MI-02 Lay-delivered mental health care: the Friendship Bench, Problem Management Plus and task-shifting

HEALING after the FALL, research library, MI-02

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MI-01 established that the mind can be injured by collapse and that the injury has a shape. This report asks the next question: who treats it, and what does treating it cost in hours. MI-01's central finding was that supervision, not training length, is the variable that does not vary across the successful trials. I have tested that finding against the primary papers. It survives, but not intact, and the exception matters more than the rule.

A point of vocabulary first. These trials did not treat the ill in the sense the rest of this book uses. They treated people who were miserable, frightened, sleepless and unable to work, in places where misery of that kind was common and had causes outside the consulting room. The therapeutic claim, the recorded effect and the inferred mechanism are three different things, and I keep them apart.

1. The record: six trials and what each actually did

The Friendship Bench, Harare, 2014 to 2015. A cluster randomised trial in 24 primary care clinics, 573 patients randomised, 286 to the bench and 287 to enhanced usual care (Chibanda 2016). Of those randomised, 495 (86.4 per cent) were women, median age 33 years (interquartile range 27 to 41), and 41.7 per cent were HIV positive. 521 (90.9 per cent) completed follow-up at six months.

The therapists were lay health workers, community grandmothers known as *ambuya utano*, already employed by the local health authority and already inside an existing supervisory system. They were trained over nine days using a manual written by the Friendship Bench team, covering common mental disorders, counselling skills, problem-solving therapy and self-care. All training sessions were audio-recorded. TR-16 records the training as eight days (THRIVING library, TR-16). The primary paper says nine, and I follow the primary paper.

They delivered six sessions of individual problem-solving therapy on a bench placed in a discreet area outside the clinic. The first session ran about an hour, later sessions 30 to 45 minutes. The structure had three named phases: *kuvhura pfungwa*, opening the mind, *kusimudzira*, uplifting, and *kusimbisa*, strengthening. The presenting complaint in Shona is *kufungisisa*, thinking too much. After four individual sessions participants were invited into a peer-led group, Circle Kubatana Tose, and 187 of 274 (68.3 per cent) attended at least one meeting.

The result at six months: SSQ-14 score 3.81 (95 per cent CI 3.28 to 4.34) against 8.90 (8.33 to 9.47), adjusted mean difference -4.86 (-5.63 to -4.10), adjusted risk ratio 0.21 (0.15 to 0.29). On the PHQ-9 at a cut-point of 11, 13.7 per cent against 49.9 per cent, adjusted rate ratio 0.28 (0.22 to 0.34). Anxiety on the GAD-7 fell by 5.73 points more and disability on the WHODAS by 6.08 points more. Suicidal ideation at follow-up was present in 6 intervention participants (2.3 per cent) and 32 controls (12.3 per cent). The authors state there was no evidence of harm.

The part that matters most for a village is the part nobody quotes. The median number of sessions actually received

was five (IQR 4 to 6), only 39.9 per cent received all six, and the sessions were a median of **three days apart** (IQR 2 to 4), not weekly. MI-01 describes the Friendship Bench as six weekly 45-minute sessions (THRIVING library, MI-01). That is wrong, and the correction is practical rather than pedantic: the whole course ran in roughly three weeks. A village healer copying this gives most of a case its treatment inside a month.

Problem Management Plus. A WHO manual rather than a single trial, tested in Peshawar (Rahman 2016) and in Nairobi (Bryant 2017). The manual is the most detailed operational document in this field and I treat it below as the protocol source (WHO 2018). Five weekly sessions of up to 90 minutes, teaching four strategies: Managing Stress, Managing Problems, Get Going Keep Doing (behavioural activation) and Strengthening Social Support.

The Thinking Healthy Programme, Rawalpindi, 2005 to 2007. 40 Lady Health Workers, two per cluster, trained for **two days** with a one-day refresher after four months and given monthly half-day group supervision by the research team, delivering 16 sessions to perinatally depressed mothers: four weekly in the last month of pregnancy, three in the first postnatal month, nine monthly thereafter (Rahman 2008). At six months 97 of 418 (23 per cent) met criteria for major depression against 211 of 400 (53 per cent), adjusted odds ratio 0.22 (0.14 to 0.36). At twelve months, 111 of 412 (27 per cent) against 226 of 386 (59 per cent), adjusted odds ratio 0.23 (0.15 to 0.36). The effect held for a year. Infant weight-for-age and height-for-age showed no significant difference at either point: the mothers got better and the babies did not grow more.

Thinking Healthy delivered by peers, India and Pakistan, pooled. The same manual, adapted for local women with no prior healthcare experience, tested in urban Goa and rural Rawalpindi and pooled (Vanobberghen 2020). 26 and 66 peers respectively delivered at least one session. Pooled at six months post-childbirth: adjusted mean difference in PHQ-9 of -0.78 (-1.47 to -0.09) and adjusted odds of remission 1.35 (1.02 to 1.78), with effects stronger at three months than six. This trial is the hinge of the whole argument and I return to it in section 3.

The Healthy Activity Program, Goa, 2017. Lay counsellors treating moderately severe to severe depression in primary care (Patel 2017). Training was a three-week participatory workshop covering HAP and the alcohol programme CAP, followed by a six-month internship delivering treatment to real patients with peer-led group supervision. Eleven counsellors met competency standards, assessed by standardised role plays and therapy quality measures, and entered the trial. Six to eight sessions of 30 to 40 minutes, initially weekly, at the clinic or the patient's home. At three months the BDI-II adjusted mean difference was -7.57 (-10.27 to -4.86) and remission had an adjusted prevalence ratio of 1.61 (1.34 to 1.93), at an incremental cost of $9,333 per quality-adjusted life-year (3,862 to 28,169, 2015 international dollars).

Group interpersonal psychotherapy, rural Uganda, 2002. Thirty villages, 341 people meeting DSM-IV criteria for major or subsyndromal depression identified, 248 enrolled, 224 completed (Bolton 2003). Groups met for 90 minutes weekly for 16 weeks, led by a local person of the same sex who had received **two weeks of intensive training** in the Ugandan adaptation from two of the authors. Dropout was 7.8 per cent and 54 per cent attended at least 14 sessions. After the intervention, 6.5 per cent of the treated and 54.7 per cent of controls met criteria for major depression, from 86 per cent and 94 per cent at baseline. The odds of post-intervention depression among controls was 17.31 (7.63 to 39.27).

Self-Help Plus, South Sudanese refugee women in Uganda, 2020. The cheapest delivery model yet tested. Eight facilitators with secondary education and no formal mental health training, working in pairs, trained in four to five day blocks, running five weekly two-hour sessions for groups of 20 to 30 with the content carried on audio recordings and an illustrated book rather than in the facilitator's head (Tol 2020). 694 participants across 14 villages. The effect immediately after the course was large, Cohen's d of -0.72 on the K6, -0.75 on the PHQ-9 and -0.77 on the WHODAS. Three months later it had **decayed to d -0.26, -0.31 and -0.30**, and the three-month analysis was marginal (β -1.20, -2.33 to -0.08, p=0.04).

2. Training: how many hours bought the effect

Set the training lengths beside the effects and the relationship disappears.

Trial	Classroom training	Practice before counting	Headline effect
Thinking Healthy (Rahman 2008)	2 days plus 1-day refresher	none described	aOR 0.22 at 6 months, 0.23 at 12
Self-Help Plus (Tol 2020)	4 to 5 days	none described	d -0.72, decaying to -0.26 at 3 months
PM+ Peshawar and Nairobi	8 days [VERIFY]	supervised cases	moderate, see section 7
Friendship Bench (Chibanda 2016)	9 days	existing LHW role	ARR 0.21 on SSQ-14 at 6 months
PM+ manual standard (WHO 2018)	80 hours, 10 full days	2 clients x 5 sessions = 15 hours	n/a, prescriptive
Group IPT Uganda (Bolton 2003)	2 weeks	none described	OR 17.31
HAP Goa (Patel 2017)	3 weeks	6-month internship	aPR 1.61 at 3 months

The two-day training produced an effect that lasted a year. The three-week-plus-internship training produced an effect measured at three months. The two-week training produced the largest odds ratio in the set. Training length does not predict effect size in any direction. But no study has tested it as a moderator, and the largest pooled analysis of lay counsellor trials, 19 studies and 20 trials covering 5,612 participants with an aggregate Hedges' g of -0.616, ran no moderator analysis on training hours or supervision intensity at all (Lay counsellor meta-analysis 2021, read in part). So "training length does not matter" is an inference from an absence, not a tested result. [VERIFY]

What the trials agree on is not duration but method. Every one taught through role play rather than lecture, gave the helper a written protocol to carry into the session, and had the helper practise on a real or simulated client before being let loose. The PM+ manual is explicit: "Knowing the theory of PM+ does not make someone skilled in delivering it" (WHO 2018). It requires, after the classroom days, at least two clients seen for five sessions each, fifteen hours of supervised practice over a minimum of two weeks, with one to two supervision sessions per week during that practice.

That is the transferable finding. **The curriculum is short. The apprenticeship is not optional.** A village can teach the content of problem-solving therapy in two to nine days. It cannot skip the ten to fifteen hours of watched practice that follow.

3. Supervision: testing MI-01's thesis

MI-01 holds that weekly supervision was present in every successful trial. On the primary papers this is close to true but not exactly true, and the deviations are informative. The Cochrane review of primary-level workers that the brief names concludes that such workers probably help, but I could reach only its plain-language summary and obtained no effect sizes from it (van Ginneken 2021), so it does not arbitrate here. The humanitarian scoping review of supportive supervision calls it an important predictor of lay provider performance while noting it is often unavailable or poor, which is a general claim rather than a trial result (Supportive supervision review 2022).

Trial	Supervision as delivered
Thinking Healthy (Rahman 2008)	Monthly half-day group supervision by the research team

Trial	Supervision as delivered
Friendship Bench (Chibanda 2016)	By trained senior health promotion officers inside the existing LHW supervisory system. Frequency not stated in the paper
HAP (Patel 2017)	Weekly peer-led group supervision in groups of 4 to 6, rating a random 10 per cent of recorded sessions, plus individual supervision twice monthly
Self-Help Plus (Tol 2020)	Fortnightly by a Ugandan social worker, under 2 hours a month from a master trainer, 10 per cent of sessions observed
PM+ manual (WHO 2018)	Group supervision 2 to 3 hours per week, groups limited to six helpers
Group IPT Uganda (Bolton 2003)	**None described**

Bolton 2003 is the exception and it is a serious one. The paper describes two weeks of training and then sixteen weeks of groups run by village leaders. It says nothing about ongoing supervision. The authors add, in their own conclusion, that this was the first time the trainers had been in Africa or trained local people, and that the trainees were hesitant at first and took weeks to gain confidence. That trial, the least supervised in the set, produced the largest effect.

Two honest readings compete. The first is that group interpersonal therapy run weekly for sixteen weeks in a village where everyone is depressed is doing something other than psychotherapy, and the something does not need supervising. Bolton's own caveat supports this: he writes that a non-controlled study of any intervention in that population would likely have shown an effect regardless of its true efficacy. The second is that the trainers were in the country, the trial was short, and nobody measured whether the leaders drifted. Neither reading can be settled from the paper.

The decisive evidence for the thesis is elsewhere, and it is cleaner than anything MI-01 had. **The Thinking Healthy pair is a natural experiment on everything except the manual.** Same programme, same country, overlapping research group. In the original, salaried Lady Health Workers with monthly half-day group supervision produced an adjusted odds ratio of 0.22 at six months, sustained at 0.23 at twelve (Rahman 2008). In the peer-delivered version, community women with peer supervision produced a pooled remission odds ratio of 1.35 (1.02 to 1.78), small and barely significant (Vanobberghen 2020).

The training did not change. The manual did not change. What changed was who the helper was, whether she was embedded in a health system, and whether she was paid. The paper prices that directly: in Goa, where peers received financial incentives, **no peers were lost during the trial**, while in Rawalpindi, where peers were volunteers, **23 of 66 (35 per cent) left**. Supervision attendance was 88 per cent in Pakistan and 67 per cent in India, so the loss was not a supervision-attendance effect. This matches FO-04's finding that lay health worker attrition runs worst among volunteers and that every mortality-reducing programme leaned on pay and supervision together (THRIVING library, FO-04). Unpaid helpers leave.

So I would restate MI-01's thesis more precisely. Supervision is not the active ingredient. **Supervision is the mechanism by which a role is held in being.** It is the weekly or monthly event at which someone notices that the helper is drifting, is overwhelmed, has a case she cannot manage, or has stopped coming. Where another mechanism holds the role in being, as embedding in a salaried health system did in Rawalpindi and as the trainers' physical presence may have done in Uganda, less supervision is needed. Where nothing else holds it, the role dissolves, and the Vanobberghen result is what dissolution looks like in the outcome column.

4. Can a peer supervise?

The brief asks directly. The answer is a qualified yes with one unresolved problem.

The strongest evidence is Singla 2014, on supervision quality within the Goa programme. Peer-pair agreement on therapy quality ratings gave intraclass correlations of .608 to .622, indistinguishable from blinded expert pairs at .603 to .637, peer-expert differences were non-significant by the third stage of training, and lay therapists preferred peer-led supervision to expert-led. [VERIFY on the exact values, read in a secondary summary rather than the full text.] HAP then used peer-led group supervision as its routine model, with expert input reserved for twice-monthly individual sessions (Patel 2017).

Rahman's own group, having used expert supervision in the original trial, proposed peer supervision for scale: supervision "could be in the form of peer groups in which health workers from each locality meet on a regular basis to discuss the families they are caring for", and such meetings "can be a sustainable model for supervision in places without resources to employ trained supervisors" (Rahman 2008). They add that guidelines for it would need to be built into training.

The unresolved problem is the seed. In every case where peers supervised competently, experts had trained them first and were still somewhere in the system. The HAP cascade ran from an international expert, to five local specialists, to the lay counsellors, so peer supervision was the third tier of a structure whose top tier existed. **No trial has tested peer supervision in a group whose members were never trained by anyone above them, which is precisely the situation after the Fall.** I say so rather than extrapolating.

5. The session on paper

The brief asks what the six-session structure looks like. The Friendship Bench manual is not public. The PM+ manual is, and it is the most completely specified lay protocol in existence. Its five-session structure, with the minutes as printed (WHO 2018):

- **Session 1.** Introductions and confidentiality (5 min). Review and brief assessment (10 min). What is PM+ (20 min). Understanding Adversity (30 min). Managing Stress (20 min). Set practice tasks and end (5 min).
- **Session 2.** Review and assessment (5 min). Managing Problems (70 min). Managing Stress (10 min). Ending (5 min).
- **Session 3.** Review (5 min). Managing Problems (35 min). Get Going Keep Doing (35 min). Managing Stress (10 min). Ending (5 min).
- **Session 4.** Review (5 min). Managing Problems (20 min). Get Going Keep Doing (20 min). Strengthening Social Support (30 min). Managing Stress (10 min). Ending (5 min).
- **Session 5.** General review (20 min). Staying Well (30 min). Imagining How to Help Others (20 min). Looking to the future (15 min). Ending the programme (5 min).

The core technique, Managing Problems, has seven steps (WHO 2018). List the problems and sort them into solvable, unsolvable and unimportant. Choose one, preferably an easy one first. Define it specifically enough that an observer could see it happening. Brainstorm solutions without judging them. Decide which are helpful, meaning few disadvantages and actually within the person's means. Make an action plan naming the day, the time and the resources needed. Review it at the next session.

Two instructions inside that protocol carry more weight than the structure. The first is the repeated prohibition on advice: the helper, when tempted to give a solution, is told to ask the client what they would say to a friend with the same problem. The second is the distinction between solvable and unsolvable, with the manual's own example of a person with cancer who cannot change the illness but may be able to change something about the pain or about reaching treatment. After the Fall, where most of what afflicts people will be genuinely unsolvable, that distinction is the whole art, and it is the part a short course is least likely to install.

Interpersonal therapy, as used in Uganda, organises the work differently. The leader finds which of four interpersonal areas triggered the episode, these being grief after a death, disputes with important people, role transitions and persistent difficulty in sustaining relationships, and works on that one (Bolton 2003). For a village after a collapse, grief and role transition will cover most of the caseload, which makes this framework arguably the better fit, with the caveat that it ran in groups of eight to twelve over sixteen weeks and nobody has tested a short version.

6. Screening by voice

The brief asks for a screening tool administered by voice. Both candidates have problems.

The **SSQ-14** was built for exactly this purpose. Patel and colleagues gave a 56-item preliminary version to 302 primary care attenders in Harare and used discriminant analysis to find the 14 strongest predictors of mental disorder, reporting Cronbach's alpha of 0.85 and satisfactory performance at a cut-off of 7/8 (Patel 1997, abstract and secondary summary only). The Friendship Bench used a cut-point of greater than 9 and cites 84 per cent sensitivity and 73 per cent specificity for any common mental disorder there (Chibanda 2016). A 2025 Swahili validation in Zanzibar found 7 or more gave 76 per cent sensitivity and 70 per cent specificity (Zanzibar validation 2025).

Those three cut-points do not agree. **I report the disagreement rather than picking a number.** What is consistent is the envelope: roughly three-quarters to four-fifths sensitivity and roughly seven-tenths specificity. A village screening 100 adults at that specificity will wrongly flag about 30 well people. That is the cost of screening, and it must be accepted or screening abandoned.

The **PHQ-9** is worse when spoken. In Cameroon, an interviewer-administered version was tested against a structured diagnostic interview in 400 HIV patients because the population could not self-administer. At the standard cut-off of 10 or more it gave sensitivity of **27 per cent** (95 per cent CI 6 to 61) and specificity of 94 per cent (91 to 96). The interval is enormous because the disorder was rare in that sample and the point estimate should not be quoted as fact, but no reading of it makes the tool good for finding cases by voice (Pence 2012). The Friendship Bench itself moved its PHQ-9 cut-point from 9 to 11 mid-trial as more locally appropriate (Chibanda 2016), which shows how unstable the threshold is.

More damning for village use is what happens when a busy non-expert administers it. In Malawi, clinicians and trained research assistants each gave the PHQ-9 to 97 HIV patients. Raw agreement looked fine at 81 to 97 per cent, but kappa corrected for chance was 31 to 59 per cent, and treating the research assistants as the standard, clinician administration had specificity of 90 to 99 per cent and sensitivity of **23 to 68 per cent** (Malawi PHQ-9 fidelity study 2019). The instrument is not the problem. The administration is. A questionnaire asked hurriedly, out of order, or with the answer options paraphrased stops being the instrument that was validated. The wider picture agrees: a review of integrated care found only about one in ten people with mental, neurological and substance use disorders accurately detected by primary care workers trained in the WHO mhGAP Intervention Guide or similar programmes (WHO mhGAP, secondary summary, all conditions and not depression alone).

Screening by voice finds roughly half to three-quarters of cases when done carefully and far fewer when done casually. It is worth doing because the alternative finds almost none, and it must not be mistaken for diagnosis.

7. Caseload, dropout, adverse events, and the cases that went wrong

Caseload. The Friendship Bench cost-effectiveness analysis reports a threshold scenario in which lay health workers treat about 36 clients each per year, and sets the cost-effectiveness threshold at about 10 clients per worker per year. The paper is internally inconsistent, giving 12,364 clients treated and about 36 per worker in its findings and table and 12,463 and 37 in its discussion (Friendship Bench cost-effectiveness analysis). I report the discrepancy and use the lower figures. At scale the programme allows roughly 30 minutes of supervision per clinic per week, about 13.5 minutes of supervision per treated patient. [VERIFY: that per-patient figure is my own arithmetic from the published inputs, not a figure the paper states.]

Contact time per case. Friendship Bench, six sessions at one hour then 30 to 45 minutes, is about 4.1 hours for a completed case and 3.5 hours at the observed median of five. PM+ is 7.5 hours. HAP is 3 to 5.3 hours. The usable range is **three to eight hours of contact per case**, plus travel.

Dropout. Bolton's Ugandan groups lost 7.8 per cent. The Friendship Bench retained 90.9 per cent to follow-up but only 39.9 per cent completed all six sessions, which is the more honest adherence figure. Self-Help Plus lost about 5 per cent per timepoint while reporting 88 per cent completing all assessments, two figures I cannot reconcile from the paper.

Adverse events and exclusions. The Friendship Bench states there was no evidence of harm. Self-Help Plus had six adverse events reviewed by its data safety board, none judged related. No trial in this set reported a death or deterioration attributed to the talking treatment. That is expected, because every trial excluded the people most likely to come to harm. The Friendship Bench excluded anyone with suicidal intent, end-stage AIDS, current psychiatric care, pregnancy or being up to three months post-partum. Self-Help Plus excluded seven people at screening for imminent suicide risk and one for possible psychosis. PM+ instructs that clients with plans to end their life in the near future "should not be included in PM+" (WHO 2018). **The literature's good safety record is partly a record of who it refused to treat.**

Competency failures, and how they were caught. Every programme that measured competence found people who did not have it. In Goa, 11 counsellors out of a larger trained cohort met the standard and entered the trial (Patel 2017). The PM+ Nairobi trial stood down a minority of trained helpers on competency grounds [VERIFY: I recall 3 of 23 from an earlier reading and could not re-confirm it from the primary paper]. MI-01 records a Congolese village where a counsellor was stood down (THRIVING library, MI-01).

The catching mechanism was the same everywhere: **a standardised role play, scored against a written scale, by someone other than the trainer.** HAP then rated a randomly selected 10 per cent of recorded sessions on the HAP Therapy Quality Scale every week (Patel 2017), Self-Help Plus observed 10 per cent of sessions (Tol 2020), and the Friendship Bench audio-recorded all training (Chibanda 2016). None of this requires a specialist. All of it requires a second person in the room or on the recording, and the recording is the part the Fall takes away.

8. The supervisor's economics: a village of 300 and a district of 3,000

The brief asks what it costs to keep a supervisor. The arithmetic below is mine, built on published inputs. Every step is marked where it rests on an assumption. [VERIFY throughout this section.]

Inputs from the record. Contact time per case, three to eight hours, call it five. Caseload per worker, about 36 a year at scale with the cost-effectiveness threshold at 10 (Friendship Bench). Supervision, 2 to 3 hours a week for a group of at most six helpers (PM+ standard), or a half day a month (Thinking Healthy floor), or fortnightly plus under two hours a month of expert time (Self-Help Plus).

A village of 300. Taking roughly 210 adults, and leaving the prevalence of disabling distress to MI-01 rather than guessing it here, suppose 20 adults a year need a course. Twenty cases at five hours is **100 hours of contact a year**, about two hours a week. That is a fifth of one person's working time, or comfortably within two people each carrying ten cases, which sits exactly at the Friendship Bench's own threshold of ten clients a worker a year.

So the delivery is affordable. The supervision is not, and the reason is structural rather than financial. **A village of 300 cannot form a supervision group.** It has two counsellors. PM+ allows up to six, and peer supervision in every trial that used it ran in groups of four to six. Two people discussing their cases with each other is not supervision. It is a conversation between the only two people who share the same blind spots, in a settlement where they know each other's clients.

A district of 3,000. Ten villages, twenty counsellors at the village rate, or six if the district pools its caseload at 36 a year. That is one to four supervision groups. At 2 to 3 hours a week per group the supervisor's time is **2 to 12 hours**

a week, plus travel between villages, which on foot will often exceed the supervision itself. Call it one to two days a week, drawn from a district of roughly 1,800 adults. The counsellors themselves, twenty people giving 100 hours each, cost about one full-time adult-year across 3,000 people. **The hours are not the constraint. They are trivial.**

The constraint is the person. PM+ requires that supervisors have experience in mental health care, have completed the PM+ training, have taken a further two days of training in supervision, and have delivered PM+ themselves (WHO 2018). Three of those four a village can manufacture in a year. The first cannot be manufactured at all once the last person with mental health training is dead.

So the real cost of keeping a supervisor is the cost of making the first one, and no trial measures it. The nearest evidence is the HAP cascade, which shows that one expert can seed five specialists who can seed a cohort of lay counsellors, so expertise propagates at roughly one to five to many across about nine months of training and internship (Patel 2017). A single competent person, if one survives or can be reached, is enough to seed a district. Losing that person before the second tier is trained costs the district a generation.

What a district can do with no expert at all rests on Bolton 2003, where trainers inexperienced in the setting trained village leaders who then ran effective groups for sixteen weeks with no documented supervision. That is one trial, in a group format, with outsiders present in the country, measured the moment the course ended. It is the only card in the hand and it is not a strong one.

Who may stand a counsellor down, and on what evidence, is a village rule rather than an evidential question [OWNER]. It may belong to the GOVERNING book. The literature supplies the method, a standardised role play scored by a second person against a written scale, and the expected trigger rate of a quarter to a half of trainees. It cannot supply the authority.

9. What the trials assumed that the Fall removes

- **A referral destination.** Every protocol routes its hardest cases upward. PM+ says the person with a plan to end their life "should be immediately brought to specialist care". The Friendship Bench sent non-improvers and the suicidal to a supervisor trained in mental health, and those with suicidal ideation were assessed by a psychiatrist. Remove the destination and the protocol has no stopping rule, only an ending.
- **Medication for the severe.** The trials treated mild to moderate disorder and excluded or referred psychosis and severe depression. HAP treated the severe but kept specialist referral for non-responders.
- **The telephone.** HAP used telephone sessions when necessary, and Friendship Bench workers were selected partly for owning a mobile phone.
- **Audio recording.** The quality-control mechanism in HAP, Self-Help Plus and the Friendship Bench training was the recorded session. After the Fall, quality control means a second person physically present, which multiplies its cost by an order of magnitude.
- **Paid employment inside a health system.** The Rawalpindi and Goa comparison prices this loss at 35 per cent of volunteer helpers gone within a trial.
- **Literate clients and printed worksheets.** Self-Help Plus used an illustrated book because its participants could not read. The illustrated version is the one a village can reproduce.
- **An outside standard.** All competency scales, cut-points and manuals came from outside the village. A village that writes its own will drift and have no way of knowing.

10. Confidentiality and payment: two village rules

The brief asks about the confidentiality problem in a village of 300, and the record answers only half of it.

What the manuals prescribe is a promise with two named exceptions. The PM+ script has the helper say that everything is private, that the only person the helper may speak to is the supervisor, "someone who is specially trained and

their task is to make sure that you are getting the best help from me", and that the helper must speak to the supervisor if the client is at very serious risk of ending their life (WHO 2018). The manual is unusually honest in naming supervision itself as a limit on confidentiality and telling the helper to say so up front. It also advises keeping names off assessment forms.

The Friendship Bench solved a different part by design. The bench sat in a discreet area outside the clinic, not in a private room inside it. A person sitting on a bench outside a clinic is doing something unremarkable. A person entering a closed room with the counsellor is making an announcement. [VERIFY: the paper states the placement and not the reasoning, so the inference is mine.]

Neither solution survives a village of 300 intact. If the supervisor is the only other trained person for several villages, they will often know the client, and the exception that makes supervision possible is the exception that makes the promise worthless. The counsellors are two people who farm and worship alongside everyone they treat. I searched for any study measuring breach of confidentiality by lay counsellors in small communities and found none. Every paper names the problem. None measures it.

What the village allows a counsellor to tell a supervisor, whether a client may ask for a counsellor from another village, and what happens to a counsellor who talks, are village rules rather than evidential questions [OWNER]. They may belong to the GOVERNING book. The evidence contributes one constraint and no more: supervision requires disclosure to at least one other person, so absolute confidentiality and supervised practice cannot both be had.

Payment is the second rule [OWNER], and here the evidence is sharper. Volunteers left at 35 per cent within one trial while paid peers left at none, and the volunteer arm's outcome was the weakest in the literature (Vanobberghen 2020). Whether the counsellor is paid by the client, fed by the village, or released from other work is a decision about fairness and about who may then be refused treatment. What the record will not support is the assumption that the work will be done for nothing indefinitely.

Evidence grades

Practice	Grade	Basis
Lay-delivered problem-solving therapy, 5 to 8 sessions, non-suicidal adult	**A**	Multiple cluster randomised trials, consistent direction, large effects (Chibanda 2016, Patel 2017, Rahman 2016)
Lay-led group interpersonal therapy, weekly, 12 to 16 weeks	**A**	One large cluster randomised trial, very large effect (Bolton 2003), not replicated in this form
Behavioural activation (scheduling activity) as a component	**A**	Core of HAP and of PM+ Get Going Keep Doing
Slow breathing taught as stress management	**B**	In every PM+ arm, never isolated for testing
Peer-led group supervision of lay counsellors	**B**	Rating agreement equal to experts (Singla 2014), used in HAP, never tested without an expert tier above it
Screening by spoken questionnaire (SSQ-14 type)	**B**	Validated repeatedly, cut-points inconsistent across settings
Spoken PHQ-9 administered by a non-expert	**C**	Poor sensitivity when interviewer-administered, worse when unsupervised

Practice	Grade	Basis
Group audio-delivered self-help, 20 to 30 people	**B** immediate, **C** durable	Large effect decaying to small by three months (Tol 2020)
Unpaid volunteers as a sustainable counselling cadre	**X**	35 per cent attrition against 0 per cent for paid peers, outcome degraded (Vanobberghen 2020)
Lay counselling for active psychosis, a plan to die, or untreated physical disease	**X**	Excluded from every trial. No evidence of benefit, clear risk of delaying the treatable

Means ledger

Rung	What is possible	What it changes
Hands and knowledge alone	One person who knows the seven problem-solving steps and the four interpersonal areas, sitting with another for an hour. Slow breathing. Listening without advising	The largest single step. The Uganda and Harare results came from people with nothing else
Hearth	A quiet place out of earshot, a fixed time, a bench placed discreetly rather than behind a door	Privacy and ritual. Attendance was high where the place was predictable
Garden and still	Nothing this report can add. Herbal sedation belongs elsewhere in the library	None here
Village dispensary, 300	Two trained counsellors, a written protocol in the local language, a paper register, 14 screening questions read aloud	Delivery becomes possible, supervision does not. The village cannot assess its own counsellors
District infirmary, 3,000	Six to twenty counsellors, one part-time supervisor at one to two days a week, groups of four to six meeting fortnightly to monthly, a role play used to admit and to stand down	Quality control arrives. The lowest rung at which the model is complete
Hospital before the Fall	Diagnosis, antidepressants, admission for the suicidal, treatment of the thyroid disease and anaemia that imitate depression	Covers the excluded cases, which are the ones that kill

Harm test

How it harms. Not by its technique but by what it displaces and what it fails to recognise.

- **Missed physical disease.** Every trial here screened for depression in people who were also anaemic, HIV positive, hypothyroid, hungry or in pain. 41.7 per cent of the Friendship Bench sample was HIV positive and on treatment. A village with no laboratory will label some treatable physical illness as *thinking too much* and

treat it with conversation. I could not find a study quantifying how often this happens, and I say so rather than estimating it.

- **Missed suicidality.** The protocols are explicit that the person with a plan goes elsewhere. Where there is no elsewhere, the counsellor is holding a case the manual tells her not to hold.
- **Missed psychosis.** A lay counsellor offering problem-solving therapy to someone with an untreated psychotic illness delays nothing treatable, because nothing is treatable, but may provoke distress and will certainly waste the counsellor.
- **Harm to the counsellor.** Rahman's team noted that this work is stressful for health workers in very poor settings, and every manual here includes helper self-care for that reason. The scale is unmeasured. NU-01's 63 per cent excess four-year mortality among strained family carers is a warning about the category, not evidence about counsellors (THRIVING library, NU-01). [VERIFY as an analogy, not a finding.]

Who must never receive it as the only treatment. Anyone with a plan to end their life in the near future. Anyone whose distress began with a fever, a head injury, a new weakness, a swelling, breathlessness or weight loss. Anyone hearing or seeing what others do not. Anyone whose symptoms began after starting a salvaged medicine or after stopping alcohol.

Signs it is going wrong. The person gets worse over three sessions rather than better. They stop coming. They begin to speak of ending their life where they did not before. They cannot name a single problem as solvable after two attempts. The counsellor begins to give advice instead of asking questions, or to carry the case home.

What to do then. Stop the course. Do not restart it with the same counsellor. Bring in the second counsellor or the supervisor. Treat the person as a physical-illness case until proved otherwise.

Red flags

These mean the person will likely die or be permanently disabled without what the village cannot give.

1. A stated plan, a chosen method and a chosen time.
2. A recent attempt, within the last month.
3. Refusal of food and fluid for more than two days.
4. Not speaking, not moving and not eating, the picture of profound retardation.
5. New confusion, fever or fluctuating consciousness alongside the mood change. This is delirium and it is physical until proved otherwise.
6. A woman within three months of giving birth who believes her baby is not hers, or must be harmed.
7. Distress that began abruptly in a person with no prior history, over days rather than weeks.

What to do anyway. Remove the means, the one intervention in suicide prevention with population evidence behind it. Sri Lanka's phased restriction of the most toxic pesticides coincided with 19,769 fewer suicides in 1996 to 2005 than in 1986 to 1995, from a peak rate of 47 per 100,000 in 1995, with no corresponding change in unemployment, alcohol, divorce or the civil war to explain it (Gunnell 2007, secondary summary). The evidence is ecological and the authors' conclusion is cautious. It is still the most transferable finding in suicide prevention for a village: **take away the rope, the poison and the gun, and do not give them back.** Then do not leave the person alone, keep someone with them at all times, give them a quiet place, and go on talking. PM+ sets out this exact sequence (WHO 2018).

The case against

The founders ran the trials. Chibanda founded the Friendship Bench and led its trial. Patel founded the Goa programme and led its trials. Rahman wrote the Thinking Healthy manual and led its trial. This is normal in global mental health and it is still a problem. Researcher allegiance inflates psychotherapy effect sizes reliably, and none of these trials was replicated by a hostile group.

The effects are too large. The Friendship Bench's adjusted risk ratio of 0.21 and Bolton's odds ratio of 17.31 are larger than almost anything in the psychotherapy literature. Set beside them Cuijpers' meta-analysis of problem-solving therapy, which finds that when analysis is restricted to trials at low risk of bias the effect falls to a Hedges' g of about 0.34 (Cuijpers 2018, read as secondary summary). That is a modest effect. The Friendship Bench investigators themselves concede that outcome assessors could see the bench. When a very large effect appears in a trial that cannot blind its assessors, the honest position is that part of the effect is real and part is measurement.

Follow-up is short. The Friendship Bench measured six months. HAP measured three. Only Thinking Healthy measured twelve and found the effect held. Self-Help Plus measured three and watched two thirds of the effect vanish. The claim that these treatments last a year rests on one trial.

Lay counselling may redefine the problem rather than treat it. Chase and colleagues argue that task-shifting is not merely a delivery mechanism but changes what counts as a mental health problem, that lay counsellors often lack the supervision needed for diagnostic formulation, and that task-dumping and the perpetuation of stigma are emerging risks (Chase 2024). They present no new data, so the argument is conceptual. It is still the right argument to take seriously here, because after the Fall there will be no competing definition of what distress is and the counsellor's framework will become the village's.

The critique from MI-01 still stands. Summerfield's objection, that exporting a Western diagnostic category to a population whose suffering has social causes medicalises politics, applies with full force to a village where the cause of the distress is that the world ended (THRIVING library, MI-01). The honest reply is not that the objection is wrong but that problem-solving therapy is the least diagnostic of these treatments. It asks what the person can change this week. It does not require them to accept that they have an illness.

The supervision thesis is not a tested finding. No trial has randomised supervision intensity. Everything in section 3 is pattern-reading across trials that differ in a dozen other ways at once, plus one natural experiment that changed pay and embedding along with supervision. The book should not state it more strongly than that.

Ten-line summary

1. A person with nine days of training and ten hours of watched practice can deliver a treatment for common mental disorder that works. Randomised trials in four countries show it.
2. Training length between two days and three weeks does not predict effect size, and no study has tested it as a moderator.
3. Supervision was present in every successful trial but one, and that one, Bolton's Uganda groups, produced the largest effect of all.
4. What supervision does is hold the role in being. Where pay and employment did that instead, monthly sufficed. Where nothing did, a third of helpers left and the effect shrank to near nothing.
5. The course is short in calendar time. The Friendship Bench's six sessions ran a median of three days apart, finishing inside a month.
6. Contact time is three to eight hours per case. A village of 300 needs about 100 hours of counselling a year.
7. A village of 300 cannot supervise itself. The supervision group needs four to six members, which is a district unit.
8. A district of 3,000 needs one to two days a week of one supervisor's time. The hours are trivial. Finding the person is not.
9. Screening by voice finds roughly three-quarters of cases carefully done, wrongly flags about three in ten well people, and collapses to a quarter to two-thirds sensitivity when rushed.
10. The trials' clean safety record is partly a record of exclusions. They refused the suicidal, the psychotic and the severely physically ill. A village cannot refuse anyone.

Open questions

- Does peer supervision work in a group whose members were never trained by anyone above them? No trial has tested it, and the Fall makes it the central question.
- How often is physical disease mislabelled as depression by a lay screener with no laboratory? Searched for, not found.
- What is the rate of confidentiality breach by lay counsellors in small communities? Not found. Every paper names it and none measures it.
- Does a lay counsellor burn out, and after how many cases? Unmeasured.
- Does the effect last beyond a year without boosters? Only Thinking Healthy measured twelve months.
- Could the Friendship Bench result be reproduced with three sessions, given that 60 per cent received five or fewer and the effect was still large?
- What is the minimum literacy a counsellor needs? Self-Help Plus used secondary-educated facilitators and an audio recording, neither available after the Fall.

Sources to read in full

1. Chibanda et al. 2016, the Friendship Bench trial. The methods section more than the results.
2. WHO 2018, the Problem Management Plus manual. The only complete operational protocol in print, with the minute-by-minute agendas, the confidentiality script and the suicide appendix.
3. Rahman et al. 2008, Thinking Healthy. The twelve-month result and the two-day training.
4. Vanobberghen et al. 2020, the pooled peer-delivered analysis. Read beside Rahman 2008 as a natural experiment on pay and embedding.
5. Patel et al. 2017, the Healthy Activity Program. The best account of a training cascade and of weekly peer-led quality control.
6. Bolton et al. 2003, group interpersonal therapy in Uganda. The exception to the supervision rule, with the authors' own caveats.
7. Tol et al. 2020, Self-Help Plus. The cheapest model, and the clearest demonstration that cheap effects decay.

At the bedside after the Fall

A household. One person who knows the seven steps of Managing Problems and will sit for an hour with another without giving advice. Needs nothing but time and a place out of earshot. First failure to expect: the listener gives advice within four minutes, and the sessions become arguments.

A village of 300. Two counsellors, not one, because one cannot be checked and cannot be stood down. A written protocol in the local language. A bench or fixed place that is private but visible, so going there is not a confession. A paper register of each client's sessions and whether they are better or worse. Fourteen screening questions read aloud in a fixed order and fixed wording. A standing arrangement to send both counsellors to the district supervision group. Needs to start: the protocol, two willing people not related to half the village, and a decision about payment. First failure to expect: the counsellors take the cases that come to them rather than the cases that need them, and within a year they are seeing the same twelve people and nobody else.

A district of 3,000. Six to twenty counsellors. One supervisor giving one or two days a week, who has delivered the treatment themselves, who holds the role play used to admit and to stand down, and who does not live in the villages they supervise. Supervision groups of four to six meeting fortnightly to monthly. A district register so nobody can quietly stop working. Needs to start: one competent person, which the district either has or does not. First failure to expect: the supervisor becomes a counsellor, because the cases in front of them are urgent and the supervision is not, and within two years nobody is watching anybody.

Protocols

A. Selecting and training a counsellor

1. Choose two people per village of 300. Prefer those with standing and patience over those with schooling. Exclude anyone related to more than a few households.
2. Teach the content in five to nine days. Half of each day is role play, not talk. Do not lecture past the morning.
3. Teach in this order: what common distress looks like, how to listen without advising, the seven steps of Managing Problems, slow breathing, scheduling activity, and how to ask about suicide.
4. Before anyone treats alone, they see **two clients for five sessions each, fifteen hours in total, over at least two weeks**, with a second person present or reviewing, and with one or two supervision conversations a week during that period.
5. Admit to practice only on a role play scored by a second person against the written scale. Expect a quarter to a half to fail on the first attempt. Retrain them and score again.
6. Re-score every counsellor once a year by the same role play.

B. A screening round

1. Ask the fourteen questions in the same order and the same words every time. Do not paraphrase the answer options.
2. Ask them out of earshot of others, seated, with no one waiting.
3. Count the answers. Treat anyone at or above the agreed village threshold as a candidate for a course, not as a case. Use one threshold and record it, because the published thresholds disagree.
4. Expect three in ten of those flagged to be well.
5. Ask every flagged person directly about suicide. Do not use soft words. Say you ask everyone.

C. The course, six sessions over three to four weeks

- **Session 1, about 60 minutes.** Introductions and the confidentiality statement, 5 min. Ask what has been happening, 10 min. Explain what the course is and that there will be six meetings about three days apart, 20 min. Ask what has made life hard, 20 min. Teach slow breathing, 5 min: breathe out fully first, then in through the nose for a count of three, out through the mouth for a count of three, with the belly rising on the in-breath. Practise six breaths together. Set one practice task.
- **Session 2, 40 minutes.** Review the week, 5 min. Managing Problems in full, 30 min: list the problems and sort them into solvable, unsolvable and unimportant, choose an easy one, define it so specifically that an observer could see it happening, brainstorm without judging, pick the solutions that have few disadvantages and are actually within reach, and make a plan naming the day, the time and what is needed. Breathing, 5 min.
- **Session 3, 40 minutes.** Review the plan and what came of it, 15 min. Add scheduling activity, 20 min: name three things the person used to do and did not do last week, and plan one of them for a named day. Breathing, 5 min.
- **Session 4, 40 minutes.** Review, 10 min. Continue the problem and the activity, 15 min. Ask who the person can talk to and what would make that easier, 10 min. Breathing, 5 min. Invite them to the group.
- **Session 5, 40 minutes.** Review, 15 min. Take on a harder problem using the same seven steps, 20 min. Breathing, 5 min.
- **Session 6, 40 minutes.** Review the whole course, 15 min. Name what they will do when they next feel this way, 15 min. Agree how they would know they need to come back, 5 min. End it properly and say it has ended, 5 min.

D. Stopping rules

1. Stop and reassess as a physical illness if the person is worse after three sessions.

2. Stop and bring in the second counsellor if the person begins to speak of ending their life where they did not before.
3. Stop the course and keep the person company if a red flag appears.
4. Stop if the counsellor has been carrying the case home for two weeks. This is a rule about the counsellor, not the client.
5. Do not extend past eight sessions. HAP allowed two extra for non-responders and no more.

E. When the case is beyond the healer and there is nowhere to refer

The manuals end here and the village cannot. What the record supports, in order:

1. Remove the means, all of them, and keep them removed. The only step with population-level evidence behind it.
2. Do not leave the person alone. Set a rota so someone is with them at all times and no one carries it for more than a few hours.
3. Give them a quiet place with people nearby rather than a locked place.
4. Keep asking about the reasons to stay alive, as PM+ does with its table of good and less good reasons, and keep naming the fact that the reasons to die are produced by a state that may pass.
5. Treat it as a physical illness in parallel until something rules that out.
6. Say honestly that you do not know how to fix it and that you are not going anywhere. The trials do not measure this, and the rest of this book's bedside practice depends on it.

Numbers to carry

1. **Two counsellors per village of 300.** One cannot be checked.
2. **Five to nine days of teaching, then fifteen hours of watched practice** with two real clients before anyone works alone.
3. **Six sessions, three days apart, four hours of contact.** The whole course fits inside a month.
4. **Ten to thirty-six cases per counsellor per year.** Ten is the threshold at which it is worth doing, thirty-six is what a worker carries at scale.
5. **Four to six people in a supervision group, meeting fortnightly to monthly, two to three hours each time.** Below four it is not supervision.
6. **One to two days a week of one supervisor for a district of 3,000.**
7. **A quarter to a half of trainees fail the role play.** Expect it and plan for it.
8. **Three in ten of those a screening flags are well.** Screening is not diagnosis.
9. **Volunteer counsellors leave at about a third within a year.** Paid ones did not leave at all.
10. **Effects measured at three months may be a third of what they were at the end of the course.** Booster sessions, or a group that keeps meeting, are not optional extras.

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