***Feasibility study and pilot trial of an evidence-based low intensity psychosocial intervention delivered by lay therapists for asylum seekers and refugees (PROSPER).***

***Phase 1: Feasibility Study Report***

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**Aim and objectives**

The aim of the PROSPER study was to assess the feasibility of conducting a randomised controlled trial in the UK of an evidence-based psychosocial intervention based on a WHO-approved low intensity intervention called Problem Management Plus (PM+), delivered by lay therapists for distressed and functionally impaired asylum seekers and refugees (AS&Rs).

The objectives of this element - **Phase 1** - of the study were to:

1. adapt the form and content of PM+ to the needs of asylum seekers and refugees in the UK;
2. assess the feasibility of the proposed training procedures, including involvement of refugees as lay therapists.

Phase 1 involved the adaptation of PM+,using two parallel and interlinked elements:

* Stakeholder engagement with local stakeholders (migrant service users, care providers and policy makers) using focus group methodology, to ensure that PM+ is adapted for use with AS&R populations in the UK.
* Evidence synthesis to identify the barriers and facilitators to uptake of psychosocial interventions delivered by lay therapists to improve mental health and wellbeing of asylum seekers and migrants, including how idioms of distress are incorporated into assessments and interventions.

During Phase 1 we also assessed the feasibility of a two stage PM+ training procedure*,* with master trainers providing a training course tailored to the needs of wellbeing facilitators from a counselling NGO, who in turn provided an 8-day training course and ongoing supervision for lay therapists in NGOs that support AS&Rs.

Ethical approval for the stakeholder engagement and training elements of this phase of the PROSPER study was gained from North-West Greater Manchester East Research Ethics Committee on 9 July 2018, reference 18/NW/0441.

**1.Stakeholder engagement**

Stakeholders, including both service providers and service users, were recruited from asylum seeker and refugee support organisations across Liverpool City Region, in north west England, using purposive sampling via a convenience approach. The research team directly contacted service providers, comprising social workers, community workers, nurses, psychological therapists, a clergyman, a doctor, caseworker, health professional, child psychiatrist and health service commissioner. Service users were approached via drop in sessions at the community organisations, a flyer distributed to the four support organisations collaborating in the research project, and publicised via social media.

All participants provided written informed consent to participate in focus groups and have anonymised quotes reported.

The research was embedded within a social constructionist paradigm. There was an emphasis on the meaning making of people’s perceptions and experiences. Data were collected and analysed following the principles of interpretative phenomenological analysis.

Twenty-four individuals participated in six focus groups. This included 16 women and eight men. The age range varied between 27 and 76 years of age. They consisted of 13 service providers (11 Caucasian, two Asian and one African) and 11 service users including seven asylum seekers and four refugees. The primary languages spoken by the asylum seekers and refugees were Albanian (1), Arabic (3), English (1), Hindi (1), Shona (1) and Urdu (4). The group size varied between three, four or five participants per group. Three focus groups were conducted with service providers and three with service users, in order to gather a balanced account of data by allowing asylum seekers and refugees a safe space in which to express themselves. The focus groups were led by two moderators using a semi-structured guide. All the focus groups were moderated and audio recorded in English. The transcripts were transcribed verbatim.

A thorough group level analysis was conducted, with the data approached as a whole entity. This process was iterative, with themes identified in initial transcripts being revised and refined in light of data in subsequent transcripts. Disagreements were resolved and consensus reached through discussion. Researcher reflexivity was actively considered

Findings

*The content of PM+.* Stakeholders generally expressed positive views about PM+ and its usefulness for distressed asylum seekers and refugees. They identified potential advantages over existing service provision, which was often seen as difficult for AS&Rs to access and (for many) only available in crisis. They saw delivery of PM+ as beneficial for lay therapists themselves, as well as for their clients. The psychoeducation element was considered to be helpful. There was approval for stress reduction techniques, and the emphasis managing problems was seen to assist in establishing realistic expectations.

Some stakeholders raised questions about the scripted nature of PM+, and whether this might inhibit the essential therapeutic element of relationship-building. Others were concerned about the risks of lay therapists going beyond the limits of PM+, offering bad advice in relation to legal issues, and triggering trauma; and others questioned the therapy orientation of PM+, suggesting that open friendship-based approaches as more suitable for their cultural group.

*Barriers to implementing PM+.* There was a common view that the daily lives of AS&Rs were very busy, that regular attendance at sessions could often be clients, and that PM+ would need to be fitted into other commitments, including child care, education and the asylum system. Stakeholders also noted the ever-present threat of dispersal to another part of the country, which would interfere with clients’ ability to complete a course of PM+ sessions. There was concern that cultural differences in understandings of mental health or depression may inhibit people from seeking help in this way.

It was felt that it was more difficult for women to talk openly about their mental health problems. Some noted the possibility of cultural or religious conflicts between therapists and clients, especially for clients who had been forced to flee their home countries following a change in religion.

Confidentiality was raised as an issue, first if lay therapists and clients came from the same community, and second if interpreters were involved in the sessions. Issues raised were not only personal, but also political.

*Facilitators to implementing PM+.* Stakeholders recommended initial contact be by telephone rather than letter, as many AS&Rs associate mail with official communications from the Home Office. They proposed locating the PM+ sessions in a familiar environment with easy access, such a voluntary agency the client is already in contact with. They also emphasised the importance of practical help with childcare and transport, so that clients were not left financially out-of-pocket through having to attend sessions. They recommended flexibility around appointments, to fit in with clients’ busy lives.

Emphasising the confidential nature of the sessions was important in building trust. Matching gender between therapist and client was seen as important, especially for women. Matching language and culture between therapist and client were often, but not always, seen as helpful. If interpretation services were needed, stakeholders felt it would be safer to use a telephone translation services such as Language Line.

They also offered practical advice on how to publicise the project, including attending community meetings and placing posters in voluntary organisations working with AS&Rs.

**2.Evidence synthesis**

We conducted a systematic review of barriers and facilitators to uptake of psychosocial interventions delivered by lay therapists to improve mental health and wellbeing of asylum seekers and refugees.

The systematic review followed the guidance of the Centre for Reviews and Dissemination. It was registered with PROSPERO (2018 CRD42018104453). 14,658 titles and abstracts were shortlisted for further assessment, from which 25 papers were identified as suitable for detailed analysis: 15 qualitative studies, seven trials and three others.

*Barriers for asylum seekers and refugees.* Beliefs about mental health can be a barrier. Some AS&Rs do not feel that being sad and stressed is a true mental illness, and think it will diminish with prayer and time. Others regard trauma symptoms as non-addressable when compared to depressive symptoms

Lack of trust and privacy and a sense of safety are important. Some AS&Rs are reluctant, or even afraid, to describe their own experiences. They prefer to talk about people they knew, and describe living in a context where such mistreatment is commonplace. In some cases, this is exacerbated by political, ethnic, clan, and religious divisions within the AS&R communities. Many are negotiating a sense of loss and isolation, experiencing a conflict between sense of dependence and independence conflict, or experiencing a sense of inferiority in relation to the indigenous population.

Uncertainty about legal status make some less willing to seek help, as do a wide variety of stigmatising and discriminatory experiences. Lack of finance or inadequate access to insurance-based care can be major barriers. Lack of appropriately trained interpreters can adversely affect AS&Rs ability to find the help they need.

*Facilitators for asylum seekers and refugees.* AS&Rs are seen as likely to benefit from interventions which were adapted to local context, culturally and linguistically appropriate. Uptake is improved by addressing mental health stigma through educational panels and workshops, community gatherings and dialogues, film screenings and cultural shows.

Free-listing of problems is useful, as is addressing social problems - such as inadequate income, poor housing, family problems and violence – before mental health. Some favour multi-ethnic peer support groups, while others emphasise understanding the needs of different groups, especially women. Community advocacy is useful especially with facilitators drawn from AS&R communities.

AS&Rs are more likely to participate and benefit if they feel supported by other asylum seekers, are able to build rapport in a safe setting, and have a sense of family comfort with discussing trauma. Knowing how others cope with problems helps people seek help. Other important facilitators include the knowledge that they are not the only one with the same problem, and understand the connection between mind and body.

*Barriers for lay health workers.* Lay health workers are less likely to engage in or persist with the delivery of psychosocial interventions for AS&Rs if they experience problems with the work itself, including lack of management direction, conflicts with co-workers, excessive workload, being asked to undertake duties beyond their abilities, or a sense of powerlessness. External barriers include experiencing their own economic and financial problems, travel difficulties, separation from relatives, temporary status in the host country or working in a hostile environment.

*Facilitators for lay health workers.* Lay health workers are more likely to engage in or persist with the delivery of psychosocial interventions for AS&Rs if they are invested in outcomes, and understand that their main role was to connect and focus on objective, non-judgemental participation. Team cohesion, social support and supervision all mitigate stress in lay workers.

Lay health workers value being recognized as a resource in the society. Engagement is most effective when people from AS&R communities who had been in the host country a few years became bridge-builders, co-creating new ways of working and building refugees trust in their relationships with staff. In these ways they may become culturally competent paraprofessionals, working with their own communities.

**3.Training procedures**

PM+ training followed a cascade apprenticeship model:

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| **Components of Apprenticeship Model in Mental Health Interventions** | **Application in PROSPER study** |
| Selection of apprentices | * Recruitment of wellbeing mentors
* Selection of voluntary peer lay therapists
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| 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 peer lay therapists to ensure they have the skills and knowledge to deliver PM+ to participants safely
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| Application of training “on the job” under direct supportive supervision | * Wellbeing mentor PM+ practice cases with supportive supervision from the master trainer
* Peer lay therapist PM+ practice cases with supportive supervision from the wellbeing mentors (with master trainer consultation)
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| Ongoing expansion of training, knowledge and skills under supportive supervision | * Master trainer ongoing coaching of the wellbeing mentors in peer lay therapist supportive supervision
* Wellbeing mentors provide supportive supervision to peer lay therapist delivering PM+
* Wellbeing mentor monitoring of peer lay therapist delivery of PM+ through observation fidelity checks on PM+ sessions, and supportive supervision
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| Mutual problem solving | * Through supportive supervision between the master trainer and wellbeing mentors, and wellbeing mentors and peer lay therapists
* Present throughout all steps to respond to challenges of embedded research and working with AS&RS
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*Recruitment of wellbeing mentors.* The wellbeing mentors are the PM+ PLTs trainers and supervisors, and are themselves “lay” professionals in that they are not mental health specialists. For the PROSPER study no specific qualifications were expected, with the emphasis in wellbeing mentor recruitment on experience of training and supporting volunteers from diverse communities within health and social care. 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 to AS&Rs.

*Recruitment of peer lay therapists.* Recruitment of 12 volunteer PLTs began with distributing emails, posters and information sheets amongst non-governmental organisations supporting AS&Rs in Liverpool. Over twenty AS&RS attended information sessions at PSS led by the wellbeing mentors where they were introduced to the PM+ intervention, and the PLT role and criteria (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 at PSS by the two wellbeing mentors and their team leader.

Following interviews, 12 candidates were selected to participate in the PM+ PLT training: seven were female, most were aged between 30 and 40; at least seven were educated to graduate level; native languages were Urdu (4), Farsi (3), Arabic (2) and one each Turkish, Thai and English/French.

*PROSPER study PM+ training model:*



*Wellbeing Mentor training and practice cases.* A five-day wellbeing mentor training was led by two master trainers in October 2018. Training followed the PM+ ToT program which foregrounds basic helping skills and the PM+ intervention sessions, emphasising core content and their underlying rationale. Training highlighted the different individual and group delivery modalities; and skills in training others such as conducting role plays and providing feedback, and leading supportive supervision. The training situated PM+ in the context of the PROSPER study, exploring the relevance of PM+ to AS&RS lives, and clarifying the intervention and research relationship. All training was experiential, concluding 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 PM+ delivery such as participant engagement, responding to difficult disclosure, and time management which were invaluable for the subsequent PLT training and supervision. Subsequently, the wellbeing mentors spent time networking with AS&RS voluntary organisations. This formed a crucial foundation for the wellbeing mentor role as they became familiar and trusted faces at organisations where PLTs, and subsequently PROSPER research participants, were recruited.

*Peer lay therapist training and practice cases.* The PLT training was separated into Group PM+ and Individual PM+, with six PLT’s trained in each modality. Training was delivered one day a week (10am-4pm days) over eight weeks from March to May 2019, with scheduling to accommodate the availability of the AS&RS PLT’s against other family, work or education commitments.

The training followed the PM+ Individual or Group training manuals covering basic helping skills and experiential learning of PM+ sessions summarised above, reinforced through discussions and role-play of the PM+ strategies and sessions for the relevant PM+ modality. Visits were made by the master trainer (AC) to observe training and provide feedback to the wellbeing mentors, to meet the PLT’s, and to answer questions about the relationship between the PM+ intervention and PROSPER research. At the end of 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, PLT’s were presented with a certificate attesting to their successful completion of PM+ training.

The training was completed by 11 PLTs, with one dropping-out due to ill health. These 11 PLTs then completed one individual or group PM+ practice case with PSS staff and student volunteers.

**4.Contextual modifications**

As a result of the findings from these three elements of Phase 1 of the PROSPER study, we proposed the following contextual modifications to promote uptake and relevance of the PROSPER Pilot trial:

* Focus on English, Arabic, Farsi and Urdu, identified as four most common languages currently spoken by AS&Rs in Liverpool City Region.
* Decision to exclude new arrivals and those in temporary accommodation: on grounds of a) high probability of dispersal and hence unavailability for intervention and/or follow-up; and b) low probability of being registered with a GP and hence unable to access trial safeguarding procedures.
* Alteration to text of PM+ manuals to reflect life in western urban settings, rather than south Asian rural settings: e.g. ‘home’ not ‘hut’, ‘reading’ not ‘rearing poultry’, ‘visit job centre’ not ‘speak with village elder’.
* Adapting the group PM+ case studies to include men.
* Matching therapists and participants on basis of gender and language, but not on basis of religion, politics or culture.
* Identification of accessible ‘safe spaces’ for research interviews and delivery of PM+ sessions, including availability of child care.
* Reimbursement of travel expenses for lay therapists and participants.
* Supervision and support of lay therapists to include boundary issues between therapy and involvement in participants’ lives, since the shared lived-experience of the asylum process takes this study beyond the boundaries that have been apparent in other contexts.

The PROSPER pilot trial is now in process, with REC reference 19/NW/0345. It has the following objectives:

* assess the feasibility of the proposed procedures for recruiting distressed asylum seekers and refugees as study participants;
* assess the feasibility of retaining both lay therapists and study participants through to trial completion;
* assess the fidelity of delivery of the intervention;
* assess the acceptability and utility of the proposed study measures, considering any linguistic and cultural barriers.

And hence, to specify the parameters for a full randomised controlled trial.

**5. Conclusion**

We achieved the two objectives of Phase 1 of the PROSPER study.

* Using a combination of stakeholder engagement and evidence synthesis, we adapted the form and content of PM+ to the needs of asylum seekers and refugees in the UK.
* Using a cascade apprenticeship model, we demonstrated the feasibility of the proposed training procedures, including involvement of refugees as lay therapists.

**6. Dissemination**

We held an open stakeholder meeting on 20 February 2019 to discuss the interim findings of this phase of the PROSPER study.

We have submitted two papers from this phase of the PROSPER study for publication:

* Khan N, Orton L, White R, Chiumento A, Uwamaliya P, Smith G, Aslam R, Dowrick C. The mental health of asylum seekers and refugees: re-traumatisation and the importance of community***.*** *Transcultural Psychiatry* (under review).
* Chiumento A, Rahman A, McCluskey R, Billows L, Mackinnon A, Khan N, White R, Dowrick C. Task-sharing psychosocial support with refugees and asylum seekers: reflections and recommendations for practice from the PROSPER study. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas* (under review).