Behaviour Research and Therapy 60 (2014) 53–59

Contents lists available at ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

Improving the scalability of psychological treatments in developing countries: An evaluation of peer-led therapy quality assessment in Goa, India

Daisy R. Singla [a], Benedict Weobong [b, c], Abhijit Nadkarni [b, c], Neerja Chowdhary [b], Sachin Shinde [b], Arpita Anand [b], Christopher G. Fairburn [d], Sona Dimijdan [e], Richard Velleman [b, f], Helen Weiss [c], Vikram Patel [b, c, g, *]

[a] 1205 Ave Docteur Penfield, Department of Psychology, McGill University, Montreal, Quebec, H3A 1B1, Canada
[b] Sangath, H No 451 (168), Survey No 50/31, Succour, Porvorim, Bardez, Goa 403501, India
[c] Centre for Global Mental Health, London School of Hygiene & Tropical Medicine, Keppel Street, London, WC1E7HT, United Kingdom
[d] Department of Psychiatry, Warneford Hospital, Oxford, OX3 7JX, United Kingdom
[e] University of Colorado, Boulder, 345 UCB Muenzinger, Boulder, CO 80309-0345, USA
[f] Department of Psychology, 2 South, University of Bath, Bath, BA2 7AY, United Kingdom
[g] Centre for Chronic Conditions and Injuries, Public Health Foundation of India, New Delhi, India

ARTICLE INFO

Article history:
Received 26 April 2014
Received in revised form
19 June 2014
Accepted 24 June 2014
Available online 30 June 2014

Keywords:
Therapy quality
Lay therapists
Peers
Supervision
Competency

ABSTRACT

Psychological treatments delivered by lay therapists, with little or no previous mental health training, have been shown to be effective in treating a range of mental health problems. In low resource settings, the dearth of available experts to assess therapy quality potentially leads to a bottleneck in scaling up lay therapist delivered psychological treatments. Peer-led supervision and the assessment of therapy quality may be one solution to address this barrier. The purpose of this study was two-fold: 1) to assess lay therapist quality ratings compared to expert supervisors in a multisite study where lay therapists delivered two locally developed, psychological treatments for harmful and dependent drinking and severe depression; 2) assess the acceptability and feasibility of peer-led supervision compared to expert-led supervision. We developed two scales, one for each treatment, to compare lay therapist and expert ratings on audio-taped treatment sessions ($n = 189$). Our findings confirmed our primary hypothesis of increased levels of agreement between peer and expert ratings over three consecutive time periods as demonstrated by a decrease in the differences in mean therapy quality rating scores. This study highlights that lay therapists can be trained to effectively assess each other's therapy sessions as well as experts, and that peer-led supervision is acceptable for lay therapists, thus, enhancing the scalability of psychological treatments in low-resource settings.

Introduction

Psychological treatments delivered by lay therapists, with little or no previous mental health training or experience, have been shown to be effective in addressing a range of mental health problems in low and middle income countries (van Ginneken et al., 2013). Successful interventions can be based on empirically-supported cognitive, behavioural and interpersonal techniques that are adapted for the local context and involved well-defined supervision protocols led by experts (Patel, Chowdhary, Rahman, & Verdeli, 2011). Supervision is considered a key, pedagogical and quality assurance tool in treatment delivery (Bernard & Goodyear, 2009; Schoenwald, Mehta, Frazier, & Shernoff, 2013; Waltz, Addis, Koerner, & Jacobson, 1993). Experts, typically mental health professionals who are experienced and trained in specific treatment modalities, are generally recognized as the gold standard in assessing supervisees' ability (whether lay supervisees or more junior mental health professionals) to deliver psychological treatments with acceptable quality (Townend, Iannetta, & Freeston, 2002). During or after an individual session, expert supervisors may provide supervision to lay therapists, with performance

* Corresponding author. Sangath, H No 451 (168), Survey No 50/31, Succour, Porvorim, Bardez, Goa 403501, India. Tel.: +91 98 22132038.
E-mail address: vikram.patel@lshtm.ac.uk (V. Patel).

http://dx.doi.org/10.1016/j.brat.2014.06.006

feedback and coaching, to maintain and further develop their skills (Baer et al., 2007). Multiple models for supervision exist and can vary across a number of variables including format (e.g., group vs. individual) and frequency (weekly vs. monthly).

Despite these advantages, experts in psychological treatments are not readily available (Kilminster & Jolly, 2000), particularly in developing countries (Patel et al., 2010). One alternative to expert supervision is self-assessment. Self-assessment requires fewer resources in terms of time and availability and may assist lay therapists to learn new skills by monitoring their own performance (Muse & McManus, 2013); however, accuracy of self-assessment has been questioned, with evidence suggesting a tendency among therapists in training to either overestimate (e.g., Brosan, Reynolds, & Moore, 2008; Perpletchikova & Kazdin, 2005) or underestimate their therapy quality (e.g., McManus, Rakovshik, Kennerley, Fennell, & Westbrook, 2012).

One solution to the dearth of experts and questionable accuracy of self-assessment may be peer-led supervision. While several models and definitions exist (see Borders, 2012), peer-led supervision has been argued to be advantageous because it encourages therapists to draw upon others' experiences and take active roles in assisting one another including the alleviation of stress, anxiety and feelings of inadequacy (Yeh et al., 2008). Although there is enthusiastic support for peer models (e.g., Golia & McGovern, 2013), most research involving peer-led supervision have not been empirically tested against other supervision models in psychotherapeutic settings (Borders, 2012; Newmann, Nebbergall, & Salmon, 2013). However, initiatives in higher education, such as the online learning platform Coursera, have demonstrated high levels of agreement between the marks given by peers (equivalent to our ratings of quality) and those of experts (https://www.coursera.org/).

The extent to which lay therapists, experts, and their peers agree about the quality of individual therapy sessions could inform practice guidelines to successfully scale up psychological treatments. For example, if peers of lay therapists could be trained to reliably evaluate sessions similarly to experts, then peer-led supervision may be the most cost-effective approach for assessing therapy quality. In the current study, we use the term “peers” to refer to the peers of lay therapists.

The objectives of the current study were two-fold: 1) to examine the agreement between expert, self, and peer therapy quality ratings of individual treatment sessions for harmful and dependent drinking and for severe depressive disorders, delivered by lay therapists in primary care in Goa, India; and 2) evaluate the acceptability of peer-led compared to expert-led supervision. Specifically, the study aimed to: a) describe the development, inter-rater reliability and internal consistency of therapy quality scales for each treatment; b) to estimate the agreement of peer and self-ratings of therapy quality against those of experts; and c) assess lay therapists' perspectives of peer-led compared to expert-led supervision across three time periods (stages) over ten months. We hypothesized that, with increasing therapist competency, the differences between lay therapist and expert ratings of therapy quality would reduce significantly.

Methods

Setting

This study was conducted in 11 purposively selected primary health centres (PHC) in Goa, India. The study is part of PREMIUM (PRogramme for Effective Mental health Interventions in Under-resourced health systeMs) which aims to develop and evaluate the effectiveness of two brief, contextually-appropriate psychological treatments for harmful and dependent drinking (Counselling for Alcohol Programme (CAP)) and depressive disorders (Healthy Activity Programme (HAP)) delivered by lay therapists (see Patel et al., 2014). Manuals for both treatments are available online (http://rubiqhosting.com/sangath/images/manuals/). Ethical approval for PREMIUM was granted by the Institutional Review Boards of Sangath and the London School of Hygiene and Tropical Medicine, and the Indian Council of Medical Research.

Lay therapists

The selection of lay therapists is outlined in Fig. 1. Lay therapists were recruited through advertisements in newspapers and a local television channel. A total of 188 applicants responded and 128 prospective candidates were selected by mental health experts to be interviewed. Exclusion criteria were any formal training or qualification in a health profession. Essential criteria were the completion of tenth grade education and fluency in local languages. Desirable criteria were having a higher education beyond tenth 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. Following the interview, 31 candidates were invited and completed the training.

Training comprised a three-week workshop focused on three domains: general counselling skills and the two manualized treatments (http://www.sangath.com/images/manuals). Training involved lectures, demonstrations by trainers, and practice of specific skills via role plays. Lay therapists' knowledge was assessed via a multiple choice exam (cut-off scores = 80% on 150 questions) as well as their performance on role plays using standardized vignettes. Of the 31 lay therapists who completed the training, 20 were selected for the Internship Stage (see below and Fig. 1). One person dropped out shortly before the Internship Stage which therefore began with a total of 19 lay therapists.

On average, lay therapists were 25.9 years of age with 15 years of education; sixteen were female. The Internship Stage (March to June 2013) involved the implementation of HAP and CAP treatments in the PHC setting with the lay therapists in training being supervised in groups by experts. At the end of the Internship Stage, twelve trainees, who achieved competence viz. standardized role plays, were selected for the Pilot Stage (July to October 2013). The Pilot Stage involved the continued treatment of patients in the PHC setting with one significant modification: group supervision was now led by a peer rather than an expert. The Pilot Stage was followed by the Trial Stage which began on October 28th, 2013 and will continue until July 2015. The current study therefore consists of data rating individual treatment sessions, from a total of19 lay therapists, from three progressive stages: the Internship Stage (Stage 1); the Pilot Stage (Stage 2); and the initial period (Nov 2013 to Feb 2014) of the Trial Stage (Stage 3).

Outcome measures of therapy quality

Our definition of therapy quality is based on that by Fairburn and Cooper (2011), who define therapy quality by whether a psychological treatment is delivered well enough for it to achieve its specific effects. In the current study, this means whether lay therapists can be trained to evaluate individual treatment sessions as well as experts. Furthermore, therapy quality refers to not only whether a lay therapist has implemented the appropriate treatment, but also whether they have done the ‘right things well’ (p. 379).