pick us up and drop us off and that's why my family agreed to this… if I had to walk there or get the bus then my family wouldn't have allowed me to go (NTP14LMIC) It would be difficult because I didn't have transport (NTP18LMIC)
2.2 Tailored training (learning style)	I'm a practical person you see, so seeing the interventions and knowing how the interventions work and then seeing the role-plays and stuff like that, that would probably work for me. Whereas, you might get someone who is more	

Sub-Themes	HIC	LMIC
	theory based and be more around the stats and think, 'Well actually, the stats are telling me this and I can work off that.' (NTP01HIC) I think I'm one of those difficult people, that I need to see it, I need to read it um, I need to experience it, I need the whole rounded experience to make it go in (NTP02HIC) I suppose you could call me a disruptive learner. So, I enjoy like sitting down for a lecture but like putting my hand up to ask questions to check my understanding of it. (NTP03HIC) I like to see things done. I think I am a visual kind of character, if I see things done, I can latch onto them better and that is important. (NTP05HIC) I very much like it (role-plays), but I find that not everybody likes it, so I'm not sure in any uh training you should have it. Maybe, it depends on the uh student and you can have plan A and B. (NTP07HIC)	
2.2 Tailored training (experience)	with the lecturers it's fine, it's good because they're obviously in their roles because they've got experience umm of doing the job; but then they've gone on to teaching or writing papers or whatever it is that they do. But then, sometimes they lose the fact that we are just lay people and some of us haven't done university training or been to university and some of us aren't academic (NTP02HIC) I don't think we needed to spend so long on safeguarding, because I've done two other safeguarding training modules just in this workplace and you know the fact that I've been involved in this working area for the last few years anyway I've, I do it every year essentially (NTP03HIC) I thought it was really good how they showed you the techniques if you weren't familiar with them, and to also kind of liaise with you on what you felt able to deliver, what was less comfortable, what was less familiar to you, because I know that a few of my colleagues hadn't done some of the techniques before, there was some I hadn't done before. So, it felt like a good chance to experiment with those things (NTP06HIC)	I didn't find anything difficult, the only thing was because of my education level some things took a bit more time and effort to understand (NTP08LMIC) The problem is education, is someone is educated they can pick it up quickly, but if I didn't understand something, we had their number so we could ask (NTP08LMIC) There was nothing difficult during training. I don't have a lot of education which I told them, but if there were any difficult words then we would ask them and they would explain it in simple language by writing it down (NTP09LMIC)

Sub-Themes	HIC	LMIC
	there was a little too much focus on children because uhh, we never worked with children. Umm, so at times we'd be talking quite a lot, and I'm aware at the time there were nursery and school practitioners in the session as well so it's relevant to them umm but I was sitting there thinking , you know, 'there's stuff on families and children here and I don't work with families and I don't work with children' (NTP03HIC)	
2.3 Experiential learning	the best way of sort of learning the MI is to sort of see how other people have done it, maybe how other professionals do it and do it yourself and just sort of have that, and sort of keep practicing it (NTP01HIC) we did get real life examples but it would have been good if some of the techniques we were being told about or being taught about, is to see a video of those in practice, because I understand that with a lot of the training you couldn't do role-play, it just wouldn't be real and it wouldn't sort of mirror what people go through when they are speaking with their clients; but if you were to watch somebody who was a professional who was using those techniques in one of their cases, then it would have resonated with me more personally just because of the way that I learn (NTP02HIC) there were people there who were psychological well-being practitioners, people there, other mental health professionals and it was quite interesting to hear their take on things as well. (NTP03HIC) We did umm, the MMP training with Self Help and it was quite interesting to see the different approaches and even across our team really, we all come from different backgrounds and it was quite interesting to see how we all tackle the same issues but we all take a different stance on it and look at it in a different way. (NTP04HIC) I think there is an ideal size, I think it's about eight. .... You get different perspectives, so somebody might raise something that might contextualise in somebody else's space, which is really good. (NTP05HIC)	Everyone shares stories about their mothers and we can see how they solved problems with their mothers and how we can do the same (NTP12LMIC) It's good in a group because that way the problem is solved one way or another. Everyone has their own way of thinking… So maybe someone might be thinking of something which is right and it might solve the problem (NTP10LMIC) They would tell us really patiently, they would say, "that you are already a mother, you know how to hold a baby, how to look after one" (NTP17LMIC) There weren't any real difficulties because we were already going out, we already doing work around the child's health (NTP19LMIC) Everyone can share their own experiences with the mothers… and in that way I might be able to solve some of the problems that I am having with my mother because they are having the same problems too (NTP11LMIC)

Sub-Themes	HIC	LMIC
2.4 Training materials	all that information is in the handbook that we received so it's always good to have stuff to go back to that you can look at, just to give you that bit of a refresh (NTP01HIC) there were PowerPoints and videos. (NTP04HIC) The training manual was useful, it was colourful, it was attractive (NTP07HIC) We did get some handouts but my expectation was that we were going to get all of the handouts sent to us and it was all going to be in a book so that we could sort of go through them as we went through the training but that didn't happen. So, it was either on the day, and afterwards I still haven't got that book with all of the course in, ...t it would have been good to have all of the stuff afterwards at least or quite soon afterwards just so you could read something and it could spark something, say that you remember the training session. (NTP02HIC)	There was a book for the group and the individual sessions on the basic principles about mother and child relations, issues surrounding the mother (NTP10LMIC) The role-plays were about health, we had cards, and posters about health. We were told about the mother's healthy and unhealthy thinking NTP11LMIC) They got awareness through the books, because there were a lot of mothers in the village who were not educated and weren't able to read, but they would look at the pictures and understand (NTP12LMIC) The white board was really good, they would write down each individual thing and if we didn't understand anything we were told to write it down in the diary (NTP13LMIC) If I have any problems then I'll read the book they gave us (NTP14LMIC)
2.5 Solution focused training	... the only difficulty is that there were some interventions that weren't in place of certain things that we'd learnt. So, we learn about a topic but it was, maybe no wrap around in terms of 'so what do we do with that', you know, 'I've opened this, but I don't know how to close it', so there was no intervention there. (NTP01HIC) I think what was difficult for the staff that are on the ground that they were thinking that, 'All this information is great and we understand why it's important but we've not actually been given any direction as to how we use these interventions.' So, some videos of somebody doing them would have been useful. (NTP02HIC) it would have been good for the time to be used effectively to give us tools, and then once you've got the tools and you've got the resources you can practice them in your own time I suppose. (NTP03HIC)	The information that we learnt was enough, because this is the first time there has been a project like this in our village... it was enough for us to be able to help them (mother) understand (NTP12LMIC)

Sub-Themes	HIC	LMIC
	I think maybe there's an element missing in training generally of what it feels like to actually deliver it and what plans you can put in place if you have a problem with it rather than just, 'okay here's the techniques, off you go', it's not as simple as that (NTP06HIC) rather than learning about the mental health condition I would like to be provided with the tools and a solution for the issues really. (NTP03HIC) it's funny because I was being shadowed by a colleague this morning who asked me about the MMP training and I said, 'It's really good and it's really informative but there wasn't much time for kind of skills consolidation.' (NTP04HIC) I think you need the background in order to be able to deliver the intervention. So rather than just being able to deliver the intervention I do think you definitely need some, you need some knowledge around the condition before you can just say, 'Well here's an intervention'. (NTP01HIC)	
2.6 Supervision as a time for reviewing, reflection and revision (reviewing)	we have caseload management as well, umm where we're talking about the clients that I'm working with and she might make suggestions based on the work that I'm doing so far with the clients. ... there might be some other asset out there that I'm unaware of that I'm not using, that (supervisor) will check that I'm aware of and using. (NTP03HIC) I think it's important for a number of reasons. That you've got that one to one with your line manager, that you can discuss any issues obviously that you are having with the job, that you can talk about your training needs and you know that you can receive praise if you're doing a good job; and I'm not saying I'm the type of person that needs a pat on the back every time I've done something well but I think good feedback is important you know when it's deserved. (NTP02HIC)	In the meeting they ask us if we have had any issues, any difficulties regarding something, how have the days gone. Then after that we do some role-play, they tell us about things, if there's anything that's missing, they will tell us about it in detail (NTP08LMIC) In that (supervision) they tell us about our work. We are going to mothers' houses so they ask us if we have any problems or worries about that (NTP09LMIC) In the meeting they tell us about the future sessions... and they'll ask us individually how we've been doing, if we've had any problems (NTP10LMIC) In the supervision they tell us... they get us to do role-plays and they tell us what we should be emphasising because we may have made mistakes in it (NTP11LMIC)

Sub-Themes	HIC	LMIC
2.6 Supervision as a time for reviewing, reflection and revision (reflection)	I'm a big believer in that (supervision) because I think for staff especially um, they need sort of that safe space to talk about things, especially if they are really struggling (NTP01HIC) she makes sure I'm taking the leave that I need to be taking. She makes sure I'm feeling ok and like that's what my supervision sessions are like and I'm asked if I've got any concerns about my role or the workplace, about lone working, things like this (NTP03HIC) supervision works in two ways doesn't it. In the sense that it works, you know people might have the opportunities to work with their experience but also it puts, the feedback in the direction, and the supervisors and the group learn how it's gone, could it go better? What areas need improvement or areas of opportunity for learning, what areas have gone very well, why was that good, could we move elements of that into other areas? So, yeh it's a learning opportunity I think which is very valuable (NTP05HIC) I think having a forum like supervision to discuss, 'Well actually I found that this bit feels really frustrating to deliver or this bit doesn't feel like it's really working and you know I've noticed that it really makes people in the audience cry and I don't know what to do about that', stuff like that really (NTP06HIC) in terms of the context of PERSUADE I think, umm, I think obviously checking out how it feels to deliver the techniques and also what it might be bringing up for you, or if there's some things in the material that you're still working through. I feel like that wasn't really covered in the training and supervision, it was more kind of, 'Here's the techniques, off you go', rather than either applying them to yourself, thinking about if they would trigger things for you. So, I think maybe something like that in supervision is worth incorporating. (NTP06HIC)	Every month we end up having training. I mean, in that we will get everything from the month before, what happened, what didn't happen, anything difficult, anything happy, good things and bad things. So, all of this ends up being a form of training (NTP08HIC) There are a lot of us, from 4 or 5 different areas. Everyone shares stories about their mothers and we can see how they solved problems with their mothers and how we can do the same (NTP12LMIC)
2.6 Supervision as a time for reviewing, reflection and revision (revision)		We also do revision and we will have role-plays (in supervision) (NTP09LMIC)

Sub-Themes	HIC	LMIC
		If I was ever worried about how to approach a topic in the groups then I would practice it in the role-plays (during supervision) and I would write it down, so I knew what to do at the time of the groups (NTP12LMIC)
3.0 Trainer Attributes		
3.1 Experience vs Expertise	I think it's brilliant... I think it's good to come to a University level, because for the lectures that were taking it are people who have worked in this field for probably years, you know they've got that, got the experience. So, they can tell you things that they've dealt with and sort of how you manage that and you know, life experience that they've dealt with and what they've gone through and to get to that point (NTP01HIC) I think you want to know that the person talking to you is knowledgeable in what they do but I think to be a good trainer, experience is more important because someone could be really knowledgeable but not be very good at teaching (NTP02HIC) I think experience rather than expertise is what's really, really, really important… experience of delivery was important... showing me that it worked was very important. Showing me how, in his (former trainer) experience, he had experience of delivery not just an academic skill. Not that, that is a bad thing but not only that, but also that experience of delivery as well which I think is important (NTP05HIC) I think when you talk in the normal language you know, straight language and say about your own experience and make it easy for them to understand, uh they more and more like to continue that. Otherwise they (trainees) are scared because they feel you know more than them and they don't want to make a fool of themselves (NTP07HIC) I think everyone sort of knew their stuff and it was obvious to me that they were academics (NTP02HIC) I'm interested in the expertise of the trainer and how well they present. So, I don't need it all to be one person just as long as it remains engaging and the person know the material well (NTP03HIC)	If someone has the knowledge and experience then they can give us the training... it doesn't necessarily have to be someone who is educated or famous (NTP14LMIC) They would read it to us and help us understand…. They taught us in a really good way, we were able to understand everything that they were saying (NTP16LMIC) Only those who have a good mind, who can give training and have the talent can do it. It doesn't necessarily have to be a big expert (NTP18LMIC) Obviously, they had a lot of knowledge, they knew everything so they were able to teach us in the best way (NTP09LMIC) I think it's necessary for them to be educated (NTP11LMIC) A lay person can't teach us as much as someone who has the knowledge and expertise might be able to (NTP14LMIC) The training should be given from someone who has knowledge who can carry this project forward (NTP17LMIC) If someone has the knowledge then we can trust that they would give us the correct training (NTP19LMIC)

Sub-Themes	HIC	LMIC
	when I attend training like PERSUADE that are a bit about teaching you how to deliver interventions, I think it usually helps if I think the person has kind of walked the walked and kind of got some knowledge about it or maybe delivered it themselves, either way. ... because then I feel like I'm more likely to ask follow up questions and they're likely to know the answer, or that it's coming from a place of more authority (NTP05HIC) For me I think it's when they understand the subjects themselves, the teacher or facilitator or trainer, however they want to they call them. When they understand the subject, they can make it simple in a way to make the student or trainee understand (NTP07HIC)	
3.2 Personal traits (approachability)	Oh, the trainers were great, dead approachable, you know easy going, you could ask them anything, dead knowledgeable, you know they had all the information that you needed. (NTP01HIC) he was quite open to questions and sort of like, the way that I've mentioned to you that I check my knowledge and things like that, and he answered those questions fully and well. Umm, and also the case examples that he gave were quite engaging and useful. (NTP03HIC)	If we had a problem, we would ask the trainers (NTP08LMIC) At the start I had a little bit of stress about what it was going to be like, I used to worry a lot but the staff greeted us really well (NTP11LMIC) If we are unwell or there are problems at home then we will call the field coordinator and tell him that we can't do it and we will do it on another day instead (NTP13LMIC) If we didn't understand something, we could constantly ask the same questions (NTP17LMIC) She was so friendly, she taught us in such a good way (NTP19LMIC)
3.2 Personal traits (friendly)		The best thing is they taught us in a loving way, in a good manner... Even though we're older than them, we have more experience than them, we're not children but we're still going by a routine, we're working respectfully, lovingly and that is why we are still doing it for so long (NTP08LMIC) Sometimes we get tired, and we don't get anything special, but they get us to work so lovingly. If we make mistakes... they've never pointed them out, they've never revealed anyone's names (NTP08LMIC)

Sub-Themes	HIC	LMIC
		It's because of them (trainers) that we have gotten to this point. I'll tell you about myself, I used to worry a lot at the start, but they spoke to us in such a friendly manner, they introduced themselves in such a way, like we had known them for ages. They taught us in a really good way and they kept a friendly relationship with us (NTP09LMIC) They would tell us what mistakes we made and how we could improve. They would tell us like sisters, it was never like a student-teacher relationship, it was never with strictness (NTP11LMIC) They are very nice people… maybe if they had been strict or gotten angry with us, we wouldn't have learnt as much as we did in the 5 days (NTP13LMIC)
3.2 Personal traits (respectful)		Rather than education, the person should be respectful... there's no point being educated if the person doesn't know how to talk to people, doesn't know how to get them to work, doesn't know how to be respectful (NTP08LMIC) If we have any difficulties, we'll go to our supervisor... any problems we have, they'll listen to us, they'll help us to understand. They speak to us so calmly; they give us so much respect. If someone gives us this much respect, looks after us so well... there is no fear (NTP10LMIC) We get respect from our trainers (NTP12LMIC) They never told me off or stopped me because I had made a mistake. If I ever had made a mistake, they would put a hand on my shoulder and I would understand that I've done something wrong and then I'd do it again (NTP14LMIC)
4.0 Facilitators for NTPs		
4.1 Altruistic gains	Yeh it's just seeing the changes in them and seeing progression that they make. Umm, just seeing like from day one till the end, and sort of how much change they've made in themselves and how they're managing and how they're coping, and how they're actually able to take care of themselves better (NTP01HIC)	From the beginning, I have never paid attention to studies, I was focused on other activities like stitching clothes, doing new things so when I start new work, I am always very happy, I don't get tired. I like doing things quickly so I can see the end results (NTP08LMIC)

Sub-Themes	HIC	LMIC
	since I left University well really umm, I was involved in community arts and also support work. So, supporting young people and adults with learning disabilities and part-time I would be using the art stuff to work with various different people within a health and well-being setting. So, that's what led me to here. (NTP03HIC) Peer support interests me, I think, I think that intrigues me and the idea of how a non-clinical approach can impact on people in a different way... it can draw people into conversations I think, so that was a big deal for me. (NTP05HIC) Long story short, I had ME (Myalgic Encephalomyelitis) for ten years, chronic fatigue syndrome and CBT was very helpful to overcome that. So, I kind of thought, once I got better and I want to try and repay this for other people and help them get better which I think is most people's motivation for getting into this line of work, is to help people. Umm, so certainly that was the initial motivation to getting into that line of work (NTP06HIC)	We don't have group sessions anymore, but my sister-in-law asks, " when are you going to do another group. It's so good, you get to learn about everything, the mothers can have discussions with each other. From this, we get to learn about the things we didn't know too." (NTP09LMIC) The first time we had groups at our house, it felt so good, all the mothers were speaking so openly (NTP12LMIC) There is a lot of mental illness around here. The family members won't do anything… a lot of the women in our village suffer from mental illnesses… but we got to learnt a lot and now we can teach the mothers (NTP13LMIC) When I go to see the mothers, they are so happy (NTP13LMIC) If a mother and child can benefit from this then it's a blessing for us… money comes and goes, but if someone's burdens can be eased because of us… if because of use someone can improve then that's a really good thing (NTP18LMIC)
4.2 Personal gains (personal development)	I think I just try to treat everyone the same really and everyone as equal. Umm, I guess before you start working with people who have got poor mental health you don't really think about people as having poor mental health. You just think everybody's 'oh yeah whatever'. (NTP01HIC) I was more sympathetic or empathetic, probably more empathetic really, you know walking around this city. On the way down now, there's a lot of bustles, there's a lot going on, a lot of people walk into you, I felt more in tune with what might be drivers behind people's unhelpful, negative behaviour because they might be driven by anxiety or stress or low mood. (NTP05HIC) it's the scale of problems that we have across the city. So, I've recently started working, I've got about four men on my caseload that have been raped, so that's not something that I expected and I didn't understand how much of a problem that is. (NTP04HIC)	My thoughts on people with depression have changed. Depression isn't a mental illness; we don't used the word depression instead we think of it as the women has bad thoughts in her head and we have to change that (NTP12LMIC) Even though I am a lady health worker I didn't know all of this, about how to look after children, about their existence, the reasons behind their actions (NTP14LMIC) I didn't know anything about mental illness. I used to think that those people were crazy and they don't understand anything so there's not point speaking to them, but from this project I learnt how to identify those who are mentally ill (NTP17LMIC)

Sub-Themes	HIC	LMIC
	my understanding and empathy for mental health is way wider than it was before. Because I think even though I've been through a difficult time myself with ME and getting over that, I still didn't really understand about things like schizophrenia or psychosis sorry, and OCD (Obsessive Compulsive Disorder) and things like that (NTP06HIC) I think I've become more self-aware, you just think, 'Actually I'm quite lucky to be the way that I am and feel the way that I feel, and I've got this around me and I've got that around me.' Because I think, when you're working with people with poor mental health and they're telling you about things that have got on and you just think, 'Right ok', and I think sometimes, it does make you feel quite lucky really. It definitely makes you more self-aware in terms of what you've got, sort of what's around you. (NTP01HIC) my level of empathy has changed...the more people I meet that struggle, the more I can kind of see how these things impact them (NTP04HIC)	Now I know that those people aren't motivated. They will get bad thoughts from stresses and problems such as unemployment... by overthinking they because mentally ill (NTP19LMIC) I always say to people, this training benefited others, but it also benefitted ourselves, because after receiving training, it has changed our thinking to more healthy thinking (NTP08LMIC) I've learnt a lot from this program… I apply all of this on my own children and how I should be raising them (NTP12LMIC) We aren't educated, we didn't know any of this. We didn't used to look after our own health... I used to get angry and hit my children, but after reading the books I've learnt that I shouldn't do that. (NTP13LMIC) I have seen some improvements. Before I used to get worried and then I would take it out on the children. From this training I've learnt to control my anger (NTP18LMIC) I learnt that if I have a problem at home, if that gets stuck in my mind and it gives me pressure then I am going to get ill. If I'm worried too much, I won't be able to focus on my work (NTP19LMIC) At first there was hesitance, but the best thing I got from this training was that I now have confidence. Before, I wouldn't talk in front of two people, I wouldn't even walk to the corner (NTP08LMIC) In the village, women will sit and share their problems at home... and all of these things I've learnt will be in my mind and I will always try my best to solve their problems through our conversations (NTP10LMIC) I've taught my 16-year-old daughter enough that she would be able to tell you everything too. I know that when she gets married, she won't have any worries (NTP14LMIC)

Sub-Themes	HIC	LMIC
		The best thing was that I got to learn a lot. I didn't know about how much a child can understand (NTP15LMIC) People get advice from me (NTP15LMIC) I gained confidence in myself that I can do other work and I can get other trainings (NTP15LMIC) I feel happiness that I am increasing my knowledge, and there are improvements in my knowledge after training. I was taught about things I didn't know in training (NTP18LMIC)
4.3 Personal gains (career development)	if you told me that I could go to this fantastic training and then I would be on the bank to deliver something, I would be paid, I would do that. I would be alright with that; I would be ok with that. Because then I would sell myself with the quality of the fact that I'm being trained and I would say to myself, if I go to training, I would have to pay for it, it's like CPD (continuous professional development), this is a form of that (NTP05HIC) I did a lot of volunteering when I was at Uni, doing things like groups and courses and like mentoring because I knew it would all me good experience to help me get me a paid job in mental health eventually. So, it depends what they want to get out of it really. Obviously, sometimes people volunteer because they want to give something back and it's not even about career progression, so it depends (NTP06HIC)	
4.3 Personal gains (feeling valued)	it makes me feel really valued as well and supported in the way it's been delivered so far, and although there are ways in way it could have been better, I can see that it's actively been improved upon, so, I'm happy with that. (NTP03HIC)	Everyone says to me, "Don't ever leave this work, you're doing good work." (NTP09LMIC) My motivation increases when people tell me what amazing work I am doing, when they praise me (NTP10LMIC) Money isn't everything. If someone is giving you respect then you can do anything (NTP12LMIC)

Sub-Themes	HIC	LMIC
		All the mothers will wait for us, and they understand everything so will and their mother-in-laws and sisters will come and join in too. They enjoy it so much and so do we (NTP13LMIC) The best thing was we are removing their worries so they are going to pray for us from their hearts (NTP19LMIC)
4.3 Personal gains (financial benefits)	I think if you tried to sell training to deliver PERSUADE unpaid, and a volunteering role to deliver it then you would struggle, you just would do. But I think, if the role is going to be paid, I think you're ok. You know, 'we'd like you to come along to this fantastic training, it's going to be a brief period of time and we'll make sure food and drink is available and then it will lead onto joining the bank of facilitators to deliver the ongoing course. The ongoing course is paid at whatever rate'. (NTP05HIC) I think somebody that's coming new to that world, if by delivering the intervention, that supports them in an academic future, you know makes that little difference at an interview for university, I can see that. But other than that, if you were able to offer payment, even if it is ... nine pounds an hour, something like that. It's still going to be great for a student who's really interested in that world (NTP05HIC)	It would be very difficult for people to get training without receiving money. If someone wants to do something, they want to get out of the house, obviously if they want to do something for their children, then they are doing it for some reason, they should receive something (NTP08LMIC) No one will come without money. I think you would have to give them something or another. If a person works then obviously they will have to put aside their home and their kids to come to the training, so if they receive something then they are more likely to work with enthusiasm ((NTP09LMIC) It depends on people's circumstances, but there are a few who do say we go so far to see mothers and we should get something in return (NTP12LMIC) Some of the women would say 3000 is not enough, we do so much work and we have to gather all the women but I would say to them that, "Yes, but we've also had the chance to learn and gain knowledge." (NTP14LMIC) I would have done this work without money (NTP15LMIC)
4.4 Support from others (direct support)	I think it's always necessary to deliver it with another person. ... I just think having that second person means you can split the voices; one can be speaking whilst the other one is observing and seeing how it's working with people. I think having that safeguarding or safety aspect, it's good to have somebody there. If somebody is unwell or it triggers something within somebody, you've got a space where you can support them, whilst somebody else is continuing (NTP05HIC)	I would be thinking that if I missed something or if I was unable to deliver something then it doesn't matter because they (supervisor) are sitting behind me and they can do it, they will cover it (NTP10LMIC) I was with her (the co-facilitator) for 10 days over the three months. Every time I would go with her. I got to learn a lot from her (NTP14LMIC)

Sub-Themes	HIC	LMIC
	I think when you're working with a co-facilitator you get an extra perspective on the techniques you're delivering (NTP06HIC) I think there are good reasons for having two people, practical, safety and just the ease and functionality of the course, I think it's much better (NTP05HIC)	If I don't know anything or if I've made a mistake, they (co-facilitator) will take over (NTP15LMIC) It was better when there were two of us because it wouldn't take long to gather all the women together (NTP17LMIC)
4.4 Support from others (indirect support)		If I ever say that I am tired, or my legs hurt then my husband will encourage me and say, "you make your own decisions but if you are delivering something good, and people are benefitting from it then continue to be strong." (NTP08LMIC) If there were any problems, my mother, my sister-in-law, they were all nearby and they would help me a lot. My husband has helped me a lot, if there was ever a lot of work, they helped out a lot (NTP09LMIC) The first time the lady health worker came I didn't agree but my sister-in-laws agree that I would do this work. Inside I was scared that they might say no. because I had to leave my work that I used to do because they weren't allowing me to do it. So, I thought that if they made me leave that job then they won't let me do this. But, when the Lady Health Worker explained it to them that a car will come to pick and drop me, then they accepted it (NTP11LMIC) One of my family members will drop me off, and when I'm done, I'll call them and they'll come and get me. I had support from my family (7; 259-260) (NTP12LMIC)
5.0 Barriers for NTPs		
5.1 Other commitments (work)	it's probably good to have gaps in between (training) because I don't think it would be, it would be difficult with you know balancing your workload if you were out for a whole week of training or two weeks of training. (NTP02HIC) There was a couple of times when it was like three or four days of it in a week, I think, and then we were finding it too much. Umm, especially as our workload grew. (NTP03HIC)	We have to be in the field from 9 in the morning till 4, so training should be in the evening (NTP15LMIC) I was doing this work alongside working as a lady health worker so I didn't find it difficult because it's almost the same (NTP15LMIC) I used to get tired from doing two jobs (NTP18LMIC)

Sub-Themes	HIC	LMIC
	I found that things like PERSUADE and other projects, for me to get enough facilitators on board to deliver those groups, and if I needed to deliver training to them, evenings and weekends were better because they had other jobs or other things in their life. (NTP06HIC)	I'm not going to lie to you. I used to work according to my own convenience. So, if I was working as a LHW then I wouldn't do this Roshni work (NTP19LMIC)
5.1 Other commitments (home)		I didn't have to take time off from anything, but I had to organise the home. At that time my children were young so I would say, "there is a child at home, so stay here so I can go to training". (NTP08LMIC) I wouldn't get tired but at the end of training I would be thinking about the work that I had left at home (NTP10LMIC) If a person is unmarried then you are able to get permission but when a person is married, then there are a lot of responsibilities, there's a lot of work at home (NTP11LMIC) It would be difficult to come on a weekend because it's the children's day off so we need to spend time with them. We can't do the evening because the children have school work. That's why our training would finish when the children were still in school so we would be home in time for the children (NTP13LMIC) There was a time when my brother wasn't feeling well so I found it difficult to go (NTP15LMIC)
5.2 Reluctance from clients and their families	when someone is very much set in their ways, I think trying to change that mind set would be very difficult because someone like that, they do have poor mental health but they don't believe they've got poor mental health, so trying to explain to someone that we need to link you in with mental health services, but they don't want to link with mental health services because they believe they're fine, it's difficult and it's difficult to have that conversation with them. (NTP01HIC) We had one recently where umm, they didn't want any help from any services but they needed some mental health services put in place, but they didn't	The first time we went (to the mother's houses) we were thinking what would they be like? Their mothers, their relatives what would they feel? What would they be thinking? (NTP08LMIC) It was difficult to get them (the mothers) to express themselves... it's difficult for the mother to all of a sudden share everything about herself (NTP10LMIC) The first time I was nervous, I was scared what they were going to say, what they were going to think of me but overtime the hesitance went away (NTP12LMIC)

Sub-Themes	HIC	LMIC
	believe they had poor mental health and thought everything was out to get them. So, I guess it's things like that, that are challenging. (NTP01HIC)	They used to be nervous as to why did we select them, but in the groups we would explain that out of a handful of mothers we will only visit one and then the rest we will invite to the groups (NTP12LMIC) There were one or two mothers who didn't have a mother-in-law, but their mothers would sit with them. I would find it difficult there, because their mothers wouldn't have a good attitude (NTP08LMIC) There was one time when I had only just started working, I was telling the mother about the thinking healthy program and what a healthy mother should be like… her mother-in-law was sitting there and she was getting angry… and the second time I went the mother told me that her mother-in-law didn't like what we were doing (NTP10LMIC) Sometimes we would have to visit the women 10 times before they would understand what we are there to do, because not everyone is educated, they don't understand (NTP14LMIC) Sometimes they would tell us to go away, "We don't want to sit with you, we have too much work at home, you come and sit here and waste 3 hours of our day" (NTP17LMIC)
5.3 Working within limitations of the role	ideally what we want to be able to do as an MMP is we want to be able to do that ourselves rather than having to always signpost, you know we want to actually, 'I actually want to give you an intervention, I want to be able to do this and this, have you come back, see me; you could tell me how that intervention has worked,' without having to link constantly like, 'Well, I'm going to send you here, I'm going to send you there, I'll send you to this place, I'll send you to that place.' (NTP01HIC) if I ever make suggestions about health, I always preface it with, 'I'm not a GP, and if you feel comfortable, check with your GP first, and these are the suggestions that you can think about and 'm not suggesting that you have to do it. It's just things that are on the NHS website'. So, it's about making	We told them that we don't have a cure, the only thing we can do is offer advice... We did whatever was in our limits (NTP11LMIC)

Sub-Themes	HIC	LMIC
	people aware as well that you know that you are not a GP and you're not a psychiatrist. (NTP04HIC) Sometimes the only thing I can say is that people, umm the group with the students, they wanted to take you in the therapist role which I had to stop myself. (NTP07HIC) Sometimes you can get clients that will come in and think you can do everything for them and you know it's just about being honest with them. (NTP01HIC) if I ever make suggestions about health, I always preface it with, 'I'm not a GP, and if you feel comfortable, check with your GP first, and these are the suggestions that you can think about and I'm not suggesting that you have to do it. It's just things that are on the NHS website'. So, it's about making people aware as well that you know that you are not a GP and you're not a psychiatrist. (NTP04HIC) if someone sends me a long text my response will always be, 'Thank you for your message, we'll discuss this at our next session', because I can't do text appointments, I can't be getting into conversations over text with clients because it's not sustainable when I've got my appointments (NTP04HIC) If you can describe yourself in those introductory sessions, how do you describe yourself? Do you describe yourself by a job title? ... Do you describe yourself based on your experience? Do you talk about your experience of feeling what people felt? Is that better? And I think it probably is because it makes the difference between you and the delivery of the service and a medic or a clinical person. But it also does a more positive thing, it also shows the group of people that you've got a connection between you and them, you're not a title, you're a person. (NTP05HIC) something we did on the PERSUADE training. Was kind of when we introduced ourselves was saying like, 'I'm not an expert, I'm not a psychologist, I'm not a psychiatrist. In the context of today, I'm someone that	

Sub-Themes	HIC	LMIC
	has obviously learnt these techniques', I would mention that I've applied them to myself (NTP06HIC)	

Appendix 26. Additional Quotes from Expert Interviews

Sub Themes	HIC	LMIC
1.0 Who are the NTPs?		
1.1 Educational and professional background	Often people that come on the courses are psychology graduates but sometimes they're not and they're people who have either built up experience working in for example, the charity sector in mental health but haven't got the formal qualifications of a degree or they're people who have had a different occupation for example, they might have worked in business or insurance or science fields (EXP01HIC) The level of existing education that they have was varied. It stretched from Level 3 to Level 6, I think. Uh, so people had existing degrees, other people had special qualifications in addition to that. Umm, other people had very few educational, umm uh, existing qualifications (EXP02HIC) they were non-professional from the point of view that they weren't registered nurses or registered social workers, or things like that. But a lot of them had worked in the field of mental health or patient services or counselling types services for quite a long time. So even though they weren't qualified, they had quite a lot of experience in fields related to health and social care really (EXP03HIC)	we'll use peer volunteers who are local lay women with at least ten years of schooling (EXP05LMIC) … but lay counsellors, such as these peer volunteers they have no idea, some of them are inter, some metric… (EXP07LMIC) Their level of qualification is intermediate you know, and then there is some, I think a diploma course for the proper training of lady health workers because the main work is around the vaccination and polio (EXP10LMIC) I did this training with community health workers and these community health workers include lady health workers. Lady health workers are qualified you know, for mother and neonatal health. And there are traditional birth attendants, they don't have formal qualifications but they do have some training provided by the lady health worker and they take care of deliveries at home. (EXP10LMIC) Some are smart. They are working as well, they have an idea about children, because they are LHWs from that area they have knowledge (EXP12LMIC)
1.2 Selection criteria	I think the fact that either they have experience or a good understanding of depression through their own experience or though work is important ...someone who communicates well with other people, that would be really important because that's something that's a bit harder to teach. You can teach someone how to deliver three or four steps of a CBT intervention quite easily but if you have to start	when we recruited peer volunteers, they need to be having at least ten years of schooling (EXP05LMIC) The peers who were delivering the intervention were also mothers who had their own experiences and knew what being mother was about which was beneficial. For the individual to have similar characteristics

Sub Themes	HIC	LMIC
	teaching interpersonal skills, that could take a lot longer. So, I guess you need someone who perhaps has some of those natural skills... (EXP01HIC)	to the person they are delivering to is good because it makes it easier to explain the intervention to them (EXP08LMIC)
1.3 Motivators for working as an NTP (incentives)	if you want to employ people who might have lived experience and who might currently be claiming benefits because they're not working, it becomes really tricky because they can only do so many hours a week or earn so much money before it starts to affect their benefits. So, sometimes we get around that by offering people other incentives that aren't cash payment, so for example vouchers and stuff like that. (EXP01HIC) if you're trying to recruit lay health workers as such from the community who are perhaps doing this in their own time and perhaps not financially well off, you're asking them to give two or three days for training time and then half a day every so often to deliver this workshop and attend supervision and all that, I think people would struggle to do that for free (EXP01HIC)	we gave them training and after the training we gave them a little bit of an incentive, that was also new for them, it was surprising for them and also nice for them. After that, yes, I think that is important. Um, if they, I mean if they say 'we're spending time and we're learning, yes we're getting something and that something is monetary' then that is good for them and especially good for their family (EXP06LMIC) Normally if their motivation was low then monetary incentives would be good for normalising that. You know so that they would be able to buy any necessities, they could buy something for their children or for themselves. They used to know that if it was far then they could travel with their husband and they would save money that way. (EXP06LMIC) If there are cases where they have to travel, then we will either give them a travel allowance or initially in some places we used to give them facility for transport (EXP07LMIC) We would provide our own transport if they lived far away, because we pay for their time and expenses, it was part of the project (EXP11LMIC) Some people say, we don't want money, we want education (EXP13LMIC)
1.3 Motivators for working as an NTP (personal gains)	if they were in a position where they were getting something for their own CV, for their own career development, helping them think about	peer volunteers they have become very very confident, um, there communications skills have improved, their social status in the villages have improved because other women they local up to them,

Sub Themes	HIC	LMIC
	how this is useful to them past the life of the training course, whether they are going to and do some further training (EXP01HIC) you would have to encourage people through thinking that, explain to them that it was a good opportunity to learn something and how to help people, so altruism I suppose (laughs). But, also potentially to help themselves, if there was something in particular that they wanted to work on, building confidence, learning more about managing depression themselves, developing public speaking skills, things like that, they want to get experience to get a different job for example running groups, facilitating workshops would be really good (EXP01HIC) I think it's always part of our responsibility to ensure that people get something positive out of it to make it worthwhile. (EXP02HIC)	and some of them, they have become teachers, uh, two of them have become Lady Counsellors in their area. (EXP05LMIC) I think for this peer volunteering work, um, the main motivating factor is the altruistic benefits which they are getting out of it, and the social status of the peer volunteers which has increased because of it. So, in villages in Pakistan they have got very very little opportunity to receive any trainings or for women to work, other than working in their homes and in the fields. So, this opportunity was very unique for them (EXP05LMIC) it has also proven to be a stepping stone for them, because some of them, they have become the polio drop administrators, some of them, they have started their own small business like shops in one of their rooms, some of them have become teachers. (EXP05LMIC) When we gave the lay workers certificates, they were very happy, it was the first time they received training like this (EXP08LMIC) when we dd the analysis post 6 months, we told them a bit about the results, that 'these are the effects from the work you are doing' and from that they felt that the work that they are doing is of some benefit (EXP08LMIC) A lot of LHWs like that rather than physical health, there is a mental health component and they are able to deliver something in terms of mental health. So, it's good for their own self efficacy, it motivates them (EXP10LMIC)
2.0 Elements of training		

Sub Themes	HIC	LMIC
2.1 Target population	I am probably a big believer in getting people together and trying to map out what people need and how things would fit … It's really important not just to think about what the managers think that their staff need, but actually you need to speak to the staff about what they think they need because sometimes there's a gap. Sometimes managers haven't worked in practice for a long time, have they? So, I'm a big believer in speaking to lots of different stakeholders if you like, to think about what the need is and the best way of facilitating that. (EXP03HIC) A little bit more idea about the experience of each of the, of the person that delivered it, a little bit more time or knowledge in advance about the experience of the people that I'm training so I would know how to tailor it, and a bit more time to select, um, ask them to select what it is that they would really like to focus on in the group (EXP01HIC) I could deliver exactly the same teaching session today and I could do it again tomorrow and it would be completely different and that's not about the techniques because it's the same, it's about the people in the room. And that's why it's really important to be able to adapt (EXP03HIC) If you're teaching, master's students, they might already have an awful lot of knowledge with regards to mental health issues so there might be more emphasis on skill. (EXP04HIC) I was asked to do a session with all the managers about doing management and um, when we got there, it was quite clear that the managers were actually extremely anxious about their lack of, or perceived lack of knowledge, or depth of knowledge they would put it as, to support their staff. So, we, instead of doing the planned program around management techniques, we actually did a different program	During the training there were times when they wouldn't understand, so we would have to explain it to them one way or another. ... The area that you are delivering it in (the training), to adapt it locally over there is very important. Otherwise, if they are not getting your point, then they can't deliver it (the intervention). (EXP06LMIC) I think before doing training, you need to have an idea about the culture, about who you are about to deliver the training to and then according to that you can modify the examples and adapt them (EXP07LMIC) If we are looking at area, then maybe there are things within the training that need to be adapted. For instance, if you are going to a village in Punjab, your training style, the examples that you give according to the culture, those will be slightly different, but if you are going to Karachi to give training, to a village in Sindh, that would maybe be slightly different (EXP07LMIC) The audience that you are delivering training to, what is their level? For instance, if they are lay workers then you will need more time to teach them, but if it is someone who is educated, who has a background in what you are training them on, then maybe you would need less time. So, it varies (EXP08LMIC) We have to look at the sustainability of something. If you ask them to commit for more days, then it becomes difficult for us to engage them … Then for the people who are organising it, the LHVs, for them it would be a difficult job, how are they going to do the job planning? how are they going to set the timetable so that they (LHWs) can come on different days? (EXP10LMIC)

Sub Themes	HIC	LMIC
	about enhancing their understanding of umm, of the techniques. So, because that was right to do, cause they needed to respond to their particular needs at the time. (EXP02HIC)	First, we need to know, what is there level? How much do they know about the things which we are training them? and then, what do they think about it, in which they are coming for the training? (EXP12LMIC) the first step in developing any psychosocial intervention is that you actually need to understand your target population. …. So, once you have a very very good understanding of your target population then, you look into the literature, what sort of similar sort of interventions have already been there, what has worked, what has not worked for people. You use your clinical experience, and then you develop the intervention. Even while you are developing that intervention, it's good to have some service users in your team as well so that you are also discussing with them. (EXP05LMIC) You need to consider what the language is going to be, what the delivery method is going to be, what audio material will be used, if a calendar will be used (EXP11LMIC) You have to look at their level. If you are going to train them, you have to use a clear language, easy words, as little English as possible. You will explain it in their language so that they can go on and explain it (EXP12LMIC) Initially we tried to find out what understanding the LHWs already had... what were their observations? What did they see? How did the women in their communities manifest depression? (EXP10LMIC) We used easy terminology, we used the word zehni sehat (health of the mind), we didn't talk about mental health, we used to tell them about zehni sehat that the mother would worry about. If someone didn't

Sub Themes	HIC	LMIC
		understand the word depression, we would use udaas (sadness), so we would give them information using wording like that. For example, the mother is crying, by giving examples like that we were able to help them understand the whole model of CBT. (EXP09LMIC) From the first day of training you get an idea of how they are absorbing the content, how they are reacting to it, so according to that I would get an idea of what I need to focus on more, what I need to focus on less (EXP07LMIC) If it's a group of lay counsellors, maybe I would keep it six days or seven days, because you have to keep the time short for them, because from my experience they have a small attention span for such long workshops... You can increase the number of days, but keep the amount of time short, I personally feel. (EXP07LMIC)
2.2 Relevant content (balanced)	when we're training the psychological wellbeing practitioners … it's vitally important that they get the diagnosis right when they meet someone and that they can quickly pick up what they're looking at. So, we spend quite a lot of time thinking about individual mental health conditions and what they might look like, how they might present. I think if you're working with just one condition like depression and you know you're recruiting people with low, mild symptoms it's a bit easier, but you still need to make sure that everyone understands what that looks like and how to know if someone's symptoms have increased (EXP01HIC) I think it should be weighted equally, I think you need to make sure that you're, and it's difficult because it depends on what you're teaching. If you're teaching, master's students, they might already have	... to deliver any psychosocial intervention, say for example depression, anxiety, you need to understand, you need to have a good understanding of the risk factors and the impact of that problem. This understanding is important because ... once you are delivering the intervention, this understanding helps you to actually understand why the mother is experiencing depression or anxiety or any other problem. So, to dedicate some time of your training into understanding the actual problem, its risk factor and its impact is very important. (EXP05LMIC) I think having a background on who they are working with is very important. For instance, if it's perinatal depression, then they need to know what perinatal depression is. But I think they only need to know what perinatal depression is and what factors are associated with it.

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	an awful lot of knowledge with regards to mental health issues so there might be more emphasis on skill (EXP04HIC) you have to be cautious about going into too much depth, particularly when you are talking to people who may not have umm the educational background to build on some of the concepts you are talking about (EXP02HIC) … if you are going to do a mental health awareness session which introduces different mental health conditions and what they look like, what the symptoms are and that kind of stuff, and about how you know, things you need to look for and refer on for, umm and then look at psychosocial interventions I think that's a good thing. Because I don't know how you can do one without the other. (EXP03HIC) we had regular meetings to try and manage this and I think that worked very well because that allowed us to be responsive as the needs changed and emerged you know. So, that worked very well, that management, being able, retaining a sort of review and flexibility response is important. (EXP02HIC)	We don't teach them any more than that because it's not like they are going to write a paper on it. (EXP07LMIC) I think it should be equal in the sense that, it shouldn't be that you're giving too much information and that you don't look at intervention delivery, but also not that you only focus on the intervention delivery and the rest of the information that is based on the intervention that you want to deliver is left. Both things should be equal (EXP08LMIC) Obviously, we focus a lot on anxiety and depression... we were doing this training session as part of Roshni project, and the main theme is maternal depression. We talked a lot about depression, obviously before introducing LTP, because the first session of LTP is psychoeducation, and psychoeducation for maternal depression, and symptoms and causes and everything. So, definitely there was a discussion on pathology (EXP10LMIC) The intervention time is more compared to awareness of mental health, but it is not like it's very little because this is an ongoing process. Sometimes in the middle for example... if there was a question about what is depression or anxiety ... so session by session if anything came up in terms of mental health it would be an ongoing discussion (EXP11LMIC)
2.2 Relevant content (credible)	for this kind of thing, where what's important is the practical application, I would think less focus on the evidence base but you might want to give people a nod to where they can find the evidence for it, so if they want in their own interest, or their own time to go read it, they can do. (EXP01HIC)	I think if you could develop these interventions then of course you need to have some clinical experience as well, which will help you identify what works, what doesn't work. And to be aware of uh what's happening, uh, you have to have good understanding of the evidences behind different sort of interventions, what is latest, what is happening, you need to be aware of the literature and all this stuff. (EXP05LMIC)

Sub Themes	HIC	LMIC
	All these interventions that we practice with the, we undertook with them have a theory and research base yeh so we are aware of that, it's just at what point they needed to be aware of that (EXP02HIC) obviously, it's really important to teach evidence-based approaches, but I don't think students who work in the real world are as worried about who it was that advocated a particular approach. They're more interested in how to use whatever technique it is (EXP03HIC) I think an evidence based is really really important. Otherwise, you're just learning intervention and techniques and you've got no background … So, you need to always make sure that you discuss evidence based really, critique different approaches. (EXP04HIC) half way through the program we paused and reviewed the content because we were getting some feedback, which is fine, about people's level of understanding about what was happening and their ability to practice that in their everyday practice. So, we took the opportunity to stop and review where we were going. From that, we identified some areas that we wanted to pursue more and other areas we felt duplicated what people were having anyway across the, uh, across their agency induction, uh, training. (EXP02HIC) I did give uh some background to where the interventions had come from and something around the evaluation base of that, you know, but primarily it was about practices and how people deliver a service really. Umm, so uh, but my approach anyway is very much around, well let's have a look what the practices are, let's see what the theory is behind that. (EXP02HIC)	The main goal is that you make them strong in the intervention because the less burden we put on their head, the more effective they are going to work. They don't have a lot of experience, so the more crisp the thing you teach them, the better they are going to be at it. (EXP07LMIC) If the thing (intervention) is evidence based and you know it's going to work, then whether a psychiatrist goes to deliver thinking healthy program or a peer volunteer... if they have a grasp on the basic concepts and they are competent in thinking healthy program it doesn't matter (EXP07LMIC) It is positive for them. When we first delivered LTP, a component of LTPP, we did that with depressed mothers. When we got effective results for that we shared it with the rest of the mothers who weren't depressed... It was a positive thing, this was a very good standardized training (EXP09LMIC) If you are developing a program which has never been utilised before, then you would have to test it… at the start it will always be that there is no evidence but we are going to change that (EXP11LMIC) Training should be evidence based however there are some things for which there is no evidence. For example, the program had not been done anywhere else, so new evidence was created from the development of the program (EXP08LMIC) It gives you an idea about the training… it gives you the chance to improve on those things. Secondly, the content that you have taught

Sub Themes	HIC	LMIC
		them, it gives you an idea in regards to whether it's ok or not, whether the next person would be able to understand it or not (EXP08LMIC)
2.3 Experiential learning	...another thing that I would quite like to do is kind of the experiential learning... getting people to have a go at one of the intervention themselves, ...so give people a bit of time to have a go at doing one of those things themselves and come back and see what they found difficult and what they enjoyed about it, and then think about how that might translate to the group they're going to teach by experience (EXP01HIC) for delivering mental health interventions I think it's really important to have both and the role-play element in there, because it allows you to go around and listen to practitioners having a go at delivering and pick up any issues as well. (EXP01HIC) I think from a learner perspective they're more interested in the practicality of how something is going to improve their practice. I think when sometimes you are too theoretical orientated, actually it just turns people off, because they can't you know, why is it relevant who said a certain thing? (EXP03HIC) I think it's hard to say, it's different for different people, that's why it's good to have balance. So, you need to explain the history, the theory and philosophy that you're talking about, but then you'd go into practical exercises, so that they're having a go at those. (EXP04HIC) we bring in the people who have done the course in previous years to help in skills practice and give feedback and talk about their own experiences... (EXP01HIC)	I do sort of a mini lecture but my emphasis is mainly on group activities, group discussions because I think that the participants, they are able to learn more if they feel that this training is more interactive, rather than just sitting there and listening to what the trainer is saying. And, one of the things which I focus a lot on in my training is the role-play. I am strong believer that role-play is a very very powerful technique for people to learn things. (EXP05LMIC) role-plays has its own drawbacks. Uh, but I think to practice something, it's a very very good technique. Sometimes when, it's like with a trainer they have to do the role-plays as well, so when they are doing the role-plays uh, I think that does the help the trainees to gain more confidence in this technique, because when the trainer is doing the role-play they can see that they are learning from it, uh, even though it is an artificial setting and sometimes things don't exactly go in the real world as it has been going in the role-play. But then you also mention all these things to them, (EXP05LMIC) I think the field training aspect is the best because you are learning a lot of good things. Generally, a psychologist will have a strong background and will be used to learning through classroom training, but lay counsellors such as these peer volunteers... they have no idea how to understand these things and how to apply them until they are applying them in the field... I think the aspect of field training is very important (EXP07LMIC) It shouldn't be teacher-student style. It shouldn't be that you are teaching them from a book, or from a lecture and things like that. It

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	I would get something that's from their experience that sort of reflecting sort of on their own experience and ask them to then approach that using the techniques, the new techniques that they've learnt (EXP02HIC) people talked about things like, so it might have been looking at for example, what they thought coaching was and how they could use that in their practice and then they would bring some examples where they were working with people where they felt coaching would be helpful (EXP03HIC)	should be interactive in the sense that you should involve the people who you are delivering the training to, I mean you should involve them by asking their opinions, questioning them a lot. I think that's better (EXP08LMIC) They are delivering in front of me, and they are doing role-play… the questions they are asking, I am sitting and watching. So, wherever there is a lack, I will stop them and say, 'no you don't do this, you do this.' So, before they go, we know their level (EXP12LMIC) I think role play session are more engaging. These role play sessions actually give them the opportunity to practice, to rehearse; and obviously the trainers are there to give feedback on selection of words even, and the tone and obviously the content as well. So, for community health workers the role play sessions are very important because you know it's difficult for them to engage with presentation after presentation (EXP10LMIC) ... we would ask them first about their experiences, we would get their feedback, 'What do you think in your views were the good things, or what do you think was lacking or could have been done better?' and normally ...they would say themselves that 'I felt that this could have been done in this way'. Or if there were any negative points, not negative points but things that needed improvements then they would say themselves that, 'Maybe she was a distraction and that's why.' So at the end they were their own teachers, now that they are very trained. (EXP06LMIC) because most of the peer volunteers that we recruited they are mothers themselves, so they have gone through this experience of being

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		pregnant, giving birth through the mothers, they are from the same area, they can actually understand what sort of a psychosocial pressures the mother can experience (EXP05LMIC) If there's one person in the group who doesn't understand, then you can repeat it two or three times, or if the rest of them have understood then you can ask them to explain it in their own way. It could be that I might not be able to explain something that I am trying to teach them as good as someone who is similar to them. (EXP08LMIC) They are all living in similar settings, they all more or less have the same sort of problems, so if one person, one LHW is sharing her own problems, then everyone else will listen intently, and she will get two to three suggestions (EXP10LMIC)
2.4 Collaborative and open environment	So, when I am teaching I can only do it as myself, so I'm very informal, I'm very smiley, I think my body language is very open, I story tell a lot, I laugh at myself. And I usually do have a good rapport with the people in my classroom... And that's not to say that somebody who is much more serious than I am, isn't as effective as I am, because they are then being themselves, aren't they? ... So, I think being yourself is really important. (EXP03HIC) the most important is how you are with other people. So, if people feel comfortable and safe with you, then they are able to learn more because they are confident knowing that they can ask a question. (EXP04HIC) I was asked to do a session with all the managers about doing management and um, when we got there, it was quite clear that the managers were actually extremely anxious about their lack of, or	... it was very friendly, we never used to say to them that there was a huge student-teacher relationship, which there wasn't at all. It was very friendly, they were very open, they had full provision to say whatever they wanted or discuss or whatever they wanted or share whatever they wanted. So friendly learning was also very important (EXP06LMIC) you are also there to learn from them, and whatever experience they are brining into the training room, that is also very important. So, not presenting yourself as an expert but rather coming to their level so that they feel alright talking to you, asking you questions and to be human in that room rather than a stiff neck professor (EXP05LMIC) First, start by sharing your own problems, so that thing is that is stopping you, that can break and others can start sharing too … If someone is sharing something personal, don't be judgemental at all and also stop others from being judgemental (EXP07LMIC)

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	perceived lack of knowledge, or depth of knowledge they would put it as, to support their staff. So, we, instead of doing the planned program around management techniques, we actually did a different program about enhancing their understanding of umm, of the techniques. (EXP02HIC)	When we were giving training, we had a friendly behaviour with them, so that helped them... at the start they were hesitant, but over time they realised that we are teaching them useful things and then they began sharing their problems with us (EXP08LMIC) Believe me, if you talk politely and lovingly then you will never lose, and I have faith in Allah that if you put me in any community, in any unknown community I will be able to make that rapport (EXP13LMIC) The relationship you have with the community worker should be one where through our conversations and our style of talking they are able to get the message (EXP13LMIC) If it feels like they are really low then toning it down a bit, so adjusting an important topic to a different time instead of wasting it and instead doing something low that they would normally understand (EXP07LMIC)
2.5 Group size	it's small enough for people to feel comfortable a lot of the time, but not so small that you feel all the pressure is on you to kind of answer every question or do every example, or whatever it is...when we've had smaller groups that are around ten or twelve, people feel like they get a really personal experience and then when we get up to thirty... that's really harder for people to feel like they're really getting any individual attention. Yeah, so I would like kind of ten, twelve-ish (EXP01HIC) you need a large enough group that will give some synergies across and some difference in terms of learning. Umm, I don't know, I think	if there are more than twelve people and as I've been telling you that I do a lot of role-plays, so if there is a very very big group not everyone will get the chance to do the role-play. (EXP05LMIC) When the group is a bit bigger, they are able to learn from one another a bit more. Everyone has their own experience, their own knowledge. But even if there is 5 or 6 in a group it's ok, some people prefer less so they can easily understand (EXP09LMIC) I think between 10 to 15 is a good size because it increases the margin that it is going to be interactive. The smaller it is the more risk there is that people won't talk, they won't participate (EXP10LMIC)

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	in terms of working together as a small group, I think umm four or five is quite good. (EXP02HIC) group size is critical really because it's about being able to walk around and listen and give feedback. (EXP03HIC) people are usually quite happy, they are quite comfortable to share what they're comfortable to share, if you know what I mean. Whereas sometimes when I'm with students who don't have lots of experience in practice but they do have their own personal experiences, sometimes people can share to a point where they feel like it's ok, but then are left feeling quite vulnerable afterwards because maybe they've over shared. So, with that group of practitioners because it was a small group and because they knew each other, it was quite easy to manage and facilitate. But if it's a bigger group and people will less experience, I'm probably more aware of those issues, (EXP03HIC) If I'm doing work that's focusing on helping people be kinder to themselves and self-care, self-practice then you need to have a smaller group because you can go round, and if there's any obstacles or any barriers or fears or blocks, it's easier for you as a practitioner to manage. (EXP04HIC) We trained four because of the restrictions we had at the time in terms of trying to recruit people that were able to deliver this within the time period that we needed, and we were only going to deliver a small-ish amount of workshops because it was a feasibility trial (EXP01HIC) So role-playing probably in a bigger group, wouldn't work because you couldn't facilitate it or monitor it or anything like that and also in	there is always two trainers, so one main trainer and another co-trainer or co-facilitator and this is because if we are doing lot of activities, so they can actually split and actually observe and give feedback. … it's also because in case anything happens to one of them, the other person can step in and deliver the training (EXP05LMIC) we trained some extra people, so there was some adjustment… if someone had to go, somebody had to leave, before going they would either provide a substitute or if not then they would tell us a month before and we would then search for a new person and train them. And she would shadow them, the person that was leaving so they would learn within the time. (EXP06LMIC)

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	a group of practitioners that didn't know each other, I don't think it would be as effective either because you have to feel comfortable and actually maybe that's where some of my dislike for it has come from because it's been used to soon as a teaching technique. (EXP03HIC) I think maybe you know in a full trial, or delivering this normally to make it cost-effective, you would want to train more people and have back up people if something went wrong (EXP01HIC)	
2.6 Supervision as a time for reviewing, refreshing and support (reviewing and refreshing)	One of the things you can do though is, if you for example run a dummy workshop which we're going to do in Pakistan, is assess people's fidelity to the intervention when they deliver that and then you can pick out any points where they might not be doing things in quite the way that you wanted them to and deal with them before they go out to deliver it for real. (EXP01HIC) having good supervision, having top-up training if it's needed. Um, really well supporting the people that are delivering the training, measuring the fidelity um, by recording workshops probably and reviewing them against, auditing them basically against the training program. (EXP01HIC) So, there's no formal assessment as such, it's very much around what have you learnt? It would be quite difficult to formally assess some of those techniques actually, um yeh, it would be difficult. (EXP02HIC) there is a value I guess in doing refresher sessions, but I think I would be comfortable enough with my own knowledge to be able, what's the point in doing a booster session around something that they don't need a booster session in? And how do you know what they need it in unless they've had a problem with it? (EXP03HIC)	to recruit someone as a peer volunteer who is not actually capable of delivering that intervention it means that you are not doing justice to the mothers, so for that reason we have to do that (EXP05LMIC) Competency in the way that; firstly, normally in supervision we are doing role-plays so we are considering this. Secondly, we are doing live observations and within that there are three points that we look at, such as how was it the first time? What is the score like now? If that is down, then we talk about retraining in those areas. But, if someone's competency is really low or it is unacceptable then we say goodbye to them (EXP07LMIC) You should assess the people who are receiving the intervention, to see that they are receiving is of good quality and if they are understanding it (EXP08LMIC) When we are doing pre and post tests, we are looking at their scores. So, we can definitely tell from that, whether the quality is being maintained, if their knowledge is there, on a monthly basis (EXP09LMIC) Generally, we do pre and post assessment as well. For that we have a structured KAP questionnaire; knowledge, attitude and practices

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		questionnaire for each developmental area, so we do a pre assessment on first day and the post assessment after completion of training (EXP10LMIC) The facilitators who need to deliver it, what are their needs? What is their knowledge base already? What needs further adding to it? What are their preferences in terms of mode, delivery and setting? So, needs assessment is important (EXP10LMIC) When we've brought the LHW from that area... after the introduction when they've delivered the first session, they've done the second session, from the reply that they give, from the results that come, we can see that she needs more... they need more to work with us (EXP12LMIC) we have refresher trainings once a year. So, all the peer volunteers they get together and then they, we revise the main content and that also gives them the opportunity to share their success stories (EXP05LMIC) But for continuous learning, for constant learning you need to have breaks in the middle, you need to have things like that, it is important, it's not like it can be done in five days. Even if you spend a month on it, the learning that you have after two years will never remain the same as the one that you had after a month, unless you don't keep topping up in between. (EXP06LMIC) So, annually we have these refresher training in which all the peer volunteers from different clusters, they get together, they can learn from each other's experience and usually it's a similar sort of challenges which women are experiencing (EXP05LMIC)

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2.6 Supervision as a time for reviewing, refreshing and support (support)	so the people you initially train you want to keep them happy and in the intervention and have them delivering the intervention for the life of the trial, so kind of looking after them, to support them so that they are able to do it. (EXP01HIC) Giving them good supervision, feel supported, making them feel like part of the team, um, making them feel valued in what they're doing, saying thank you and providing them with feedback that highlights their strengths and what they're doing well but also helps them to develop. (EXP01HIC) supervision should be part of the resilience network around people. So, it should be providing where the agency, part of how the agency provides a framework of support for people to enable them to be resilient against some of the difficult stuff they have to deal with. (EXP02HIC) you're also looking at your supervisee's well-being and ethical codes of conduct and practice. So, yeah, your primarily thinking about the client or patient that you're working with, but there's lots of other things you'd be focused on like, is your supervisee talking about symptoms of burnout? or they're feeling overloaded or something's too much? are they struggling with an assignment? You know, there's lots (EXP04HIC)	for example, I had one or two PVs that I felt had no motivation. So, then I sat with them in person and I talked to them. What normally used to happen was that they would have a lot of severe issues at home. We would advise them, 'Do you think that you can continue this work or not?', because they had a good affiliation mostly, they would say 'We will do it and we feel good, now we feel good that we come here and are worries go away and we are able to relax.' But, if they cannot continue then we would say 'Let's see', but normally it would work out and they would do it. (EXP06LMIC) ...but you are watching them, you are giving them confidence, you are assuring them that everything will be fine. You give your input even if it's for one second that's fine, they build up (their confidence) a lot from that (EXP06LMIC) We are involved in their own personal things as well. If they have any problems then they can talk to us (EXP07LMIC) We are in contact with them. They have our official contact number with them so that if there is any difficulty, they can speak to us on that. We have visits, or when they have a need then we will facilitate (EXP09LMIC) Sometimes when they have to deliver a session in someone's house, 'you will decide who's house it will be in', we empower them a bit, give them a leadership role... sometimes the insecurity element that they have decreases ... We try and leave the decision making in their hands ... they have a bit of ownership (EXP10LMIC)
3.0 Unique considerations for LMICs		

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3.1 Challenges faced by NTPs		peer volunteer sometimes were facing problems within their own families, who were asking them that they should not be doing this work because they are not getting any money (EXP05LMIC) then there were many people, who only received training and then after training two or three people who skipped (the intervention), because their families didn't accept it (EXP06LMIC) There's many challenges at the start, 'How will we get there? How will we get back? We are interacting for the first time; we are very shy.' I mean, these are the issues. 'Our family members don't agree, or are family members agree but there is no one to go with, the journey is far, the mother isn't getting involved, how do we involve the mother, what are her issues at home?', I mean there were issues like these. (EXP06LMIC) LHWs are part of a household, so to schedule timings would be difficult (EXP11LMIC) They have their own job commitment as well. The LHWs are so overburdened (EXP10LMIC) There are no working hours for them when there is a campaign, they are always packed, so they say, 'In what time are we supposed to tell the mother about these things' (EXP10LMIC)
3.2 Selection criteria specific to LMICs		when we recruited peer volunteers they need to be having at least ten years of schooling, umm they need to be local, umm they need to be able to move in the community uh freely, because some of the local women who actually wanted to work as peer volunteers but they were not allowed by their families to be going from home to home, so it became really difficult (EXP05LMIC)

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		Because they are from the same community, they know the area very well, whatever the environment is, the situation at home, any issues... so they can deal really well according to that (EXP08LMIC) They are already working women so they have a setup from the start that they leave their children with their grandmother or whoever. They are working women so they definitely have their own arrangement, their own system (EXP09LMIC) When we go and deliver it's a language problem as well. Like people going in Gadap, there are more Sindhi speaking people there. So, if I train a person who does not speak Sindhi, how will that person deliver to those who are Sindhi? (EXP12LMIC)
3.3 Flexibility of training		Their timings were flexible, it wasn't that they had to deliver the session between nine and five and then go back home… They were able to look at their own convenience as well as the mother's, what time would be the best to go deliver it (EXP07LMIC) usually the trainings in the UK is between nine till five o'clock, uh, but in Pakistan it's a bit different. So, when you train people over there, the day starts maybe at eight o'clock and then it tends to finish by one o'clock, for the peer volunteers. Like, if you're training the professionals then it is different, you can train them nine to five, but if you are delivering the training to non-professionals, um, usually by the time it's one o'clock they want training to finish. (EXP05LMIC) Because our peer volunteers were from the area and they couldn't spend more time on this than that. For them, we had to adjust the time for their feasibility. Otherwise, like you know, a lot of people there

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		wouldn't attend unless you accommodate them on things like this. (EXP06LMIC) If it is the days for polio vaccinations then we know we aren't going to get any LHWs. So, we make sure that we do it (training) at a time when it is convenient for them to come. So, when the polio days are 9 to 1pm and they are engaged, we try that it is the second half of the day. Our team has to try and accommodate as well. (EXP10LMIC)
3.4 Motivators for the trainer		The most rewarding thing for me is when I hear a mother doing well or a peer volunteer doing well, it's amazing to be listening to that. I think if you actually going in the field, because I have been in the field a few times, I have spoken face to face with the peer volunteers and when you listen to how it has impacted their lives, not only the mother's life, you feel very very proud of yourself that you have contributed towards making this change. (EXP05LMIC) the smile you see and the affiliation you get, that itself, that was everything. The satisfaction when they say, and when they are giving you their blessings and when they are telling you with full teary eyes, that for me was very important. (EXP06LMIC) I really feel that if I train 12 people in a training program, for me this is fascinating. Those 12 people will approach 1200 families, and if my training is able to reach 1200 families, in terms of child health and well-being, in terms of reducing maternal mortality or child morbidity... this is really fascinating for me (EXP11LMIC) If I can give more awareness through people, because especially in our country there is no awareness on mental health… so I see how much I've contributed, and if I've done .1%, I will feel good about it, that I've

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		done it and I've been able to explain it to someone who has then further gone on to tell other people (EXP12LMIC)
4.0 Trainer attributes		
4.1 Experience vs Expertise	People value experience, so they want a trainer who has had experience in delivering the intervention (EXP01HIC) I'm very flexible in how I approach things and it would have been counterproductive to carry on with a lesson plan, if you like, that wasn't actually what their priorities were. So, I'm very flexible in able to, because I'm very experienced and skilled in this, I can respond to people's expressed need on the day and just do something different. (EXP02HIC) you can be really good at delivering an intervention, whatever that intervention is, and a rubbish teacher, can't you? That is the reality (EXP03HIC) I think storytelling is quite a powerful tool when you are teaching, so being able to give real-life examples (EXP03HIC) They certainly need to have high expertise I think, to understand the content they are delivering but also to be able to deliver that in a way that's umm particularly helpful for people. So, there's two strands to that, there's the content and there's the process of learning. (EXP02HIC)	you can be a very very good therapist but it doesn't mean that you can be a good trainer or you can be a perfect trainer but you can't be a good therapist. So, these are different type of skills of what you want, to be a good trainer you need some skills which does make you a good trainer. (EXP05LMIC) I think it's very important to look at both things, that they are psychological minded and second, what is their experience from before, how involved have they been? And maybe a third thing which I think is important, what is their style of teaching like? Because we're not just getting them to deliver it, we're asking them to do the training. So, if I'm a good therapist, that that definitely doesn't mean that I'm also going to be a good trainer (EXP07LMIC) Definitely in five years it has become easier, we can tackle things easily (EXP09LMIC) I apply all of those things on myself first, everything I've learnt, some were counselling skills. Because when we go to teach someone else, only when we have practice of it on ourselves can we teach others (EXP08LMIC) Even if the trainer does not have a background in mental health or psychology, if they are able to teach the information well, then the other person will still be able to learn (EXP08LMIC)

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		...obviously the trust has been built with that person because of the questions they have or because he understands them. If a person doesn't have that personality or he hasn't studied in that area, they wouldn't be accepting that, it's not something that they would accept at all. So, that person, I think that someone, should have a little bit of background (EXP06LMIC) You definitely need to have the expertise because until you don't have the full grip, you don't have the full knowledge about that thing then you can't go and deliver the training (EXP08LMIC) Because it's training regarding mental health, there should be knowledge, they should have knowledge about common mental disorders, what are they? What are its effects? And then they can train lay persons (EXP11LMIC) If a psychologist is delivering training then they have the strength that they are interacting with patients daily. So our exposure to different kind of mental conditions is more as compared to a lay person (EXP11LMIC) A lay person can deliver training perfectly, if they have any problems it would be in terms of psychological aspects or mental health, otherwise training is not about being a professional (EXP11LMIC)
4.2 Challenges for the trainer	… but some of the challenges would also have been some people's experience, because if people deliver things in a different way or work from a different psychological model and then you ask them to change to deliver CBT, that can be quite tricky to do (EXP01HIC) awful lot of content and a short space of time, so it was harder to find time to really explore with the participants on the training exactly what	out of those forty-five peer volunteers which were initially recruited we have been able to uh, the retention rate is very high. So, out of those forty-five, I think thirty-five are still working, which is very very high. And again, these are the peer volunteers who have not been paid for their work, so they are doing work voluntarily. They are paid to attend the supervision sessions, travel allowance, but other than that

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	they knew and didn't know, and what they wanted to get out of it really (EXP01HIC) And sometimes that's about not getting too invested and referring on to the appropriate people... it is really tricky and I struggle with that (EXP03HIC) you have to be cautious about going into too much depth, particularly when you are talking to people who may not have umm the educational background to build on some of the concepts you are talking about (EXP02HIC) I think if you were to cover depression in quite a lot of depth but not to the extent of a nurse, and same with things like schizophrenia, then I worry personally that people would then leave the room thinking that they've got as much knowledge as a registered health nurse or a psychiatrist or whatever. And then that might make them not refer on when they should do because they think that they can manage those issues because they think they know it (EXP03HIC)	they are not being paid. So, to be working for so long, to maintain their motivation is a big challenge for us. (EXP05LMIC) For us to travel far from here, from the field office to over there and then to organise everything and then to build rapport with them and then to come back and then to do it all again, the travelling was an issue. (EXP06LMIC) Being able to withhold yourself is the most challenging situation… when you know a lot of things but you also don't want to go into that much information, I think that is very challenging, to be able to hold that back (EXP07LMIC) The people who you are training don't have a background knowledge in regards to what you are teaching them in, so to help them understand what kind of words to use, what kind of examples to give, in what way are you going to go down to their level and teach them. So, at the start it was difficult (EXP08LMIC) Sometimes there is a language barrier... they are more comfortable speaking in Sindhi (EXP10LMIC) At the start there was definitely difficulty because they were like, 'we have been doing this for so long and now you have come to tell us' (EXP11LMIC) Our beliefs having been running for generations. Like at the start, it is in generations that if they show a child a mirror, their child will fall ill. Now, to tell them no, it's difficult to convince them no… to tell them logically, to tell them no, it's difficult (EXP12LMIC)

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4.3 Facilitators for the trainer	actually, it was easier in some ways because they had lots of examples that they could bring into the classroom (EXP03HIC) Some of the strengths were people's experience that we were training (EXP01HIC)	the trainers who are actually training the peer volunteers, some of them were local trainers so they belonged to the same area where the peer volunteers were living. So, it becomes much more easier for the trainers to develop that rapport with the peer volunteers, uh, and they were more comfortable during the training, they were able to ask questions. (EXP05LMIC) We work alongside the lady health workers, they work with us to identify the peer volunteers, and when we do introductions with the mother then the lady health workers are present with us so that it doesn't feel like an outsider has come… so there quite a lot of support from the lady health worker (EXP07LMIC) We never enter a community without a community leader… they have a different trust for the community leader… this helps a lot, when the leader is introducing you they engage with it (EXP10LMIC)
5.0 Why is information on training lacking?		
5.1 Reluctance to disclose	I suppose it might be concerns about giving away sometimes the details of what was done in those areas (EXP01HIC) It might be because they are concerned it is getting out into the etho and they have no control over it. Umm, it could be that people enjoy the idea of being important in that interaction with individuals, find that online approach a threat because it may question their personal value through the process. (EXP02HIC) People are probably quite precious about something that they've worked hard to develop (EXP03HIC) maybe there's a worry about, I think one of my worries not around coaching particularly, but might be, around the currency of things. So,	Maybe the main point of making it public was so that others can learn from it… whatever obstacles there are or whatever experiences you have had, someone can use that to start from an even higher step and they will already have the background (EXP06LMIC) I personally feel that if you are working for sustainable development goals 2030 and you're doing everything towards that, no poverty, no hunger... when you are doing things to achieve that, then make knowledge available. It may be free of cost or low cost... otherwise what is the purpose of doing all of these kinds of things to improve health and well being if there are restrictions (EXP11LMIC)

Sub Themes	HIC	LMIC
	if I was responsible for keeping those sessions up to date online, then that would be one thing. But if they are there online, if somebody picked them up in three years' time, actually health changes a lot. So, if they use my techniques and actually, they're no longer the most current up to date evidence and if something goes wrong, am I then, I would feel that I was responsible. (EXP03HIC)	I think the more you keep your things sort of open for people to see and learn from it, at the end of the day it will benefit them as well as it will benefit you in many ways. (EXP05LMIC) Maybe they are thinking about their position, that they are a psychologist or a psychiatrist and they didn't deliver the intervention, so that people don't question the value because it was a normal person that delivered the intervention (EXP07LMIC) I think that that we make it into a form of making money and maybe that's why it's not available… I am involved in the intervention development also, and I have also faced that when I found something that was very relevant to me on the internet that I wanted to see, when we would ask to see it, they would ask for payment (EXP07LMIC) If there is a manual available online, a lot of researchers have the tendency that, 'this is available so use it', without giving due consideration on the importance of training and at times you are using that manual to some vulnerable population like self harm you have that manual but you don't have the expertise in terms of how to use that so may be this is the one reason that people don't upload it so it can't be used outside (EXP10LMIC) It depends on the researcher. When they developed the training program, when they received the grant, what did they commit to the funding body? (EXP11LMIC) I think that they would want money for it or it might be that the don't want other people to copyright it or want to share the copyrights (EXP12LMIC)

Sub Themes	HIC	LMIC
5.2 Outcome focused	I suspect it mostly comes down to that people want to publish and they want to publish in high impact journals and what people want to see is the methods and the results and how it fits in with existing literature, and often in this kind of field in health care and health services research, you're aiming the paper at wanting to get clinicians, other researchers but also clinicians to read it and use it in their practice and they probably don't care so much about how you trained trainers. (EXP01HIC) They either don't think about it, it comes to the end of the project, their money has run out and the big paper that they wanted to get out has gone, the researchers have left, there's no one to do it. Often that's another thing, so it's just not prioritised. (EXP01HIC) I guess people don't focus on what happens in the classroom do they? They just focus on what comes out the other end really… So, they are less focused on what should happen and more focused on need and outcome. We're an outcome driven society, aren't we? But sometimes we don't think about the journey and how we get to where we want to be. (EXP03HIC) because the journals are wanting more about theory rather than the practical aspects. (EXP04HIC)	I think that that maybe they are more results oriented, they focus more on results. What has happened in training, probably they think more about the results, 'what are our endpoints or what's happening with our outcomes?'. (EXP06LMIC) Sometimes the word count in papers is not enough and you have to report on more important things… When you are doing a randomised controlled trial, which is very sophisticated or a cluster randomised controlled trial, there are so many factors that you have to report on so there will only be one paragraph on the intervention and the paragraph will only have three lines. (EXP07LMIC) Sometimes if they have only carried out an intervention, they will only focus on that and not do qualitative interviews afterwards and then do a process evaluation. So, I think doing a process evaluation and things like that should be highlighted (EXP07LMIC) I think maybe the culture has been developed in which training data isn't given just as much importance (EXP10LMIC) Maybe a lot of the times, like we do supervision, field notes, documenting processes, maintaining training logs, maybe that is missing, you don't have that trail of how your training was done... and when your project is two years long and you have to remember everything... it's hard and maybe the proper documentation is not there like it is for outcomes (EXP10LMIC)
5.3 Importance of guidelines	we all know if you're reporting a trial you have to follow the CONSORT guidelines or you have to use PRISMA if you're doing a systematic review, um, and that you won't get published if you don't follow that. So, that it would be for journals to bring that in, a stipulation that you have to clearly reported your training in the	Reporting guidelines are very useful. Definitely, you would know, but you will also lack on a lot of points. If you need to inform them about something and you're not allowed to and things like that (EXP06LMIC)

Sub Themes	HIC	LMIC
	appendix or whatever that is, I think that would be the main thing that would encourage people to do it. (EXP01HIC) Guidelines can be helpful but they can also be too prescriptive as well, so umm, sometimes if you apply a template actually you only, you only work to the template and miss things that are not within that framework that can be of value (EXP02HIC) I think guidelines are good, but I think that people need to be able to deviate from them (EXP03HIC) my experience of guidelines in clinical practice from a nursing perspective are, that people stop thinking outside. So, all of sudden you do something because the guidelines say it rather than because it's the best option and then people don't understand why they're doing what they're doing. They're doing it because the guideline said that they've got to do it, and I think that's a really dangerous path to go down, to be too prescriptive. (EXP03HIC) if you could read other people's training ideas, that would be good, because probably teams across the country are delivering the same mistakes over and over again that aren't helpful for people so it would be nice to see better evaluations of training so that it stops people making the same mistakes (EXP01HIC)	yes you get a structure from it. ... if you know that there is a structure, if you know that you have to follow that, then it becomes a bit easy to write. (EXP06LMIC) I think if they (guidelines) are there that would have been really beneficial. I think that is good, there should be some so that it actually guides the people on what sort of things they should be reporting. (EXP05LMIC) There should be guidelines which are standardised… definitely if you are writing, you are writing for a lay person who can easily understand your paper and they can gain knowledge from it then there should be a standard for how we can report things easily (EXP09LMIC) But, when we look at training in this way, especially CASCADE training there are no clear guidelines anywhere on what there should be? How it should be? What things should we be considering? So, I think that there is a big need for this, that there is work and guidelines on this (EXP07LMIC)