Cross-Site Implementation Manual:

Generic field version

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Authors

Juliet Nakku	Butabika National Referral Hospital, Kampala, Uganda
Grace K. Ryan	Centre for Global Mental Health, London School of Hygiene and Tropical Medicine, London, UK
Rabeea'h Aslam	Centre for Global Mental Health, London School of Hygiene and Tropical Medicine, London, UK
Dave Baillie	East London NHS Foundation Trust, London, UK
Inbar Adler Ben-Dor	Department of Social Work, Ben Gurion of the Negev, Beer Sheva, Israel
Ashleigh Charles	School of Health Sciences, Institute of Mental Health, University of Nottingham, Nottingham, UK
Lion Gai Meir	Enosh the Israeli Mental Health Association, Kfar Saba, Israel
Paula Garber-Epstein	Department of Social Work, Ben Gurion University of the Negev, Be'er Sheva, Israel
Alina Grazyman	Department of Social Work, Ben Gurion University of the Negev, Be'er Sheva, Israel
Shimri Hadas Grundman	Yozma Derech Halev Consumers Providers, Kfar Saba, Israel
Cerdic Hall	East London NHS Foundation Trust, London, UK
Maria Haun	Department of Psychiatry II, Ulm University, Ulm, Germany
Imke Heuer	Department of Psychiatry, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
Ramona Hiltensperger	Department of Psychiatry II, Ulm University, Ulm, Germany
Jasmine Kalha	Centre for Mental Health Law & Policy, Indian Law Society, Pune, India
Palak Korde	Centre for Mental Health Law & Policy, Indian Law Society, Pune, India
Sadhvi Krishnamoorthy	Centre for Mental Health Law & Policy, Indian Law Society, Pune, India
Arti Kulkarni	Centre for Mental Health Law & Policy, Indian Law Society, Pune, India
Eric Kwebiiha	Butabika National Referral Hospital, Kampala, Uganda
Manfred Lohner	Department of Psychiatry II, Ulm University, Ulm, Germany
Candelaria Mahlke	Department of Psychiatry, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
Anita Mlay	Ifakara Health Institute, Dar es Salaam, Tanzania
Galia S. Moran	Department of Social Work, Ben Gurion University of the Negev, Be'er Sheva, Israel
Richard Mpango	Butabika National Referral Hospital, Kampala, Uganda
Rachel Mtei	Ifakara Health Institute, Dar es Salaam, Tanzania
Annabel Müller-Stierlin	Department of Psychiatry II, Ulm University, Ulm, Germany
Shamila Mwanga	Ifakara Health Institute, Dar es Salaam, Tanzania
Fileuka Ngakongwa	Ifakara Health Institute, Dar es Salaam, Tanzania Department of Psychiatry and Mental Health, Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania
Jackline Niwemuhwezi	Butabika National Referral Hospital, Kampala, Uganda
Rebecca Nixdorf	Department of Psychiatry, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
Lena Nugent	Department of Psychiatry, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
Mary Ramesh	Ifakara Health Institute, Dar es Salaam, Tanzania
Vibhaben Gunvantbhai Salaliya	Hospital for Mental Health, Ahmedabad, India
Sofia S. Sanga	Ifakara Health Institute, Dar es Salaam, Tanzania
Gwen Schulz	Department of Psychiatry, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
Donat Shamba	Ifakara Health Institute, Dar es Salaam, Tanzania
Mike Slade	School of Health Sciences, Institute of Mental Health, University of Nottingham, Nottingham, UK
Godfrey Swai	Ifakara Health Institute, Dar es Salaam, Tanzania
Maria Wagner	Department of Psychiatry II, Ulm University, Ulm, Germany
Bernd Puschner	Department of Psychiatry II, Ulm University, Ulm, Germany
Julie Repper	ImROC, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham, UK

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*Joint first authors
**Joint last authors

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The Implementation Manual is informed by the experiences of these partners in implementing other projects and programmes involving peer support: the Brain Gain Projects I & II (Uganda), ImROC (UK), QualityRights Gujarat (India), Ex-In (Germany), Healthy Options (Tanzania) and the Yozma Derech-Halev consumer-provider program (Israel).

Contents

Introduction

UPSIDES is a six-country research consortium that aims to help replicate and scale up formal peer support for people with severe mental health conditions. As part of the UPSIDES multi-site randomised controlled trial (RCT), the UPSIDES peer support intervention was implemented in a geographically, economically and culturally diverse selection of study sites (located in Europe, South Asia, the Middle East and East Africa; see "Acknowledgments") which had varying levels of experience in the delivery of peer support, within very different mental health systems. As a result, the intervention and its implementation required adaptation to meet the needs of different settings and over time. For example, COVID-19 resulted in lockdowns and other restrictions to the delivery of peer support that varied both between and within sites as the pandemic ran its course. UPSIDES produced an Implementation Manual to capture these adaptations as well as the experiential learning of sites involved in implementing the intervention. The UPSIDES peer support intervention is described in further detail in the *UPSIDES Peer Support Training Manual and Workbook*:

> Mahlke CM, et al. (2020) *UPSIDES Peer Support Training Manual and Workbook: field version*. Ulm: UPSIDES. Available at: https://www.upsides.org/multilingual-area/output/#32Manuals

Other UPSIDES materials, including a full list of scientific publications, are available on the "Output" section of the project website: https://www.upsides.org/multilingual-area/output/

About this manual

What is this Implementation Manual?

This is a public-facing, generic field version of the cross-site Implementation Manual used by participating UPSIDES study sites during a multi-site RCT (2020-2022) and revised to incorporate adaptations to COVID-19 and other key information on implementation gathered through routine monitoring and evaluation (M&E) and reporting. Together with the *UPSIDES Training Manual and Workbook*, this describes key elements of the complex intervention delivered at participating sites. The aim is to facilitate further replication of the UPSIDES Intervention, while recognising the need for flexibility in implementation across diverse and often challenging contexts.

How was it developed?

This manual was developed through an iterative process. During the first stage, we carried out a series of cross-site conference calls to discuss key topics related to the implementation of peer support. Then, we recorded important points raised during the UPSIDES Training of Trainers held in February 2019. We also drew from an ImROC briefing on the implementation of peer support:

> Repper J, et al. (2013) Peer Support Workers: a practical guide to implementation. London: ImROC. Available at: https://www.centreformentalhealth.org.uk/publications/peer-support-workers-practical-guide-implementation

And two systematic reviews carried out by UPSIDES researchers:

> Charles A, et al. (2020) *A typology of modifications to peer support work for adults with mental health problems: systematic review*, British Journal of Psychiatry, 216, 301-307.

Ibrahim N, et al. (2020) *A systematic review of influences on implementation of peer support work for adults with mental health problems*, Social Psychiatry and Psychiatric Epidemiology, 55, 285-293.

The result was a first-stage cross-site Implementation Manual outlining essentials of UPSIDES implementation, additional recommendations and considerations, and frequently asked questions (FAQs) across six key areas of implementation:

1. **Recruitment:** Identification and recruitment of peer support workers (PSWs)
2. **Capacity-building:** Training and ongoing development
3. **Delivery:** Delivery of peer support to peers
4. **Quality assurance:** Monitoring, supervision and incentivisation
5. **Ethical practice:** Codes of practice, management of adverse events/safeguarding, management of personal information
6. **Stakeholder engagement:** Engagement of stakeholders and institutional readiness.

For the second stage, UPSIDES sites were asked to complete a worksheet for each of these six areas, describing how they intended to implement the intervention locally. Areas of overlap were identified as common strategies and summarised in the field version of the cross-site Implementation Manual, to better characterise the complex intervention that UPSIDES would test via the trial. Key outliers among the sites and points for further clarification were also noted, and additional information was added to better harmonise the Implementation Manual with the post-pilot *Training Manual and Workbook.*

During a third stage meetings were arranged with each site to revisit points for clarification and key outliers from the second stage, as well as changes related to COVID-19 (which interrupted the trial for varying lengths of time at each site). An additional section was added to the manual:

7. **Lessons from COVID-19**: Adjustment to implementation in light of the pandemic

Many of these changes were also documented in the UPSIDES Restart Plan and UPSIDES COVID-19 Crisis Management Plan (available upon request) and in publications discussing challenges specific to the implementation of peer support in different contexts:

Mpango R, et al. (2020) Challenges to peer support in low- and middle-income countries during COVID-19. *Globalization and Health*, 16:90. https://doi.org/10.1186/s12992-020-00622-y

Goldfarb Y, et al. (2022) UPSIDES mental health peer support in the face of the COVID-19 pandemic: Actions and Insights. *Community Mental Health Journal*. https://doi.org/10.1007/s10597-022-01030-9

In the fourth stage following the conclusion of the UPSIDES Trial, the cross-site Implementation Manual was reviewed again in light of findings from UPSIDES biannual implementation reports (Appendix 4), to better reflect how peer support was ultimately implemented across participating sites. Notes on outliers and clarifications were removed from this public-facing version for readability. Appendices containing site-specific examples of materials supporting implementation have also been removed for proprietary reasons.

1. Recruitment

Before implementing training or beginning to deliver peer support, we must first identify our peer support workers (PSWs). There may already be existing PSWs or other cadres of peer providers available from which to recruit. Or you may be identifying potential PSWs for the very first time. Regardless, in order to ensure fidelity to the UPSIDES model, there are a few essential characteristics which PSWs must have, as described further below. It is worth noting that in the original UPSIDES pilot and trial, many sites found themselves adopting similar strategies for recruitment, even though these were not pre-specified. We have also outlined these below, along with some frequently asked questions, for further consideration.

Essential for UPSIDES

While the roles of PSWs may vary in different contexts, all PSWs on UPSIDES must draw primarily on their own lived experience to support others. This has several important implications. A PSW for UPSIDES should:

1. Have **lived experience** of a mental health condition.
2. Be on the "road to **recovery**" and willing and able to support others.
3. Be willing and able to complete the **UPSIDES PSW training**.
4. Be given a clear **role description** that is in line with UPSIDES core principles.

A clear role description tailored to the local context is one of the key outputs of UPSIDES training. However, there are important underlying principles to UPSIDES peer support which must be reflected in this role description. Please refer to the *UPSIDES Training Manual and Workbook* for further information on recovery, core principles, and how to develop the role description through a collaborative process that promotes understanding and ownership of the role.

Common strategies

While these recruitment strategies were not prescribed by UPSIDES, they were commonly used by UPSIDES sites in the conduct of its pilot study and trial.

1. Planning for attrition

UPSIDES sites recognised that not all PSWs will complete their training, not all will be ready to start peer support after completing training, and not all who start peer support will continue providing peer support indefinitely. One option when planning for attrition is to recruit more PSWs than are immediately required (putting some on a "reserve list" or similar), though this makes it especially important to manage disappointment (see below). Another option is to plan multiple rounds of recruitment and training, which can also be a nice opportunity to harness growing enthusiasm for peer support as it gains visibility. Often peers who have been helped by peer support will aspire to become PSWs themselves, and it can be encouraging to know that there will be future opportunities to get involved.

2. Open advertisement and referral

UPSIDES sites often used a combination of open advertisement (e.g., posters or flyers in clinical settings) and referral (e.g., by mental health workers or at experienced sites by current PSWs) for the recruitment of PSWs. This may be a good way of helping to ensure a diverse pool of potential candidates, as both recruitment methods can be subject to various biases.

3. Assessing empathy and communication skills

All UPSIDES sites agreed that empathy and communication skills were among the most important attributes to assess in a potential PSW. During recruitment, targeted interview questions were frequently used to assess these criteria. For one site that focused mainly on group peer support, group work was also included in the interview process. Further, the UPSIDES training (discussed in the next section) offers valuable opportunities to observe potential PSWs' strengths in these areas.

4. Considering candidates' wellness

Although this can be a difficult criterion to assess in the selection process, it is important that PSWs have reached a stage in their recovery where they are able to help others while still helping themselves. Those who are already struggling to keep themselves well may find the challenges that come with working as a PSW are too much to handle for now. That said, it is not necessary (or perhaps even realistic) to insist that all PSWs are symptom-free or treatment adherent. Recovery is not a linear process, and what supports one person's recovery is not always helpful for another person's recovery. All UPSIDES sites considered wellness in making their recruitment decisions, but the way this was defined, operationalised and assessed was context-specific.

5. Conducting interviews

Given the qualitative nature of key selection criteria (i.e. empathy and communication skills, above) and the need to consider wellness, it is perhaps unsurprising that interviews featured as the main method of selection at all study sites. Although sites varied in what they asked and assessed, common topics included:

- Availability: number of hours/week available for peer support work, consideration of other jobs and responsibilities
- Peer support: comfort sharing own experiences, motivation for becoming a PSW, understanding of peer support
- Next of kin: who to contact if potential candidate feels unwell during/after training

6. Formalising the role

All UPSIDES sites issued some form of paperwork to officialise the PSW as a member of the team. Typically this would be an employment contract (except where peer support is delivered through a volunteer programme) and identity card as required by the employer. Depending on local human resource requirements, this might also require additional screening, police-checks, confidentiality agreements, etc. Candidates may need to investigate whether they are eligible for employment as PSWs without losing benefits (an issue previously reported by Repper et al. (2013) which has important implications for the pool of eligible applicants for peer support work).

7. Managing disappointment

For someone who is eager to become a PSW, it can be a serious blow to discover they have not been selected. Consider carefully how you will break the news, what support needs to be available when this happens, and what alternatives you can offer. For example, are there support groups, Recovery College sessions, or other peer-led activities that someone interested in peer support might enjoy? Will there be future rounds of PSW recruitment and training? UPSIDES sites generally scheduled face-to-face meetings with unsuccessful PSW candidates to break the news as sensitively as possible and help explore other options.

8. Meetings to introduce PSWs

All UPSIDES sites planned at least one face-to-face meeting (in addition to the Organisational Readiness workshop, described later) to introduce PSWs to the clinical staff with whom they would work. Most sites also involved other types of staff (e.g., research, administrative, other peer providers where applicable).

9. Additional onboarding

There is a lot to learn when starting at a new workplace. While meetings with other staff (see above) can help new PSWs to build relationships and understand who to come to with questions, additional onboarding activities can help make a smoother transition into a new role. Additional onboarding can be particularly valuable for those who have not been in formal employment for some time (if ever) and may not be up to speed on current practices and systems. The UPSIDES training includes an optional module on work preparation, though this was not taken up by all participating study sites. Two sites that already had experienced PSWs in place offered job-shadowing to help new PSWs settle into their role. Most had mandatory onboarding processes with briefings for new staff on a range of topics (e.g. health and safety, data protection, IT systems, etc.)

10. Equipping PSWs

UPSIDES sites recognised that PSWs are often unemployed or underemployed for quite some time before starting their new role and face a lot of financial strain. Therefore, it was important to ensure that they were supplied with all the essential materials they needed to deliver peer support. Common items included office supplies (notebooks, pens/pencils) and airtime (for a personal or work-issued mobile phone). Depending on the salary and other benefits available locally, transport reimbursements (perhaps with allowances for meals out of the home) were sometimes necessary (see "Material and financial incentives" in the "Quality assurance" section). A few sites had office space with computers and/or learning materials available to PSWs for their ongoing learning and personal development, in addition.

FAQs

1. **Q: How many PSWs are needed?** A: UPSIDES was originally funded as a trial, with scientific considerations guiding the sample size calculation. Based on the experiences of UPSIDES partners, it was decided that each site should have a minimum of 10 PSWs to support a sample size of 93 in the intervention group (approximately 10 peers supported by each PSW). Regardless of the number of peers you intend to serve, we would recommend no fewer than two PSWs working at any given time, as PSWs themselves often benefit from having someone to "peer support" them in their role. This also allows for more than one gender to be represented (see Q3, below). However, it is worth noting that the *UPSIDES Training Manual and Workbook* recommends capping each training at 16 participants total (see "Capacity-Building"); if you wish to train a larger peer support workforce, you may want to consider hosting multiple rounds of recruitment and training.

2. **Q: Sometimes clinicians also have lived experience of a mental health condition. Wouldn't these people who have both lived experience and professional experience be the best qualified to act as PSWs?** A: A PSW must *primarily* draw on their lived experience as opposed

to their professional experience in order to support others. Sometimes after receiving professional training, it can be difficult to put that expertise aside to draw primarily on lived experience. For this reason, it is not necessarily best to recruit people with both lived and professional experience as PSWs, though it is possible.

3. **Q: Should I consider the representativeness of the PSW—in terms of clinical, social or demographic characteristics—in the selection process?** A: Peer support is often most effective for those who are most marginalised from the mental health system. So it can be beneficial to include PSWs from under-represented groups as well as groups that are broadly representative of the target population. However, many experienced sites say that individuals' personal skills and competencies are more important and can allow PSWs to overcome many—though not necessarily all (e.g., language)—differences with their peers. In certain cultural contexts, gender and religious differences are more readily addressed by ensuring adequate representation among PSWs to enable "matching" (discussed further in the "Delivery" section).

4. **Q: Do all PSWs have previous experience of being hospitalised?** A: What constitutes lived experience may vary from site to site. Many experienced sites feel it is important to recruit people who have previously been hospitalised for a mental health condition as PSWs, particularly when many peer support recipients will have also been hospitalised for their condition. However, it is worth noting that in many settings, it is prohibited by law to ask direct questions about someone's experience of a mental health condition or service use during a job interview. Creative solutions may be needed to work around this barrier, for example by asking open-ended questions about someone's motivation for becoming a PSW or how they feel their life experience will inform their work as a PSW. In some cases, lived experience may also be inferred from the source of recruitment (e.g., referral by a mental health provider, recruitment from an established peer provider service, etc.)

5. **Q: Should we finalise recruitment before or after training?** A: You may decide to assemble your team of PSWs first, then train all of them together, or you may decide to train a larger number of potential candidates from which to select. There are pros and cons to each strategy. For example, training a smaller number who have already committed to becoming PSWs might give the training a different "feel", with more focus on team-building and practical application of what is learned—as trainees are aware that they will be called upon to use their new knowledge and skills imminently. This also avoids disappointing potential candidates who might be particularly upset about not being offered a PSW role after having devoted their time and energy to training. On the other hand, training a larger number allows for potential candidates to gain a better understanding of the role before making a commitment. It allows trainers (who may be involved in recruitment decisions) to get to know potential candidates in a different context, outside of the interview. And if high attrition is expected among PSWs, it means that some trainees can be kept on a "reserve list" or similar, so that they can get up to speed more quickly when an opportunity arises. Again, keep in mind that the *UPSIDES Training Manual and Workbook* recommends capping each round of training at 16 participants (see "Capacity-Building").

6. **Q: Should PSWs wear uniforms?** One UPSIDES site felt that it was important for PSWs to have uniforms (branded t-shirts) in order for peers to trust in peer support as a formal service. This was a low-resource setting in which there was growing suspicion that imposters could pose as community workers in order to gain access to vulnerable people's homes. PSWs also expressed pride in their appearance when wearing their uniforms, as these signalled a position of respect that was not often afforded to them in their communities. However, other sites felt that uniforms were unnecessary, and it is possible that uniforms could also distinguish PSWs from peers in an unhelpful way. For example, if a uniform were to clearly identify a PSW's affiliation with a mental health service, then conducting a home visit in uniform might inadvertently disclose a peer's mental health status to neighbours. This is a question best answered by PSWs and peers themselves, with a willingness to be flexible if needed (for example, offering optional uniforms and having each PSW-peer pair agree whether it is preferable to carry out visits in uniform or not).

2. Capacity-Building

Capacity-building is one of the most crucial aspects of UPSIDES implementation. Some of the original sites participating in the UPSIDES pilot and trial already had trained PSWs and other peer providers in place. But even these sites needed to retrain using a locally adapted version of the *UPSIDES Training Manual and Workbook* in order to promote fidelity to a common model of peer support. Capacity-building is also about more than just holding training sessions. It is worthwhile to consider PSWs' personal and professional development needs and how to help PSWs eventually transition into other activities that they find meaningful and rewarding, to support their long-term recovery. Supportive supervision—which will be discussed later under "Quality Assurance"—is also important to build and reinforce knowledge and skills.

Essential for UPSIDES

While capacity-building could vary slightly between sites, all PSWs on UPSIDES had to be trained in the following ways:

1. In a training delivered primarily by **UPSIDES trainers** (participants in an UPSIDES Training of Trainers Workshop) including at least one trainer with lived experience.
2. Using a locally adapted (and translated, if necessary) version of the *UPSIDES Training Manual and Workbook.*
3. Completing **all 10 core modules** of the UPSIDES training (although the pace and length of the training could vary).

Other recommendations provided to trainers in the original field version of the Implementation Manual are listed in the call-out box below.

Box A.

Recommendations for UPSIDES trainers:

1. **Read the *UPSIDES Training Manual and Workbook* before planning the training.** It includes a number of recommendations such as how to set up the training room and what materials to have on hand.
2. **Keep it small.** While it is tempting to be as inclusive as possible, it is also important to keep trainings intimate and manageable. The *Training Manual and Workbook* suggests having no more than 16 participants, and having even numbers to facilitate paired exercises.
3. **Keep a gentle pace.** From previous experience, many sites recommend against full-day trainings. Holding the training on several consecutive days may be easier logistically but can also be tiring and mean that participants don't have time to digest what they've learned each day. Consider holding several half-day training sessions, with a few breaks between sessions, to better manage energy levels. The *Training Manual and Workbook* suggests blocking off ten days (not all consecutive) of approximately five hours each (including a long break).
4. **Try to keep the training participatory.** While some people do appreciate more didactic learning, opportunities for critical reflection and discussion are crucial when engaging with complex topics like recovery and peer support. It is important to recognise and harness the expertise in the room with group work, role plays, open discussion, etc.
5. **Embrace "learning by doing".** Consider running a follow-up training session after the PSWs have already begun working, to reflect on their experiences in the new role and share learning.
6. **Consider how you will support capacity-building once the training is over.** Simply participating in a training is not enough to prepare someone to deliver peer support for the first time. As discussed under "Quality Assurance", supportive supervision is one way to improve on-the-job learning. Other ideas could include, for example, job-shadowing a more experienced PSW, homework or reading assignments, and online platforms for knowledge sharing (e.g., a private PSW chat room, Facebook group, Wordpress blog, etc.)
7. **Plan for personal and professional development beyond peer support.** At many sites, peer support is not seen as a long-term vocation, but rather a stepping-stone into other meaningful work. Consider how UPSIDES can help PSWs prepare for the future, for example by providing training certificates and job recommendations, development opportunities for employable skills, etc. Some sites may also consider career pathways within services, for example by creating supervisory roles for experienced PSWs to move into.
8. **Start building a supportive community of practice.** The training participants are the first links to the UPSIDES peer network, and could eventually become trainers themselves, helping to sustain peer support at your site. Think about how you will support them to connect with each other and with resources that they may find useful. For example, is there a room where they can hold network meetings, perhaps at your site or in the community? Could you grow the peer network, maybe by helping them link to other sites or organisations?
9. **Consider offering additional modules.** The UPSIDES training includes six additional modules which can be delivered according to local needs: Empowerment; Rights and Advocacy; Share Your Story; Forming, Organising and Delivering Peer Groups; Work Preparation and Placement; How to do "Community-Facing".

Common strategies

While these capacity-building strategies were not prescribed by UPSIDES, they were commonly used by UPSIDES sites in the conduct of its pilot study and trial.

1. Comfort and wellness of trainees

All sites encouraged comfort breaks throughout the training, including both planned breaks (e.g. meals) as well as allowances for participants to take unplanned breaks in order to manage their wellness. Several sites designated specific spaces for breaks in advance of the training and ensured participants were made aware of these. All sites provided refreshments, and some went to extra lengths to make a safe and hospitable environment for training (e.g. purchasing flowers for the training room, creating a discrete signage system to communicate participants' needs). Sites also considered in advance how to help participants access support if they became unwell during the training.

2. Providing transport, learning materials and certificates

All sites provided writing/drawing materials for individual (notebooks/blank paper, pens/pencils) and group work (flip-charts, markers), plus copies of the Workbook section of the *UPSIDES Training Manual and Workbook*. Although not necessarily formally accredited, all sites also offered certificates of training completion, to help PSWs build up a portfolio for future work opportunities from their time on UPSIDES. Transport reimbursement was offered to all participants, except at one site where trainees had no travel costs.

3. Group cohesion

Several of the UPSIDES sites incorporated additional activities into the training schedule to promote group cohesion. At one site, these included a mixture of icebreaker activities, with some led by the trainers and some provided by training participants. At another, each session began with a prayer led by a trainer or participant. A third used the arts (improv theatre, writing poetry) to liven up their training. Experienced trainers may already have an idea of the sorts of activities that work best in their context, but training participants all have unique skills and interests that can be harnessed to make training sessions more personal and enjoyable, and to encourage their ownership of the training.

4. Post-training assessment and revision

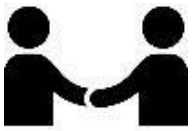
UPSIDES does not use a typical pre-post training assessment format, though most sites did assess learning outcomes. Some used written questionnaires, while others used either verbal or written reflections at the close of training (e.g., reflective interview, personal assessment of readiness). Two sites carried out revision sessions (e.g., review of flip-chart, role plays) before initiating peer support. One site also facilitated an initial peer contact with each PSW to help them get started.

FAQs

Q: Do all PSWs need to be trained in exactly the same way? A: Not necessarily. All UPSIDES PSWs had to be trained according to the *UPSIDES Training Manual and Workbook*, but this manual was adapted for use at each site. At its most basic, adaptation consisted of translation into the main local language that trainers intended to use for the training. Other adaptations could include, for example: rearranging the structure of the training; providing more contextually appropriate prompts and scenarios e.g., for role plays; introducing new activities; and incorporating additional optional modules.

Q: Do all training modules need to be completed before peer support can commence? A: As described above, the *UPSIDES Training Manual and Workbook* outlines several core modules which must be included in any UPSIDES PSW training. However, there are also some optional training modules that you can choose whether or not to deliver, depending on the needs of the trainees. The optional training modules can also be delivered after the PSWs have already started working. These optional modules start with a refresher of the relevant core modules and then address specific topics in more detail.

Q: Where should the training take place? A: UPSIDES sites typically carried out training in either a university or clinical setting, as opposed to a community-based setting (e.g., offices of a user-led organisation). This was generally seen as the most efficient way to make use of research teams' existing resources and to ensure that trainees would have easy access to supportive services if any part of the training proved to be distressing or if they were to become unwell over the course of the training. However, these settings may not be ideal in terms of providing a conducive learning environment in which trainers and trainees feel they can relate to one another on an equal footing. Trainees may have accessed these facilities in other capacities—as students, research subjects or service users—in which they felt disempowered or had other negative experiences that can cast a pall over the training. On the other hand, if PSWs are going to need to visit these facilities frequently (for inpatient peer support, meetings with researchers/clinicians, etc.), then it could be argued that training is a valuable opportunity to build familiarity and confidence in accessing these spaces. Trainers will need to consider how to address these issues with as much sensitivity as possible when selecting the location for their training.



3. Delivery

UPSIDES peer support aims to support recovery by promoting hope and encouragement, enhancing a sense of empowerment and control over one's life and helping to open up opportunities and connections with the community. UPSIDES peer support should be provided without hierarchy or judgement, accepting that mental health is not a dichotomy, nor does it define someone, though it can be helpful to accept and integrate one's experiences of mental ill-health in order to move forward. UPSIDES PSWs also promote a recovery orientation within mental health teams. Specific tasks include practical support with daily life as needed (e.g., accompanying a peer to appointments or activities), helping to endure and understand crises, and actively supporting recovery planning. It is possible to deliver peer support in an individual (one-to-one) or group format, or a combination of the two. The actual delivery of peer support will be heavily shaped by the guidance provided by trainers and supervisors, which is one reason why it is so important to think through the practical aspects of delivery in the early stages. Many UPSIDES sites found the pilot study particularly valuable as an opportunity to work through operational issues on a small scale before recruiting the full sample of participants required for the trial.

Essential for UPSIDES

Although peer support is a flexible intervention that varies from person to person, sites were instructed that the peer support delivered through UPSIDES should have the following characteristics:

1. It should be delivered **face-to-face** by a trained PSW to a service user with a severe mental health condition.
2. It should be delivered—at least in part—in a **community setting** (not exclusively in hospital or other clinical settings)
3. It should reflect the **core principles** outlined in the *UPSIDES Training Manual and Workbook*.
4. It should consist of a **minimum of three contacts** between the PSW and the peer.

Other recommendations provided to UPSIDES sites in the original field-version of the Implementation Manual are listed in the call-out box below.

Box B.

Recommendations for UPSIDES peer support:

1. **Be thoughtful about assigning PSWs:** Rigid formulas for assigning PSWs to potential recipients—for example, based on diagnosis—are not advisable. Instead, it may be useful to have an experienced PSW in a supervisory role, who can take into consideration more subjective aspects of the experiences of the PSW and potential recipient when assigning PSWs. Taking into account the wishes of the potential recipient (for example, whether it might be preferable to speak to a PSW of the same gender) has also been shown to be helpful and should be encouraged.
2. **Have clear thresholds from the outset:** In order to help boundary the PSW role, it is important to have clear minimum and maximum thresholds for how much contact will take place between the PSW and recipient, and to communicate this to both parties from the outset. During the

pilot stage, peer support is delivered over a three-month period. During the UPSIDES Trial, peer support will be delivered over a six-month period. UPSIDES requires a minimum of three contacts to take place, and weekly or biweekly meetings are recommended, but frequency may vary between individuals and between sites. PSWs should also be encouraged to agree with recipients the appropriate hours, means of contact, preferred meeting places, etc.

3. **Always go back to the core principles:** Because peer support varies across UPSIDES sites, it is important to always keep in mind the core principles and actively try to embed them in all aspects of delivery. These emphasise the need for peer support to be: (1) mutual; (2) reciprocal; (3) non-directive; (4) recovery-focused; (5) empowerment; (6) strengths-based; (7) inclusive and community-focused; (8) trialogue; (9) safe.

Common strategies

While these strategies for delivery of peer support were not strictly prescribed by UPSIDES, they were commonly used by UPSIDES sites in the conduct of its pilot study and trial.

1. Linked to facilities

At each site, the PSW programme was based in a clinical (or in one case, community residential) facility, where eligible peers could easily be identified and recruited for the purposes of the trial. It can also be reassuring to have supportive services easily accessible to peers who become distressed or unwell, and the physical presence of PSWs in these facilities may help to challenge the status quo and promote a recovery culture within mental health services. However, in order to meet UPSIDES essential criteria, delivery must extend into the community. This is where PSWs can be most helpful in terms of activating community resources. There may be liability issues or other concerns that need to be resolved in order to facilitate community-based service delivery.

2. Concluding peer support

Ending peer support can be difficult, but it is important for PSWs' own well-being to have boundaries in place and to know when their responsibilities to a peer will come to a close. Each UPSIDES site ensured that the PSW-peer relationship concluded with some discussion of what to do in case of distress. At one site, where peer support was already available through a public initiative, peers were simply informed that they could access the service again at any point. At another site with a more robust history of recovery-oriented service delivery, each peer completed a formal process of recovery and crisis planning and was transitioned into a peer network bridging a number of other community services and activities. At other sites, peers were encouraged to link into other support networks or services; for example, one site provided an emergency toolkit with contact numbers to call in case of future distress.

3. Individual peer support

All but one of the UPSIDES sites offered individual (one-to-one) peer support, either exclusively or in combination with peer support groups. However, the *Training Manual and Workbook* recommends combining individual with group support. One site intended to deliver both, but was unable to convene many group sessions due to COVID-19. Another site intended to deliver only individual peer support, but ultimately decided to introduce group peer support as well, in response to PSWs' concerns around the safety of home visits (particularly when PSWs were visiting peers of the opposite sex, visiting slums, etc.) Offering both formats from the outset

might help to mitigate these issues, accommodating individual preferences while also providing a back-up option if circumstances change.

FAQs

1. **Q: Are peers allowed to "swap" PSWs?** A: Yes; unanticipated logistical challenges, attrition and ill-fit between a PSW and peer sometimes call for a new PSW to step in. This is normal and allowed. However, it's a good idea to monitor swapping, for quality assurance. For example, if a PSW loses several recipients in a row, it could indicate an issue with their performance.

2. **Q: Can PSWs give money to recipients?** A: This is a difficult question, as in some settings, it is considered appropriate to bring gifts when visiting someone, and peers can sometimes be in very vulnerable situations. However, in the context of a research study, it could also be considered coercive—and therefore unethical—to give money or other gifts to participants. If your site does not already have a clear policy on this, it would be wise to consult with PSWs, staff and other key stakeholders to create one. If carrying out a research study, any participant compensation must be protocolised and approved by relevant institutional review boards.

3. **Q: What happens if a PSW experiences a relapse?** A: The *UPSIDES Training Manual and Workbook* covers a number of topics related to self-care, such as keeping yourself well, reflecting on your mental health and monitoring your personal resources. However, it is also important to create an atmosphere in which a PSW can seek support for distress if it arises. It is important to think through in advance what support will be in place and to communicate to PSWs how to get it and from whom. If a PSW needs to take a break from work, the peer should be informed and offered an alternative (e.g., another PSW).

4. **Q: Can PSWs help clinical staff?** A: This is a difficult question. Peer support entails a spirit of co-production that means PSWs should be respected as colleagues of medical staff, and collegiality often involves helping one another. But if PSWs' responsibilities start to be more about assisting medical staff in their duties than about using their lived experience to support peers, this can lead to role confusion. In these cases, it can be helpful to return to the core principles of UPSIDES peer support, to decide what kinds of help a PSW should and should not provide to medical staff. For example, because UPSIDES peer support must remain non-directive (core principle #3), it is probably not appropriate for PSWs to act as assistants to staff in distributing medications on a psychiatric ward.

5. **Q: How often should PSWs meet with peers?** A: As described above, UPSIDES provided some initial guidance (weekly/biweekly meetings, minimum three meetings total), but the number, duration and spacing of contacts between PSWs and peers varied significantly between sites and often between individual PSWs and peers, particularly after COVID-19 restrictions came

into effect (see "Lessons from COVID-19"). Ideally, general guidelines should be agreed in consultation with peers and PSWs and fine-tuned in response to individual needs and preferences.

6. **Q: What "counts" as a peer support visit?** A: For the purposes of UPSIDES research, we decided to define a peer support contact as a planned face-to-face visit between a PSW and a peer; however, this was no longer feasible after COVID-19 restrictions came into place (see "Lessons from COVID-19"). We adjusted our criteria to allow for "remote" contacts (by phone, videoconferencing, etc.) but still required that all peers receive at least one initial face-to-face meeting (which could take place outdoors with appropriate personal protective equipment and other precautions as stipulated by local health authorities when restrictions allowed). Depending on your specific context, you may decide that more or less remote peer support is allowed; however, there should be clear guidance distinguishing a remote peer support contact from other forms of communication (e.g. brief calls/messages for scheduling, quick check-in's, etc.)

7. **Q: What should we consider when assigning peers to PSWs?** A: Several UPSIDES sites reported difficulty matching PSWs to peers based on personal characteristics, as the pool of available PSW candidates did not always reflect the diversity among peers, particularly those in 'hard-to-reach' groups (see "Recruitment" section). More often, PSWs were matched with peers based on common interests or experiences, geographic location (to reduce cost and complication of transport, particularly in congested urban areas) and/or gender, though these criteria were not always strictly applied. As recommended above, it can be helpful to have an experienced PSW in a supervisory role responsible for weighing these and other considerations in making a "best fit" match between a PSW and peer, and reassigning peers if needed.

8. **Q: How should we prepare for emergency situations?** A: The COVID-19 pandemic was an unforeseen event that challenged UPSIDES in numerous ways (see "Lessons from COVID-19"). At the same time, it made peer support all the more important to the PSWs and the peers they served during an exceptionally difficult period. Largely due to climate change, there is a significant risk that we will experience more disease outbreaks and other emergency situations within our lifetimes. Building more resilient peer support programmes will mean that we can continue to provide this service when it is most critical, in ways that are safe and respectful of the unique needs and preferences of PSWs and peers. Particularly for those working in fragile contexts, it would be prudent to develop safety protocols for various scenarios in advance, ideally in collaboration with trainees and/or experienced PSWs (if available), and to include these in training and/or other onboarding activities.

4. Quality Assurance

Quality assurance covers processes for improving fidelity in how peer support is delivered; namely, monitoring, supervision and incentivisation. Incentivisation varied substantially between UPSIDES sites, as some treated PSWs more like healthcare staff, whereas others expected PSWs to operate on a volunteer basis. Supervision and monitoring varied less, as there were some basic expectations laid out that all UPSIDES sites were expected to meet.

Essential for UPSIDES

For the purposes of quality assurance, all UPSIDES study sites were expected to:

1. Put in place some mechanism for **supervision** of PSWs by a person with lived experience, likely in combination with other forms of supervision;
2. Put in place locally adapted tools for **monitoring and evaluation** of service delivery and supervision (Appendices 1-4). For the purposes of the trial, these include:
    a. M&E forms completed by supervisor at each supervision meeting
    b. M&E forms completed by PSW at each PSW-peer contact (either individual or group)
    c. Standardised reports compiling M&E data at six-month intervals

Other recommendations provided to UPSIDES sites in the original field-version of the Implementation Manual are listed in the call-out box below.

Box C.

Recommendations for UPSIDES quality assurance:

1. **Provide different types of supervision:** Different kinds of supervision work better for different people and can also be complementary. Consider whether you might be able to offer group and individual supervision, face-to-face and remote supervision (e.g., by phone/email), supervision by clinicians and by other PSWs.
2. **Put supports in place for PSWs' own well-being:** It can be very challenging to take care of yourself while also supporting other people's recovery. Consider how you might build supportive communities among and around PSWs, and whether there is any scope to help PSWs improve their own self-care. However, be careful to avoid practices that reinforce unequal power dynamics within the peer support programme—such as having a clinician from the peer support programme routinely assess PSWs' symptoms. This would be out of keeping with the overall ethos of UPSIDES.
3. **Ensure PSWs can meet their basic costs:** Particularly in low- and middle-income countries where the benefits system may be underdeveloped, PSWs may be unable to do their work as planned unless basic costs (e.g., essential transport, airtime to coordinate with recipients, etc.) are met.
4. **Don't have PSWs working in isolation:** It can be very challenging to work in a new position

as a PSW, especially when you are all alone in this role. We would recommend having at least two PSWs in an organisation. That way, they can readily support each other, act as sounding-boards to help tackle challenges as they arise, and share experiences.

Common strategies

While these strategies for quality assurance were not strictly prescribed by UPSIDES, they were commonly used by UPSIDES sites in the conduct of its pilot study and trial.

1. Individual supervision

Because the number of PSWs trained via UPSIDES was relatively low, all sites reported that they could provide one-to-one supervision either exclusively (at two sites) or in addition to group supervision (at four other sites). Supervision was relatively frequent; for example, one site with no group supervision component aimed to schedule a supervision meeting after every two to three PSW contacts. Another had weekly group supervision, alternating between peer-to-peer supervision and group supervision facilitated by clinical supervisors, with additional one-to-one supervision as needed. On the other end of the spectrum, one of the most experienced sites felt that monthly one-to-one supervision meetings between PSWs and UPSIDES trainers was sufficient, though additional supervision was available on an as-needed basis. As a rule of thumb, we would suggest that less experienced sites offer more intensive supervision using a variety of different approaches and continue checking in regularly with PSWs to understand which formats (group versus individual) and modes (remote versus face-to-face) of supervision prove most helpful and with what frequency, with the expectation that supervision will ease off as team members become more accustomed to their new roles.

2. Emphasising wellness

All sites recognised the importance of PSWs' wellness to the quality of their work. However, their efforts to promote wellness varied in their intensity and diversity. Examples of activities planned to promote PSW wellness include: basic workplace mental health (encouraging breaks, discussing wellness during supervision sessions, outreach to staff members for support); mechanisms for group and individual PSW-to-PSW support ("Mutual Support Group" meetings, PSW "Buddies"); recovery planning (preparing advance directives in case a PSW became unwell); art therapy and other arts-based activities (film club); group exercise (jogging, yoga); and other recreational activities (trips to the beach and other outdoor excursions). Involving PSWs in designing a programme of wellness support is a great way to draw on their unique interests and strengths, account for contextual differences in terms of the types of support and other resources available, and to promote ownership and collective responsibility for workplace wellness.

3. Material and financial incentives

Material and financial incentives (i.e., payment) varied across sites depending on the type of contract available, though all sites offered some compensation and aimed to provide the basic materials necessary for PSWs to effectively carry out their duties (see "Equipping PSWs" in the "Recruitment" section). Two sites had existing, publicly-funded peer roles and were able to recruit with minimal extra expense. Two others offered new salaried roles within host institutions, though contracts proved a challenge—at one site, for example, PSWs on state benefits were not allowed

to work for more than six hours per week, meaning the overall pay they could take home was very low. The site tried to help compensate in other ways, by ensuring that PSWs had access to office space, free coffee and other soft drinks, and books. The remaining two sites were in low-resource settings that could not offer formally recognised, paid positions within mental health services, so instead provided compensation on a "pay-per-day" basis. At one site, this was an allowance linked to the number of days worked; at the other, this was a travel reimbursement that aimed to cover all transport to and from PSWs' homes for peer support-related activities, plus meals. Although a "pay-per-day" structure may seem desirable as a way to motivate PSWs to stay in close contact with peers, we would advise against these types of arrangements, where possible—as PSWs who become unwell or are unable to carry out their duties because of other circumstances outside their control can find themselves in extremely vulnerable situations (as described further in the section "Lessons from COVID-19").

FAQs

1. **Q: Should PSWs be given material incentives to do their work?** A: There is conflicting advice on providing material incentives. One site that already had publicly-funded peer cadres within the mental health system felt that material incentives might actually harm motivation. Others found material incentives to be useful "work-arounds" to support PSWs financially in settings where they cannot be treated as salaried staff or where paid hours must be capped to avoid interfering with other entitlements. If you do not already have a system in place for incentivising PSWs, it may prove useful to consult with other sites operating in similar resource settings.

2. **Q: What are some other ways to incentivise good work?** A: Incentivisation isn't just about pay or other material benefits. There are plenty of other ways to motivate people to do their best work which are not at all unique to peer support. For example, one site created a pathway for truly stand-out PSWs to be promoted into a supervisory role. Another introduced formal recognition of high-performing PSWs in meetings. However, it is important to remember that rewarding only certain individuals for their good work can leave others feeling unnoticed or underappreciated, and some rewards (like promotion) are not going to be available to everyone. A good supervisor will look for different ways to recognise and build upon individuals' strengths, so that everyone feels valued as a part of the peer support team.

3. **Q: What do we do with all our M&E forms?** A: M&E can be valuable for quality assurance even outside the context of a formal study. But any additional information collected about peers and PSWs needs to be kept secure. The easiest solution is to integrate M&E forms into existing personnel and patient files, where possible. However, depending on the employer and type of contract that PSWs and supervisors hold, they may not actually have access to these systems. In this case, it will perhaps be necessary to set up a parallel M&E system specific to the peer support programme, following the best available guidance (e.g., General Data Protection Regulation), including provisions for secure storage of hard copies (e.g., locked filing cabinets stored in a locked office to which only programme staff have access) as well as any information that may be entered electronically (e.g., removal of identifying information, use of encryption

keys, etc.) If there is any intention of publishing data collected through M&E, it would be wise to partner with a university or other research institution that can provide guidance on data storage, informed consent, ethical approval and other important considerations.

4. **Q: What do we do when PSWs become unwell?** A: Recovery is not linear, and even PSWs who have not experienced a relapse for many years may become unwell. In addition to the different approaches to wellness promotion described above (e.g., developing advance directives), it is important to consider how the programme will respond. For example, what criteria will be used to decide when a PSW should no longer be delivering peer support, and who is responsible for making that assessment? How will the PSW's workload be redistributed, and how will this be communicated to the peers they were supporting? Does this have implications for their compensation, and if so, is it possible that they may feel obliged to work even when they're not well? What are the criteria for returning to peer support, and who is responsible for making this assessment? What extra support might they need while they are off work and in the process of transitioning back into work? Peer support programmes that are embedded within mental health services may be tempted to draw on their own clinicians' expertise and other resources to support PSWs, though Repper et al. (2013) argue that delivering peer support within the same service of which one is a patient can complicate the dynamics between the PSW and the service providers involved in the programme. The first version of the UPSIDES Implementation Manual also advised that sites avoid having their own staff review or treat PSWs, but this proved impractical in low-resource settings where suitable alternatives were not always readily available.

5. Ethical Practice

Ethical practice covers a wide range of issues related to the protection of PSWs, recipients of peer support, and others engaging with services through UPSIDES (e.g., family members, clinicians, etc.). As UPSIDES is a research project, all study sites are required to secure ethics approval, which covers a number of these issues (hence, this section of the Implementation Manual is fairly brief). However, unforeseen ethical issues do arise, and it is also important to consider what ethical practice looks like in your unique context even when there is no data being collected.

Essential for UPSIDES

As part of ethical practice, all UPSIDES study sites were expected to:

1. Create and adhere to a **Code of Practice** for PSWs;
2. Follow the **ethical guidelines** (e.g., on confidentiality, data management, coercion, etc.) described in UPSIDES research protocols.

Other recommendations provided to UPSIDES sites in the original field-version of the Implementation Manual are listed in the call-out box below.

Box D.

Recommendations for UPSIDES ethics:

1. **Agree clear boundaries from the outset:** Establishing boundaries is important for the safety of PSWs as well as recipients of PSW. These should be made explicit in a code of practice, and there should be clear consequences for PSWs and recipients who do not adhere to the code of practice.
2. **Ensure PSWs know how to stay safe:** The risks to which PSWs and recipients are exposed will vary substantially from site to site. Avoiding night-time travel and visiting isolated locations, for example, may be wise. Some sites have also found it beneficial to train PSWs in de-escalation and other skills to help manage conflict.
3. **Have a plan for when things go wrong:** Adverse events do happen, and even if they are unrelated to the intervention delivered through UPSIDES, it is still necessary to prepare for them. How will you handle a serious illness or death? To whom would you report, and what records would you keep? The answers to some of these questions are already covered in part by UPSIDES research protocols, but there may be additional procedures that could prove beneficial in your local context.

Common strategies

While these strategies were not strictly prescribed by UPSIDES, they were commonly used by UPSIDES sites in the conduct of its pilot study and trial.

1. Common stipulations in codes of conduct

All but one of the UPSIDES sites had a written code of conduct, which was developed and discussed with PSWs during their training (the sixth site provided a short verbal summary). All three of the UPSIDES sites located in low- or middle-income countries explicitly prohibited romantic relationships between PSWs and peers (see FAQ 1, below).

2. Identifying risks and safeguarding issues

While the local implementation manuals of UPSIDES high-income country sites were not as detailed in their descriptions of possible risks, the three low- and middle-income country sites provided in-depth accounts of the various risks and other safeguarding issues that peers, PSWs and other staff could potentially face (e.g., bullying, sexual harassment, serious injury or illness, death or bereavement, road accidents). This is perhaps a reflection of the less heavily regulated working environment and high levels of exposure to situations of adversity, requiring programmes to take a great deal of responsibility for safeguarding in lower-resource settings. Advice from other organisations and services working in the catchment area can be extremely helpful in identifying and mitigating risks from the outset.

3. Defined working hours

Four sites explicitly restricted PSW visits to working hours. In most cases, this was to avoid exposing PSWs to risky night-time travel. At one site where gender-based violence is especially prevalent, PSW visits took place in the hospital during restricted working hours (09:30-13:30), with PSWs and peers matched by gender. Defined working hours can also help support work-life balance and help PSWs to hold boundaries with peers.

4. Clear consequences

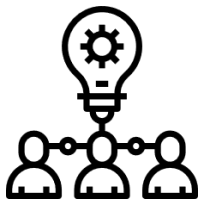
Consequences for violating the code of conduct were somewhat varied across UPSIDES sites, though the majority (four) planned for a first-instance warning system followed by suspension in case of a repeat.

5. Additional training on risk management

Although the content varied, four sites offered training on issues related to risk management. In some cases, this was limited to the standardised workplace safety training and other induction processes (e.g., data protection workshops) already in place at the organisation hosting the UPSIDES Intervention. At one of the more experienced sites working in a lower-resource setting, extra attention was paid to conflict resolution, de-escalation and sexual harassment, in particular.

FAQs

1. **Q: Are romantic relationships between PSWs and recipients allowed?** A: Given the potentially uneven power dynamic between a PSW and the person receiving support from the PSW, it would not be appropriate for them to instigate a romantic relationship. However, when the PSW is no longer formally supporting the recipient, this dynamic may change, in which case it may then become acceptable. Ideally, rules around relationships should be agreed with PSWs before initiating peer support.



6. Stakeholder Engagement

Evidence suggests the success or failure of implementing a peer support intervention depends as much on other stakeholders as it does on PSWs. Stakeholder engagement is therefore crucial to implementation and should begin even before piloting peer support. The UPSIDES Implementation Plan provided guidance on setting up a Local Advisory Board (Appendix 5) and engaging stakeholders in design and planning using a participatory Theory of Change approach (Appendix 6). UPSIDES also offered assistance with communications—for example by preparing a standardised newsletter template. But which stakeholders you engage and how will naturally vary from site to site and forms an important part of your local implementation strategy.

Essential for UPSIDES

UPSIDES recognised the importance of stakeholder engagement and advised that all sites should, at a bare minimum:

1. Have a **Local Advisory Board** that meets at least twice annually;
2. Hold at least one **Theory of Change workshop** with key stakeholders, typically at a Local Advisory Board meeting;
3. Hold at least one **organisational readiness workshop** prior to piloting and a second before starting the trial.

Other recommendations provided to UPSIDES sites in the original field-version of the Implementation Manual are listed in the call-out box below.

Box E.

Recommendations for UPSIDES stakeholder engagement:

1. **Give an orientation:** You may think new PSWs are the only ones who need some orientation or training on peer support. However, staff often have a low baseline understanding of peer support and recovery and many practical questions about day-to-day work alongside a PSW.
2. **Allow staff to air concerns:** Healthcare providers and administrators can be anxious and even antagonistic toward peer support. It is important to create opportunities to respond to their concerns in constructive ways; however, these interactions must also be well-managed to avoid derailing the programme.
3. **Give real-world examples and evidence:** Some stakeholders may question the value of peer support and whether it can be delivered with the resources available. This is where it can be useful to present some of the evidence about peer support from around the world, including examples of peer support programmes operating in low-resource settings, such as in India and Uganda.
4. **Cultivate potential champions:** People in formal (e.g., a hospital director) and informal (e.g., a well-respected colleague) leadership roles can both be influential. Finding and cultivating relationships with leaders who are open to the idea of peer support can help foster organisational change.

Common strategies

While these strategies were not strictly prescribed by UPSIDES, they were commonly used by UPSIDES sites in the conduct of its pilot study and trial.

1. ### Face-to-face meetings

   All sites required face-to-face meetings with stakeholders, particularly with those seen as most likely to resist peer support at the site. (This was possible in advance of the pilot and trial, as COVID-19 had not yet been declared a pandemic.) However, the frequency of these meetings varied. During the pilot phase, one site held weekly update meetings with directors, with Ministry of Health representatives also invited to attend. On the other hand, three sites sites felt it was sufficient to plan a stakeholder meeting once every six months. Another site aimed for quarterly meetings, and the last site aimed for monthly meetings. Although active engagement is important, more meetings are not necessarily better—as time-constrained stakeholders may feel they cannot keep up and end up disengaging entirely.

2. ### Public sector engagement

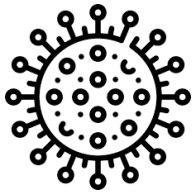
   All sites proactively involved key stakeholders in government to improve the chances of long term sustainability of their work. At four sites, these were ministry officials. At another, a specialist in peer support work and nursing employed by the district government was directly involved in delivery. At the sixth site, a PSW involved in UPSIDES was already active in one of the regional parties.

3. ### Anticipating resistance

   Most sites anticipated some resistance to implementing peer support, though the stakeholders identified as most likely to resist often varied. Two sites reported concerns that PSWs might create competition or interfere with the work of existing providers (social workers or clinical staff), though at other sites clinical staff were considered most likely to champion peer support. At one site, these concerns were rooted in negative experiences with a peer support project that preceded UPSIDES. At another site, administrators (particularly in the human resource department) were seen as most likely to resist, due to poor understanding of peer support roles. Identifying these potential sources of conflict early on can allow for more targeted stakeholder engagement to encourage buy-in.

FAQs

1. **Q: How can I develop a targeted stakeholder engagement plan?** A: We can all do better when it comes to sharing about our work, but there isn't always enough time or resources available to reach everyone who might possibly be interested. Developing a targeted engagement plan means first mapping out your key stakeholders, figuring out which ones are the most important to reach and why, and what you want to change with your messaging to them. The Policy Influence Toolkit developed by the Mental Health Innovation Network and Overseas Development Institute offers a structured process and tools for doing this: https://www.mhinnovation.net/resources/global-mental-health-policy-influence-toolkit



7. Lessons from COVID-19

The UPSIDES trial officially started in early January 2020. As reports of the first COVID-19 infections began to break, sites faced increasing uncertainty. Adaptations to implementation during this period may prove instructive for other sites seeking to build more resilient peer support programmes. Key learning is outlined below, in relation to each of the six areas of implementation covered in this manual.

Recruitment

For the UPSIDES pilot and trial, the initial PSW recruitment took place before COVID-19 restrictions came into effect. A very small number of new PSWs were recruited at some sites in response to attrition after research was already underway, but this was generally carried out during periods when social distancing rules were relaxed and face-to-face meetings were allowed to take place (masked/outdoors if needed). Those intending to deliver peer support over longer periods of time and/or in fragile contexts may need to place extra emphasis on planning for attrition, including how to adapt recruitment activities (advertising, interviews, onboarding, etc.) to situations in which it may be unsafe to meet face-to-face.

Capacity-building

The initial UPSIDES PSW training also took place before COVID-19 was declared a pandemic. When re-initiating peer support after restrictions were lifted, some sites introduced additional training, for example on safe use of personal protective equipment, hand-washing, physical distancing, etc. As mentioned above, a very small number of new PSWs were trained to account for attrition. Training was scheduled for periods when face-to-face meetings between individuals or small groups were allowed. However, it is important to note the *UPSIDES Training Manual and Workbook* is designed to be delivered in an interactive group format, making use of the experience in the room—which may prove more difficult to achieve in one-off trainings with just a few participants. Those intending to deliver peer support over longer periods of time and/or in fragile contexts may need to consider how to adapt; for example, by training and/or retraining on a rolling basis, adapting training materials for small-group/individual formats, and/or incorporating more job-shadowing and other opportunities to learn from others' experiences outside of the training room (e.g., using technology to connect current/former trainees remotely). Trainers should also ensure that basic information on health and safety is provided as part of the training, if it is not covered in other onboarding sessions.

Delivery

Only a few weeks after the UPSIDES Trial began, COVID-19 was declared a global pandemic, leading to lockdowns and other measures that impacted the delivery of peer support. Across all sites, peer support was paused for varying lengths of time on the advice of local health authorities. Key changes to service delivery included: extra tracing of PSWs and peers, extra emphasis on PSW well-being, protective measures for face-to-face meetings, and remote delivery. These are described further below, with additional information on protective measures detailed in UPSIDES COVID-19 Restart Plan.

Tracing

A number of factors led peers and PSWs to relocate during the pandemic, such as social isolation and economic uncertainty. Particularly at low- and middle-income country sites, many PSWs and peers moved out of the urban and semi-urban areas where UPSIDES was based and into family homes in rural areas where cost of living was lower. UPSIDES research teams put in extra effort to contact PSWs and peers regularly, to avoid losing them from the study. Those who did not have their own mobile phones were particularly difficult to trace, but could often be located by contacting family members.

PSW well-being

UPSIDES sites recognized that PSWs were in particularly vulnerable situations during the pandemic and made extra efforts to engage with them. For example, at higher-income sites where most PSWs had computer access, videoconferencing was used to convene PSWs remotely and discuss the issues they were facing. At other sites, phone calls and WhatsApp messages were used; one site in particular made use of WhatsApp to share public health information about COVID-19 and help dispel distressing misinformation that PSWs were receiving in their communities. Another lower-income site went to exceptional lengths to support PSWs when supply chains broke down, delivering their prescriptions door-to-door by motorbike.

Protective measures

Sites adhered to the recommendations of public health authorities. When restrictions allowed, peer support visits were held outdoors with physical distancing in place and with protective equipment (masks, gloves) as advised. However, the feasibility of outdoor visits was dependent on local weather conditions, which were often unfavourable during rainy or cold seasons. When indoor meetings were allowed, these had to be well-ventilated and large enough to enable physical distancing, with extra cleaning and hand-washing protocols in place, and protective equipment as necessary. Protective measures were sometimes challenging to adhere to; for example, some PSWs reported underlying conditions that made it difficult to wear a mask. On the other hand, the high level of comorbidity between severe mental health conditions and a range of physical health conditions that also increase COVID-19 risk (e.g., obesity, diabetes, cardiovascular diseases) meant that PSWs and peers were also exceptionally vulnerable. There were instances where some PSWs and peers were simply unable to participate in face-to-face activities, no matter what measures were put in place.

Remote peer support

Perhaps the most significant change to UPSIDES service delivery as a result of COVID-19 was the relaxation of essential criteria stipulating that peer support should be delivered face-to-face in a community setting over a minimum of three visits. In order to mitigate risk and accommodate the needs and preferences of peers and PSWs, sites were allowed to deliver peer support remotely (by phone, video-conferencing, etc.) following an initial face-to-face visit for rapport-building (with protective measures in place, as above). However, remote delivery was not a perfect solution: not all peers or PSWs had their own phones and

intrafamily politics meant that their communication needs were not always prioritised; not all peers or PSWs had a conducive environment for making calls (quiet, private, good connection) particularly during lockdowns; and there were real concerns around the intangible aspects of face-to-face communication that were lost and whether remote peer support could be effective.

Quality assurance

Perhaps the most notable change to quality assurance during the COVID-19 pandemic was that more supervision had to be carried out remotely. Face-to-face individual and group supervision faced the same challenges as peer support, at a time when supervisor contact and PSW-to-PSW support were both especially important for PSW wellness. Although M&E forms were able to accommodate either remote or face-to-face supervision sessions (see Appendix 3), the forms used for recording PSW visits and peer support groups defined a peer support contact as a face-to-face interaction (Appendices 1-2). Consequently, there was some confusion about how to record and ultimately report on the delivery of peer support during the pandemic, resulting in data quality issues that had to be corrected retrospectively. Another important challenge was related to the "pay-per-day" model of compensation at two of the UPSIDES sites. When the trial was paused, sites that paid PSWs transport reimbursements or other allowances linked to face-to-face service delivery (as opposed to consistent PSW salaries) saw PSWs fall into extremely precarious financial situations during the pandemic, particularly as these sites also did not have robust benefits systems in place for people with psychosocial disabilities. This contributed to the high levels of internal migration observed, as many PSWs could no longer meet their basic needs and had to move in with members of their extended family living in cheaper, typically rural areas (where connectivity was often also poorer).

Ethical practice

The COVID-19 pandemic raised new questions about how to balance the added risks of travel and face-to-face contact with the potential benefits of peer support against a backdrop of increasing social isolation and distress. While remote delivery seemed to be the best option, several sites raised concerns regarding the privacy of phone calls in crowded households. This was especially the case in lower-resource settings where phones were commonly borrowed from relatives. Sites also understood the vulnerability of PSWs and peers to COVID-19, as there is a high prevalence of various risk factors (e.g., obesity, smoking, diabetes, cardiovascular diseases, etc.) among people with severe mental health conditions. The Implementation Work Package organised a series of video calls for implementing sites to discuss these issues and learn from one another. Ultimately, sites were responsible for following their own institution's guidance in line with advice from local public health authorities, as well as the UPSIDES Restart Plan, to minimise risks associated with the delivery of peer support and research activities during the pandemic.

Stakeholder engagement

As with group supervision and peer support group meetings (see "Delivery" and "Quality assurance" sections), stakeholder meetings could no longer be carried out face-to-face when COVID-19 restrictions were in place. Five of the six implementing sites held at least one stakeholder meeting online, with face-to-face meetings resuming following the same guidelines outlined in the Restart Plan.

Appendices

Appendix 1—M&E individual forms

UPSIDES M&E Form: One-to-one PSW

TO BE COMPLETED AT EACH CONTACT BETWEEN A PSW AND "PEER" (RECIPIENT OF PEER SUPPORT)
Please note that for the purposes of UPSIDES, this refers to face-to-face contact, not contact by text, telephone, email, etc.

A. ADMINISTRATIVE INFORMATION

1. **Today's date** D D / M M / Y Y Y Y

2. **Name of peer*** First name(s) _____ Surname(s) _____

3. **Name of PSW*** First name(s) _____ Surname(s) _____

4. **Instructions for how to get in touch with this peer next time*** (i.e. phone, email, address, directions to home, days/times available, etc.) _____

B. INFORMATION ON PREVIOUS CONTACT

5. **When was the peer's most recent contact with a PSW (*before* today)?** D D / M M / Y Y
(if today is the first contact with a PSW, enter "00/00/00")

6. **Since the most recent contact, have you been in touch with the peer in any other ways?** (tick all that apply)
☐ Phone call(s) ☐ Text message(s) ☐ Email(s) ☐ Other (describe) ☐ None
If "other", please describe: _____

7. **Since the most recent contact, how much time do you think you have spent keeping in touch with the peer?** (in minutes)
☐ Less than 15 min. ☐ 15-30 min. ☐ 30-60 min. ☐ More than 60 min.

C. INFORMATION ON THIS CONTACT

8. **Did anyone else participate in *this* (today's) contact with the peer?** (tick all that apply)
☐ Carer(s)/Family member(s) ☐ Mental health professional(s) ☐ Other (describe) ☐ None
If "other", please describe: _____

9. **Where did this contact with the peer take place?** (i.e. ward, home, community meeting place, etc.) _____

10. **Approximately how long was this contact with the peer?** (in minutes)
☐ Less than 15 min. ☐ 15-30 min. ☐ 30-60 min. ☐ More than 60 min.

D. SIGNATURES (IF REQUIRED BY LOCAL FIELD SITE)

10. **Peer signature*** (confirming contact took place) _____

11. **PSW signature*** (confirming contact took place) _____

[YOUR SITE NAME GOES HERE]
***Instruction for data entry:** skip all questions marked with asterisk, for confidentiality* 1

UPSIDES M&E Form: One-to-one PSW

E. DETAILS ON THIS CONTACT

12. **During this contact, did you use any of the exercises/activities described in the UPSIDES workbook?** (tick all that apply)

[X] Tree of Life	[X] Circles of Safety	[X] Recovery planning	[X] Goal setting
[X] Problem solving	[X] Other (describe)	[X] None	

If "other", please describe:

13. **During this contact, were any steps taken to improve the peer's support system?** (tick all that apply and describe)

- [X] Improving relationships with family or friends (e.g. improving communication, conflict resolution, etc.)
- [X] Improving relationships with service providers (e.g. improving communication, conflict resolution, etc.)
- [X] Identifying or creating links with services (e.g. mental health, housing and social services, etc.)
- [X] Identifying or creating links with other community resources (e.g. sports, clubs, faith-based organisations, etc.)
- [X] Other (describe below)
- [X] None

If "other", please describe:

F. NOTES (STAPLE AN EXTRA BLANK PAGE TO THIS FORM IF MORE SPACE IS NEEDED)

14. **Notes*** (e.g. peer's current situation, what was done with the peer, ideas of what to cover in future contacts with the peer)

Appendix 2—M&E group form

UPSIDES M&E Form: Group PSW

TO BE COMPLETED AT EACH CONTACT BETWEEN A PSW AND "PEERS" (RECIPIENTS OF PEER SUPPORT)
Please note that for the purposes of UPSIDES, this refers to face-to-face contact, not contact by text, telephone, email, etc.

A. ADMINISTRATIVE INFORMATION

1. Today's date D D / M M / Y Y Y Y

2. Name of PSW* First name(s)

Surname(s)

3. Signature of PSW* (confirming contact took place)

4. Names and signatures of participating peers* (confirming contact took place)

i. Name (first and surname)		Signature	
ii. Name (first and surname)		Signature	
iii. Name (first and surname)		Signature	
iv. Name (first and surname)		Signature	
v. Name (first and surname)		Signature	
vi. Name (first and surname)		Signature	
vii. Name (first and surname)		Signature	
viii. Name (first and surname)		Signature	
ix. Name (first and surname)		Signature	
x. Name (first and surname)		Signature	
xi. Name (first and surname)		Signature	
xii. Name (first and surname)		Signature	

UPSIDES M&E Form: Group PSW

B. INFORMATION ON PREVIOUS CONTACTS

5. **When was your last contact with this group of peers (*before* today)?** D D / M M / Y Y
(if today is the first contact, enter "00/00/00")

6. **Since the most recent contact, have you been in touch with this group of peers in any other ways?** (tick all that apply)

[X] Phone call(s) [X] Text message(s) [X] Email(s) [X] Other (describe) [X] None

If "other", please describe:

7. **Since the most recent contact, how much time do you think you have spent keeping in touch with this group?** (in minutes)

[X] Less than 15 min. [X] 15-30 min. [X] 30-60 min. [X] More than 60 min.

C. INFORMATION ON THIS CONTACT

8. **Did anyone else participate in *this* (today's) contact with the peer group?** (tick all that apply)

[X] Carer(s)/Family member(s) [X] Mental health professional(s) [X] Other (describe) [X] None

If "other", please describe:

9. **Where did today's contact take place?** (i.e. ward, home, community meeting place, etc.)

10. **Approximately how long was this contact with the peer group?** (in minutes)

[X] Less than 15 min. [X] 15-30 min. [X] 30-60 min. [X] More than 60 min.

D. DETAILS ON THIS CONTACT

11. **During this contact, did you use any of the exercises/activities described in the UPSIDES workbook?** (tick all that apply)

[X] Tree of Life [X] Circles of Safety [X] Recovery planning [X] Goal setting
[X] Problem solving [X] Other (describe) [X] None

If "other", please describe:

12. **During this contact, were any steps taken to improve the peers' support systems?** (tick all that apply and describe)

[X] Improving relationships with family or friends (e.g. improving communication, conflict resolution, etc.)
[X] Improving relationships with service providers (e.g. improving communication, conflict resolution, etc.)
[X] Identifying or creating links with services (e.g. mental health, housing and social services, etc.)
[X] Identifying or creating links with other community resources (e.g. sports, clubs, faith-based organisations, etc.)
[X] Other (describe below)
[X] None

If "other", please describe:

UPSIDES M&E Form: Group PSW

F. NOTES (CONTINUE ON THE BACK OF THIS PAGE IF MORE SPACE IS NEEDED)

14. **Notes***

General notes (e.g. peers' current situations, things that do/do not appear to be improving, etc.)

Today's group session (i.e. what was covered, observations on what did/did not go well, etc.)

Thoughts for next group session (e.g. topics to cover or revisit, specific peers to check in with)

Appendix 3—M&E supervision form

UPSIDES Supervision Form

TO BE COMPLETED BY SUPERVISOR AT EACH SUPERVISION WITH PSW

Please note that for the purposes of UPSIDES, this refers to a supervision meeting or observation of a PSW's activities

A. ADMINISTRATIVE INFORMATION

1. **Today's date** D D / M M / Y Y Y Y

2. **Name of PSW*** First name(s) _____ Surname(s) _____

3. **Name of Supervisor*** First name(s) _____ Surname(s) _____

4. **Special instructions for how to contact this PSW if needed*** (i.e. phone, email, address, days/times available, etc.) _____

B. INFORMATION ON PREVIOUS SUPERVISION

5. **When was the PSW's most recent supervision *before* this one?** D D / M M / Y Y Y Y

6. **Since your most recent supervision, have you been in touch with the PSW in any other ways?** (tick all that apply)

X Phone call(s) X Text message(s) X Email(s) X Other (describe) X None

If "other", please describe: _____

7. **Since the most recent contact, how much time do you think you have spent keeping in touch with the PSW?** (in minutes)

X Less than 15 min. X 15-30 min. X 30-60 min. X More than 60 min.

C. INFORMATION ON THIS SUPERVISION

8. **In what format was today's supervision provided to the PSW?** (tick one)

X One-to-one meeting X Group meeting X Observation (e.g. "shadow visit")

9. **Was supervision provided in-person (i.e. face-to-face) or remotely (i.e. phone, Skype)?**

X In-person X Remote

10. **Where did this supervision take place?** (i.e. ward, home, office, community meeting place, phone, Skype, etc.) _____

11. **Approximately how long was this supervision?** (in minutes)

X Less than 15 min. X 15-30 min. X 30-60 min. X More than 60 min.

D. SIGNATURES (IF REQUIRED BY LOCAL FIELD SITE)

12. **PSW signature** (confirming supervision took place) _____

13. **Supervisor signature** (confirming supervision took place) _____

[YOUR SITE NAME GOES HERE]

***Instruction for data entry**: skip all questions marked with asterisk, for confidentiality*

1

UPSIDES Supervision Form

E. CONTENT OF THE SUPERVISION

14. **Main topic discussed during this session**
(if you run out of space, additional details can go under 17. "Notes")

15a. **Since your most recent supervision, has the PSW had difficulties working in alignment with any UPSIDES principles?**
(Tick one for each principle. If "some" or "more" is selected, provide details under 13b.)

i. Mutual	[X] No difficulty	[X] Some difficulty	[X] Much difficulty
ii. Reciprocal	[X] No difficulty	[X] Some difficulty	[X] Much difficulty
iii. Non-directive	[X] No difficulty	[X] Some difficulty	[X] Much difficulty
iv. Recovery-focused	[X] No difficulty	[X] Some difficulty	[X] Much difficulty
v. Strength-based	[X] No difficulty	[X] Some difficulty	[X] Much difficulty
vi. Inclusive and Community-focused	[X] No difficulty	[X] Some difficulty	[X] Much difficulty
vii. Trialogue	[X] No difficulty	[X] Some difficulty	[X] Much difficulty
viii. Empowerment	[X] No difficulty	[X] Some difficulty	[X] Much difficulty
ix. Safe	[X] No difficulty	[X] Some difficulty	[X] Much difficulty

15b. **For each difficulty noted above, please describe an exemplary situation and the options/solutions discussed**
(if you run out of space, additional details can go under 17. "Notes")

16. **Since your most recent supervision, has the PSW had any difficulties staying well?** (Please describe below.)

X

UPSIDES Supervision Form

17. **Notes** (i.e. PSW's current situation, what the PSW has achieved, what the PSW may be struggling with, recommendations)

Appendix 4—Reporting format

Interim Report 1 (Implementation Phase: 0-6 months)

1.1. Start date for implementation

Please type date below. This should be the official start date of the UPSIDES trial at your site.

1.2. Were there any major interruptions to implementation during this period?

Please tick one option below. If "No", skip to question 1.3.

☐ Yes

☐ No

1.2.1. Dates of interruption to implementation

Please type approximate dates below.

1.2.2. Brief description of interruption (reason for interruption, how implementation was changed during this period as a result, etc.)

Please respond briefly below (1 paragraph or less). Alternatively, feel free to refer to further documentation appended to this report.

1.3. Were there any other major changes to implementation during this period?

Please tick one option below. If "No", skip to question 1.4.

☐ Yes

☐ No

1.3.1. Dates when change was implemented during this period.

Please type approximate dates below.

1.3.2. Brief description of the change (reason for the change, how implementation was changed during this period as a result, etc.)

Please respond briefly below (1 paragraph or less). Alternatively, feel free to refer to further documentation appended to this report.

1.4. Were there any other major challenges, accomplishments or key learning points related to implementation during this period that you can (briefly) share with us?

Please respond briefly below (1 paragraph or less). Alternatively, feel free to refer to further documentation appended to this report.

1.5. Programme data on PSWs

Please enter numbers in the boxes provided below.

1.5.1. Number of PSWs recruited to training	
1.5.2. Number of PSWs who completed training	
1.5.3. Number of PSWs who started work	
1.5.4. Number of PSWs who stopped working during this period	

1.6. Please comment on any PSW attrition observed during this period (i.e. if PSWs who were recruited did not complete training, if those who completed training did not end up working, or if those who started working stopped).

Please respond briefly below, describing why you think this may have occurred (1 paragraph or less). Alternatively, feel free to refer to further documentation appended to this report.

1.7. Monitoring and evaluation (M&E) data on service delivery* *Please ensure all necessary M&E data from this period has been entered into the online portal. The UPSIDES data manager can then generate these numbers for your report.*	
	1.7.1. Number of peers who received PSW (individual and/or group)*
	1.7.2. Number of individual, face-to-face PSW contacts*
	1.7.3. Number of face-to-face PSW group sessions*
1.8. Monitoring and evaluation (M&E) data on supervision* *Please ensure all necessary M&E data from this period has been entered into the online portal. The UPSIDES data manager can then generate these numbers for your report.*	
	1.8.1. Number of one-to-one supervision meetings*
	1.8.2. Number of group supervision meetings*
	1.8.3. Number of observation sessions for purposes of supervision*

Introduction to Local Advisory Boards

A **Local Advisory Board** is a group of local stakeholders created to provide guidance and support to the management of a project.

Although it has no formal legal responsibilities or decision-making authority, a Local Advisory Board is a crucial resource for designing and planning for the implementation of an intervention tailored to the unique context in which you are working. Local Advisory Boards can also play an important, ongoing role in implementation; for example, by helping to identify locally appropriate solutions to emerging challenges and issues. It is not uncommon for Local Advisory Board members to become passionate advocates of your work, helping to also secure buy-in from the communities with which you are engaging, and eventually assisting in dissemination of findings.

Every implementing site involved in UPSIDES must have regular meetings with a Local Advisory Board. This is an important deliverable of Work Package 5, which must be reported to the funder. This kind of engagement is so important, journals like *BMJ* now require a statement on patient and public involvement to be included in every submission for publication. For UPSIDES, there are a couple of tasks in particular for which the Local Advisory Board is especially important:

- Helping to characterise the current stage of implementation using the **framework** (WP2)
- Feeding into the design of the **intervention** (WP3)
- Developing a **Theory of Change** to map out how the intervention will be implemented and evaluated (WP5)
- Helping to disseminate key **communications** (WP8)

Setting up the Local Advisory Board

In order to encourage different perspectives, **it is important to aim for diversity** in the selection of advisory board members, particularly in terms of gender, disability and other underrepresented groups (e.g., religious and ethnic minorities). At a minimum, **your Local Advisory Board must consist of the following**:

- Two **service user representatives**
- Two **carers of people living with mental illness**
- A **senior clinical staff member**
- A **Ministry of Health representative** and/or **hospital director**, as appropriate
- A **local community leader**

For some sites, it may be appropriate to also invite **traditional healers** or **religious figures** as community leaders and representatives of the informal care sector.

Keeping advisors engaged

With a voluntary role like Local Advisory Board member, retention can sometimes be a problem. You want to ensure that your Local Advisory Board will provide meaningful inputs for the duration of the project, so it is important to **think through the barriers a member might encounter and how to address them**. For example:

- Consider whether attending meetings will require **travel** for members.

    - Can your budget accommodate compensation for travel?
    - Can you provide light refreshments in case members miss meals while travelling?
    - Can you hold your meetings some place central that is easy for members to access?
- Consider the **timing** of meetings.
    - Will members with work and family commitments be available?
    - Can you set a standing meeting for members to plan around, or alternatively use a scheduling tool like Doodle to find the most convenient times and dates?
- Consider how you will handle **language differences**.
    - Can someone translate during the meeting, if needed?
    - Can you translate materials in advance of the meeting to ensure that all members understand and can participate meaningfully?
- Make the **expectations** clear from the beginning.
    - Consider the roles, responsibilities and time commitment required of your members, and discuss these ideally before or at your first meeting.
    - Agree the circumstances under which members may be substituted or replaced; for example, if they miss a certain number of meetings.

Introduction to Theory of Change

What is a Theory of Change?

Theory of Change is an approach to designing, describing and evaluating complex interventions that is increasingly being used in concert with the Medical Research Council's Framework for Complex Interventions in order to help structure the research process.

A Theory of Change is often depicted as a **map** describing all the different components of a complex intervention, how they relate to one another, and how they are expected to work. A detailed Theory of Change map should include the components outlined in the below table (adapted from DeSilva et al. 2014 and Ryan et al. 2018). An example map is also provided at the end of this document.

Core components of a Theory of Change map

Terminology	Definitions	Examples
Outcomes (i.e. "Pre-conditions" or "Milestones")		
‣ Short-term, Intermediate	The intended results of the interventions. Things that don't exist now, but need to exist in order for the logical causal pathway not to be broken.	Change in knowledge, attitudes and skills of lay health workers to enable them to successfully deliver talking therapy.
‣ Long-term	The final outcome the program is able to change on its own.	Reduced prevalence of CMDs in the population receiving talking therapy.
‣ Ultimate (i.e. "Impact" or "Goal")	The real-world change you are trying to affect.	Reduced prevalence of CMDs among survivors of humanitarian crises.
Interventions (i.e. "Strategies")	The different components of the complex intervention.	Training of lay workers on the delivery of talking therapy.
Indicators	Things you can measure and document to determine whether you are making progress towards, or have achieved, each outcome.	Reduction in symptom severity for CMDs.
Rationale	Key beliefs that underlie why one outcome… [leads to] the next, and why you must do certain activities to produce the desired outcome.	Humanitarian responders need to be educated about signs and symptoms of CMDs in order for CMDs to be detected during crises.

Assumptions	An external condition beyond the control of the project that must exist for the outcome to be achieved.	Task-sharing with lay workers is socially and politically acceptable.

Why have a Theory of Change?

There are many benefits to having a Theory of Change which have been described in the academic literature. For UPSIDES in particular, there are three main reasons why it is important:

- **To better understand similarities and differences across UPSIDES sites:** Peer support is going to be implemented in slightly different ways across each of the UPSIDES sites. Theory of Change maps are useful visual tools to help us compare and contrast how peer support will look at each site.
- **To inform methods for process evaluation at each site:** Because UPSIDES is an implementation research project, it is particularly important that we capture data on processes, not just outcomes. Theory of Change can help us think through the processes that we need to evaluate and assign indicators to them.
- **To ensure meaningful involvement of key stakeholders:** The process of developing a Theory of Change can help to improve stakeholders' understanding and buy-in. The resulting map can also be a useful communications tool to explain to stakeholders what is being done at each site and how.

Creating a Theory of Change

How do I conduct a Theory of Change workshop?

The best way to start developing a Theory of Change map is with a **Theory of Change workshop**. This is where key stakeholders are gathered in a room to first consider the ultimate impact that peer support aims to achieve, and then work backward to identify the key steps necessary to bring about this change. Often, a Theory of Change workshop will consist of 5-15 stakeholders with complementary expertise (e.g. service providers, service users, caregivers, researchers, etc.) led by a facilitator. The facilitator will ask a number of questions to the group, such as:

- *"What is the impact or change in the real world that we want to achieve?"*
- *"What outcomes are needed to produce this impact?"*
- *"What interventions are needed to produce these outcomes?"*

As stakeholders' respond to these questions, the facilitator summarises their responses on sticky-notes or sheets of loose paper, and continually arranges and rearranges them on a wall, a large table or even the floor, to give a sense of the sequence of steps on the map.

At the end of the workshop, the facilitator typically takes photographs of the initial map that has been produced and may even keep the original sticky-notes or pieces of paper.

When should I conduct a Theory of Change workshop?

As many key stakeholders are already involved in your Local Advisory Boards, we recommend that you use one of your earliest **Local Advisory board Meetings** to hold a Theory of Change workshop.

However, you are very welcome to conduct additional Theory of Change workshops with other relevant stakeholders as you see fit.

What should be the output of my workshop?

It is very rare that a single Theory of Change workshop is sufficient to produce a complete map. The facilitator should take some time soon after the workshop to revisit what was done in the workshop and try to refine and develop it further, typically using Powerpoint. The **Powerpoint slide** can then be fed back to the stakeholders who participated in the workshop and also shared with others who didn't participate in the workshop, for further input.

What are the next steps after the workshop?

Once you have a draft Theory of Change map ready to share in Powerpoint, please send it to the **Work Package 5 leads**, who can give advice on how to refine and develop it further. The aim will be to have a complete, revised draft ready in time for your next Local Advisory Board meeting, so that your stakeholders have an opportunity to review it.

The Theory of Change map will be **a living document** that is revised throughout the life of the project as it evolves, as you encounter challenges and new solutions to overcome those challenges, and as you collect data. We suggest revisiting the Theory of Change map at each Local Advisory Board meeting. The Theory of Change map will only be finalized after the implementation and evaluation phases of UPSIDES have concluded.

Where can I learn more about Theory of Change?

The Mental Health Innovation Network also has an online Theory of Change Toolkit including a practical guide to creating a Theory of Change map. This is particularly useful for the workshop facilitator to review.

If you're interested in learning more about Theory of Change from an academic perspective or seeing how it has been used in previous multi-country research projects and/or research evaluations of mental health interventions in low- and middle-income countries, here are some additional references:

- Asher et al. (2015). Development of a Community-Based Rehabilitation Intervention for People with Schizophrenia in Ethiopia. *PLoS One*, 10(11):e0143572.
- Breuer et al. (2016). Planning and evaluating mental health services in low- and middle-income countries using theory of change. *BJ Psych*, 298(s56):s55-s62.
- Breuer et al. (2018). Theory of change for complex mental health interventions: 10 lessons from the programme for improving mental health care. *Glob Ment Health*, 5:e24.
- Chibanda et al. (2016). Using a theory driven approach to develop and evaluate a complex mental health intervention: the friendship bench project in Zimbabwe. *Int J Ment Health Syst,* 10(16).
- DeSilva et al. (2014). Theory of Change: a theory-driven approach to enhance the Medical Research Council's framework for complex interventions. *Trials*, 15:267.
- Hailermariam et al. (2015). Developing a mental health care plan in a low resource setting: the theory of change approach. *BMC Health Serv Res*, 15:429.