Field Report

Task-Sharing Psychosocial Support with Refugees and Asylum Seekers: Reflections and Recommendations for Practice from the PROSPER Study

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Abstract

To address the unmet need for accessible mental health services for refugees and asylum seekers in high-income countries, the PROSPER study is testing implementation of the World Health Organization Problem Management Plus (PM+) intervention. Incorporating task-sharing strategies, the intervention is delivered by Peer Lay Therapists with lived experience of seeking asylum or migration. The PM+ training adopts a cascade apprenticeship model, where Master Trainers train and supervise Wellbeing Mentors; who subsequently train and supervise the Peer Lay Therapists. We describe application of this training and supervision approach in PROSPER, drawing on Master Trainer and Wellbeing Mentor perspectives. We then reflect on our experiences, highlighting logistical challenges when working with refugee and asylum-seeking Peer Lay Therapists, the strategies to promote their ongoing engagement and the opportunities for team and personal growth. A core learning point has been the role of straddling the intervention and research components of the PROSPER study. Based on our experiences, we make recommendations for others adopting a task-sharing approach by training refugees and asylum seekers as Peer Lay Therapists in high-income countries, so that this might inform service programming and/or associated research activity.

Keywords: asylum seekers, mental health and psychosocial support, Problem Management Plus (PM+), refugee, task-sharing

Introduction

Task-sharing[1] offers an approach to expand the mental health workforce, increasing access to care (World Health Organization, 2007). In mental health this involves *sharing* intervention delivery from specialists to Lay Therapists[2] without formal mental health qualifications or training, who are trained and supervised by mental health professionals with higher levels of training and experience (Hoeft et al., 2018). In a review of task-sharing interventions in low- and middle-income countries (LMICs), van Ginneken et al. (2013) found that Lay Therapist-delivered interventions may increase the number of adults recovering from depression or anxiety, as compared to usual care.

Refugees and asylum seekers (R&AS) experience a high prevalence of common mental health problems and functional impairment (Lindert et al., 2009; Close et al., 2016; Priebe et al., 2016; Mangrio & Forss, 2017). When seeking asylum in high-income countries, R&AS can experience adversity from negotiating the asylum process, acculturation stress, economic uncertainty and discrimination (Ryan et al., 2008a,b; George et al., 2015; Priebe et al., 2016; Khan et al., under review). R&AS also experience barriers to accessing and negotiating health care, including language barriers, as well as different and potentially stigmatising attitudes toward mental health and discrimination (Summerfield, 2001; Priebe et al., 2016; Kang et al., 2019; van der Boor & White, 2020; Khan et al., under review). These factors leave R&AS facing substantial unmet mental healthcare needs (Bradby et al., 2015).

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Lay Therapist-delivered psychosocial support embedded within community-based organisations offers one way to provide more accessible, and culturally appropriate, mental health care (McLean et al., 2009; Hoeft et al., 2018; Shahmalak et al., 2019). Research evaluating peer support workers' integration into mental health services in high-income settings indicates benefits for both the peer support worker and those receiving support (McLean et al., 2009; Repper & Carter, 2011). However, challenges remain, such as determining the level of training and supervision required to ensure peer support workers maintain intervention fidelity (Shamalak et al., 2019), and systemic challenges to integrating peer support workers into health systems (Ibrahim et al., 2020). Research from LMICs exploring Lay Therapist roles suggests that recipients of support prefer Lay Therapists who share common socio-demographic characteristics (e.g. age and gender) and life experiences, and have good communication skills and character traits such as trustworthiness (Singla et al., 2014; Atif et al., 2016). Additionally, evaluations of Lay Therapists' experiences of task-sharing found high levels of self-efficacy and personal motivation to help others; and indicate Lay Therapist satisfaction in confidence and skills building, and interaction with new people (Shahmalak et al., 2019; Wall et al., 2020). This corresponds with the role of community in promoting R&AS wellbeing in high-income countries, where *community* is understood to encompass shared identity, as well as support from, and offering support to others (Khan et al., under review). Therefore, there are significant potential benefits to task-sharing interventions for Lay Therapists and those receiving care.

The PROSPER study assessed the feasibility of task-sharing with R&AS Peer Lay Therapists (PLTs) to deliver the Problem Management Plus (PM+) intervention through community-based organisations in Liverpool, UK (see Rawlinson et al., 2020). We explore the experiences of recruiting, training and supervising PLTs with lived experience of migration or seeking asylum to deliver the intervention. We draw recommendations for task-sharing mental health research and service delivery involving R&AS PLTs in high-income settings.

Reflective Approach

The reflections arose through monthly supportive supervision between the Master Trainer and Wellbeing Mentors, captured in supervision notes and refined through three reflective workshops that involved brainstorming, additional reflection, literature searches and collective writing. The aim was to contribute to an understanding of how task-sharing interventions function in practice (Hoeft et al., 2018; Kemp et al., 2019), focussing on engaging R&AS PLTs in a linked service delivery and research study. The reflective approach is underpinned by Schön's (1983) concepts of reflection in- and on-action. Through a semi-structured process, the lived experiences of implementing PM+ with R&AS PLTs are actively engaged with and reflected upon, producing cycles of learning, action and reflection (Kolb, 1984; Fowler, 2019). Our reflections fill a gap in the task-sharing literature by privileging the experiences of trainers and supervisors. The PROSPER study is conducting a qualitative process evaluation to retrospectively explore trainer, supervisor and PLTs' experiences of task-sharing, complementing the perspectives presented here.

Problem Management Plus

For a full description of the PM+ intervention please see the editorial of this issue (Ager et al., 2021), and Dawson et al. (2015). As PM+ aims to help adults experiencing symptoms of common mental health problems including depression, anxiety, stress or grief; and practical problems such as unemployment or interpersonal conflict, it offers a potentially appropriate approach for R&AS living in high-income settings. PM+ manual adaptations to fit the lives of R&AS in the UK for the PROSPER study were approved by the World Health Organization (WHO). For example, Group Problem Management Plus (Group PM+) adaptations include creating a male case study and amending the case study narrative and images to the UK context (e.g. replacing help-seeking from a "village elder" with "voluntary or statutory organisations").

PROSPER PM+ Training Model

PM+ training and supervision broadly follows the cascade apprenticeship model (Murray et al., 2011), outlined in Table 1.

The apprenticeship model foregrounds supportive supervision (Schwerdtle et al., 2017; WHO, 2007). This approach promotes cycles of experiential learning, doing and reflecting (Kolb, 1984). This is important for enhancing Lay Therapist competency and fidelity, whilst encouraging motivation and job satisfaction (Kemp et al., 2019). Supportive supervision prioritises and integrates "tacit knowledge" gained through experiential practice with intervention principles to enhance the skills, knowledge and values of those delivering the intervention (Welsh & Lyons, 2001). We describe and reflect on our experiences of cascade apprenticeship training and supervision to draw recommendations for others implementing this model, focusing on adjustments when working with R&AS PLTs.

Recruitment

Wellbeing Mentors

The Wellbeing Mentors are the PM+ PLTs trainers and supervisors. For the PROSPER study, the Wellbeing Mentors are themselves lay professionals, with no mental health specific qualifications or training expected. Instead, the emphasis in Wellbeing Mentor recruitment was on experience of training and supporting volunteers from diverse communities within health and social care.

The two recruited Wellbeing Mentors had counselling qualifications, and between them also had qualifications in education and youth work, and voluntary work experience in mental health settings. They were recruited and employed by the PROSPER intervention partner, Person Shaped Support (PSS) in Liverpool, a social enterprise providing mental health and social care services, including

Table 1: *Apprenticeship Model for Mental Health Interventions*

Components of apprenticeship model in mental health interventions	Application in PROSPER study
Selection of apprentices	• Recruitment of Wellbeing Mentors • Selection of voluntary PLTs
Training	• Training of Wellbeing Mentors in the PM+ intervention; and in training and supervising peer Lay Therapists, delivered by the Master Trainer • Cascade training in the PM+ intervention by the Wellbeing Mentors to the peer Lay Therapists • Wellbeing Mentors conduct competency checks on PLTs to ensure they have the skills and knowledge to deliver PM+ to participants safely
Application of training "on the job" under direct supportive supervision	• Wellbeing Mentor PM+ practice cases with supportive supervision from the master trainer • PLT PM+ practice cases with supportive supervision from the Wellbeing Mentors (with Master Trainer consultation)
Ongoing expansion of training, knowledge and skills under supportive supervision	• Master Trainer ongoing coaching of the Wellbeing Mentors in PLT supportive supervision • Wellbeing Mentors provide supportive supervision to PLT delivering PM+ • Wellbeing Mentor monitoring of PLT delivery of PM+ through observation fidelity checks* on PM+ sessions, and supportive supervision
Mutual problem solving	• Through supportive supervision between the Master Trainer and Wellbeing Mentors, and Wellbeing Mentors and PLTs • Present throughout all steps to respond to challenges of embedded research and working with R&AS

*Note. Murray et al. (2011). *For information about the observation fidelity checks, please see Rawlinson et al. (2020). PM+, Problem Management Plus; R&AS, Refugees and asylum seekers.*

to R&AS. The Wellbeing Mentors (AM and LB) receive day-to-day support from their PSS Team Leader (RMC), monthly supportive supervision with the Master Trainer (AC), and participate in PROSPER Project Management Group (PMG) meetings.

Peer Lay Therapists

Recruitment of 12 volunteer PLTs began with distributing emails, posters and information sheets among nongovernmental organisations supporting R&AS in Liverpool. Over 20 R&AS attended information sessions led by the Wellbeing Mentors where they were introduced to the PM+ intervention, and the PLT role and criteria. Criteria included being over 18 years; with knowledge and/or lived experience of migration and/or the asylum process; sufficient levels of spoken, reading and written English; and residing in Liverpool, UK. Fifteen candidates who met these criteria and expressed an interest in becoming PLTs attended individual interviews conducted by the two Wellbeing Mentors and their team leader. Interviews involved a task to produce an Origami object, testing the candidates' English language skills and ability to follow instructions; and five questions about the skills, knowledge, experience and personal qualities they brought to the PLT role. Following interviews, 12 candidates were selected to participate in the PM+ PLT training (Table 2).

Training and Supervision

Figure 1 summarises the PM+ cascade training and supervision model.

Wellbeing Mentor Training and Practice Cases

A 5-day Wellbeing Mentor training was led by two master trainers (including AC) in October 2018. Training followed the PM+ Training of Trainers (ToT) programme, which foregrounds basic helping skills and the PM+ sessions, emphasising core content and their underlying rationale. The training was experiential, developing skills in training others such as conducting role plays and providing feedback and leading supportive supervision, and highlighting the different individual and group delivery modalities. The training explored the relevance of PM+ to R&AS lives in the UK, and clarified the PROSPER study intervention and research relationship. Training concluded with role plays with volunteers who had no prior experience of PM+.

Following training, the Wellbeing Mentors each completed three individual PM+ practice cases with volunteers (including a medical student with lived experience of migration, social work students and PSS staff). The practice cases embedded knowledge and skills in implementing the PM+ intervention, equipping the Wellbeing Mentors with experiences of common challenges to delivering PM+, such as participant engagement, responding to difficult disclosure and time management.

Following training and practice cases the Wellbeing Mentors spent time networking with R&AS voluntary organisations. This formed an important foundation for their role, as the Wellbeing Mentors became familiar and trusted faces at organisations where PLTs, and subsequently PROSPER research participants, were recruited.

Wellbeing Mentor Supportive Supervision

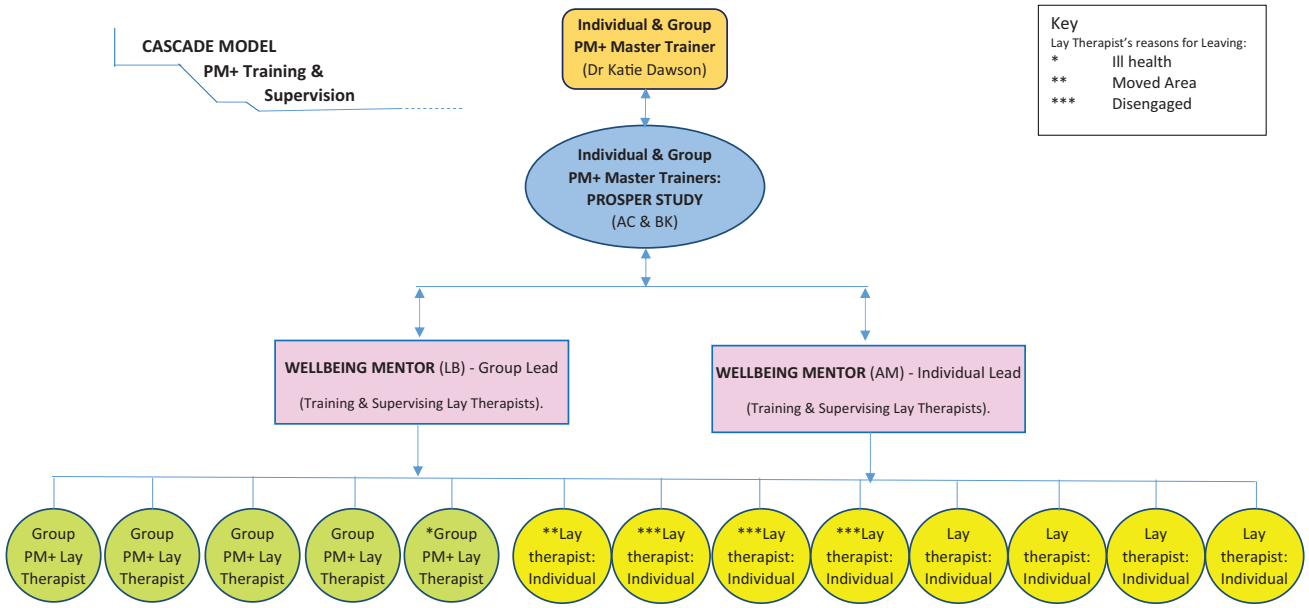
Following training, the Wellbeing Mentors have received monthly supportive supervision with one master trainer and the PSS team leader lasting between 1.5 and 2 hours, complemented by e-mail and telephone discussions where required. Additional PROSPER PMG meetings

Table 2: *Peer Lay Therapists Characteristics*

Sr. no.	Gender	Age (years)	Native language	Education level	Employment/voluntary role in UK	Individual or Group PM+
1	Female	30	Urdu	Undergraduate	Trainee Dental Assistant	Individual
2	Female	30–40	Farsi	Graduate	Studying Fashion, English, Maths	Individual
3	Male	30–40	Arabic	Graduate	Studying English and enrolled in prestudies for Pharmacy	Individual
4	Male	30–40	Urdu	Graduate	Business owner	Group
5	Female	30–40	Arabic	Graduate	Studying English, preparing for Masters studies	Group
6	Female	40+	Turkish	Graduate	Training in English and transferring social work qualifications	Group
7	Female	30–40	Thai	Graduate	Training in English and working in hospitality	Group
8	Male	20–30	Farsi	Not known	Studying	Individual
9	Male	20–30	Farsi	Graduate	Studying Pharmacy	Individual
10	Female	40+	English/ French	Not known	Working	Individual
11	Female	20–30	Urdu	Not known	Studying	Individual
12	Male	40+	Urdu	Not known	Teaching English in conversation groups	Group

Group PM+, Group Problem Management Plus.

Figure 1: *PROSPER Study PM+ Training Model.*



are conducted bimonthly. These provided a forum for input into the PLT team development, and offered space for reflection and learning about PM+ implementation in partnership with R&AS voluntary organisations and statutory healthcare systems (Ibrahim et al., 2020).

Supervision content has been tailored to the project stage, moving from an initial focus on embedding PM+ knowledge and skills to planning for the PLT PM+ training, including refreshing training skills, and then concentrating on skills for leading supportive supervision with PLTs. Supportive supervision enhances the Wellbeing Mentors knowledgeable application of skills to practice by providing a reflective space to develop the capabilities to enhance the PLTs skills through cascade supervision (Kolb, 1984). Finally, Wellbeing Mentor supervision has incorporated logistical research planning and additional trainings (e.g. on good clinical practice, data protection and basic first aid).

Peer Lay Therapist Training and Practice Cases

The PLT training was separated into Group PM+ (led by LB) and Individual PM+ (led by AM), with six PLTs' trained in each modality. Training was delivered 1 day a week (10 a.m.–4 p.m.) over 8 weeks from March 2019–May 2019, with scheduling to accommodate the availability of the R&AS PLTs against other family, work or education commitments.

The training followed the Individual or Group PM+ training manuals covering basic helping skills and experiential learning of PM+ sessions summarised above, reinforced through discussions and role plays. Visits were made by the master trainer (AC) to observe training and provide feedback to the Wellbeing Mentors, to meet the PLTs, and to answer questions about the relationship between the PM+ intervention and PROSPER research. At the end of the training, the Wellbeing Mentors conducted competency

assessments with each PLT to ensure they had the knowledge and skills to deliver PM+ to participants safely. Following this, 11 PLTs were presented with a certificate for successfully completing the PM+ training (one PLT dropped out due to ill health). These 11 PLTs then completed one individual or group PM+ practice case with PSS staff and student volunteers.

Peer Lay Therapist Supportive Supervision

PLT group supportive supervision took place throughout the practice cases, led by the Wellbeing Mentors. In addition to discussing how PM+ sessions were progressing and delivering top-up training in PM+ strategies, the Wellbeing Mentors incorporated self-care tasks to equip the PLTs with techniques to promote their own wellbeing – important for therapeutic interventions (Rothwell et al., 2019). A second PLT dropped out during the practice cases due to compulsory relocation to another city.

PM+ sessions are delivered by PLTs at PSS offices, with the Wellbeing Mentors available before and after. It became natural for supportive supervision to take place immediately after PM+ sessions, with PLTs eager to reflect with Wellbeing Mentors on their delivery of PM+, including which parts went well, where they encountered challenges and why they felt this way. The PLTs sometimes asked the Wellbeing Mentors for clarification of a strategy or checked they had responded appropriately to participants' questions or responses to PM+ strategies. This supervision allowed space for the PLTs to build confidence, gain a focus for the next session and to off-load before returning to their day-to-day life. This individualised supervision approach immediately after PM+ sessions has been highly effective, complemented by group supervision when logistically feasible. This approach demonstrates flexibility and attention to feasibility in supervision structures (Rothwell et al., 2019), with individual supervision reducing travel time and costs for the PLTs to attend separate group supervision.

Wellbeing Mentors conducted fidelity checks to assess PLT delivery of PM+ against a standard checklist by observing a random selection of PM+ sessions. These provide a mechanism for monitoring PM+ quality (Rothwell et al., 2019), learning where PM+ knowledge and skills may have been misinterpreted by PLTs. As above, individual supervision with the PLT occurs immediately after the fidelity check, ensuring experiences of the session are fresh and clear. To enhance supportive feedback and reflection, the Wellbeing Mentor and PLT complete self-care activities before giving fidelity check feedback.

Reflections on PM+ Training and Supervision

We share reflections here based on our experiences, which address themes that emerged in reflective workshops: (1) logistical challenges to working with R&AS PLTs, (2) strategies to encourage PLT engagement and (3) team and personal growth. We identify examples to illustrate these, focussing on considerations relevant to implementing a task-sharing intervention with R&AS PLTs.

Logistical Challenges

The PLTs were enrolled on free and fee-charging English language, educational and vocational courses as it was important to improve their English, upskill and adapt their qualifications to UK education and employment systems. Some PLTs also had families to care for. These all presented challenges to negotiate when planning training schedules. Recognising that R&AS receive meagre financial benefits (Mayblin & James, 2019), financial hardship was mitigated through reimbursement of travel expenses, and providing lunch and childcare during training. It is likely that most R&AS would have been unable to take on the PLT role without financial and childcare support. Furthermore, many PLTs had the uncertainties of personal asylum cases which could impact on their wellbeing and flexibility that PROSPER schedules needed to accommodate.

Ethical approval delays meant PROSPER research timelines were extended, and PM+ delivery to participants was delayed. Due to this dip in project activity, several PLTs left their roles. To maintain the commitment of continuing PLTs, the Wellbeing Mentors and PLTs conducted supportive supervision to review the PM+ intervention, practise self-care strategies and to socialise. The PLTs also made an information video about PM+ aimed at service providers, offering an opportunity to reinforce their knowledge of PM+ strategies and the research design, whilst actively contributing to the PROSPER study and building their confidence.

The impact of delays reflects broader challenges at the research/service delivery interface. Whilst the research and intervention teams' relationship has been supportive and provided opportunities such as additional trainings, it has also brought frustration due to the processes to adhere to clinical trials regulations, the time for ethical approval and slow initial recruitment. To navigate this, the Wellbeing Mentors have played an important role managing the rigid timelines and governance processes of a research trial against the expectations of PLTs keen to commence PM+ delivery.

Peer Lay Therapist Engagement Strategies

Collective informal engagement such as shared lunches during training (with attention to cultural appropriateness by offering halal meals and observing Ramadan) and sightseeing tours helped build intervention team cohesion within and beyond PM+ roles. The linguistic and cultural diversity of the PLTs added value to the PM+ intervention team and promoted a lively training atmosphere. The PLTs displayed a comfortable vulnerability with Wellbeing Mentors, opening up to talk about cultural differences and personal migration experiences. This was complemented by discussions with the Wellbeing Mentors about the local Scouse dialect. Positively recognising this diversity provided bonding experiences, helping the PLTs to understand the local culture, and the Wellbeing Mentors to appreciate the PLTs' migration experiences, promoting open and trusting relationships.

During initial stages of recruitment, the PLTs were encouraged to set the level and type of interaction with

the Wellbeing Mentors. For example, some requested weekly check-in phone calls or meeting for coffee; whilst others preferred text message contact, or only to be contacted when there was a participant for them to deliver PM+ to. Whilst additional time and effort is required for this approach, tailoring engagement to each PLT has avoided problems of over- or under-communication, demonstrating mutual respect that is essential for trusting peer and supervisory relationships (McLean et al., 2009; Rothwell et al., 2019).

Team and Personal Growth

The PM+ ToT was intensive and demanding, with a breadth of material to cover, and knowledge, skills and confidence to build. This was aided by a supportive, open and trusting training atmosphere; including open acknowledgement of areas of confusion, and collective problem solving. Whilst intensive, this training rapidly built relationships, establishing a cohesive intervention team that recognised the strengths each person brought.

During the PM+ training and supportive supervision, the PLTs have benefitted from opportunities to improve their English, communication skills, and confidence. Initially many PLTs were shy to do PM+ role plays, but overcame this through encouragement and support from Wellbeing Mentors and their peers, developing confidence in delivering individual or group PM+.

Wellbeing Mentor supportive supervision has stimulated approaches to PLT training and supervision that draw upon the Wellbeing Mentors' personalities and strengths. This includes bringing together individual and group PLTs to share PM+ delivery skills, such as individual PM+ PLTs demonstrating effective explanation of key strategies, and group PM+ PLTs demonstrating facilitation skills such as bounce-back questions. This peer and supervisor-led training in dynamic individual and group supervision formats has proven effective in expanding the knowledge, skills and confidence of PLTs (Rothwell et al., 2019).

Shared learning across the PROSPER intervention team and PROSPER research team has included taking into account PLTs' English literacy levels and familiarity with form-filling and the logistical coordination of delivering PM+ sessions. The PMG meetings have provided a forum for the Wellbeing Mentors and master trainer providing on-the-ground insights to ensure the research logistics remained practical for R&AS PLTs unfamiliar with research procedures.

Recommendations for Practice

- Maintain schedule flexibility to accommodate R&AS lives, recognising that they are often engaged in educational, vocational and voluntary/employment opportunities; have family care responsibilities, and may have asylum claims to attend to.
- Ensure extensive logistical support, given the precarious financial situation of R&AS (e.g. reimbursement of expenses, childcare provision and refreshments).
- Be conscious and supportive of the complexities of R&AS ongoing asylum applications, recognising that this may affect PLTs' mental wellbeing that could necessitate suspending or stopping their role.
- Provide training certification, building the R&AS Lay Therapists CVs for future opportunities.
- Promote R&AS Lay Therapists' development of supportive professional relationships, and where appropriate peer social relationships, strengthening their personal networks.
- Be responsive to changes in research timelines and find innovative ways to manage these that promote PLT ongoing engagement and preparation for intervention delivery.

Discussion

Ensuring accessible mental health services for R&AS is of critical importance. Task-sharing psychosocial interventions delivered by PLTs with lived experience of migration or the asylum process and embedded within community-based organisations offers one way to achieve this. Evaluations of peer support workers embedded within mental health services identify the benefits of shared lived experiences, and they can contribute to mental health professionals' understanding of the recovery journey (McLean et al., 2009). Our experience with R&AS PLTs supports these evaluations, highlighting the value of peer support models for grounding intervention delivery in lived experiences of migration. There are particular opportunities in high-income settings to explore collaborative care models and integrate telemedicine into Lay Therapist supervision (Hoeft et al., 2018), developing task-sharing models that respond to the context in which they are delivered.

Recognising that the feasibility of task-sharing approaches in high-income countries remains underexamined, we have described and reflected on our experiences of the PM+ cascade model of training and supervision. The reflections reported here arose during supportive supervision, presenting trainers' and supervisors' lived experiences of task-sharing interventions, filling a gap in knowledge. However, limitations remain: only the master trainer and Wellbeing Mentors' perspectives are considered, leaving out those of the PLTs or research participants. As noted, the PROSPER process evaluation is exploring the views and experiences of the PLTs and Wellbeing Mentors, complementing the reflections here.

Our experiences demonstrate challenges to retaining volunteer R&AS PLTs, in part due to competing priorities of education, family, work and asylum claims; and where project timelines are extended. It also highlights the benefits to engaging R&AS who have embraced the PM+ intervention and PLT roles, reinforcing previous research (Shahmalak et al., 2019; Wall et al., 2020). Many of the experiences in this study are reflected in research with other Lay Therapist populations, including the importance of PLT integration into organisational cultures (Ibrahim et al., 2020); providing supportive supervision that responds to wellbeing needs (McLean et al., 2009; Kemp et al., 2019) and tailored training and ongoing supervision

of those supervising Lay Therapists (Atif et al., 2019; Kemp et al., 2019).

Conclusion

Recognising the importance of empirical evidence about implementing task-sharing mental health service models, we have reflected on our experience of implementing the PM+ intervention with R&AS PLTs in a high-income setting. A key finding is that successful delivery requires full accommodation of R&AS PLTs' lives in high-income countries – such as uncertainties in asylum applications, negotiating health and education systems, financial insecurities, and family responsibilities – through logistical coordination and support for their wellbeing, alongside careful research planning to ensure feasibility. Our experience highlights the enriching possibilities offered by PLTs who bring lived experience of migration, and demonstrate that these that can be successfully drawn upon to enhance service and research implementation.

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Conflicts of interest

There are no conflicts of interest.

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[1]Task-sharing is also referred to as task-shifting

[2]Other terms to refer to this role include Lay Health Worker, Lay Helper, Paraprofessional and Peer Volunteer