THE POTENTIAL OF TASK-SHARING TO IMPROVE THE MENTAL HEALTH SUPPORT AVAILABLE TO WOMEN WHO ARE SINGLE PARENTS ON LOW INCOMES IN SCOTLAND

By

Natalie Dewison-Koplinski

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Natalie Dewison-Koplinski

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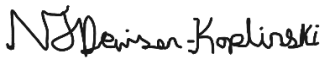
Signed:  Date: 24/10/2024

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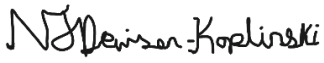
Signed:  Date: 24/10/2024

UNIVERSITY OF STRATHCLYDE

ABSTRACT

The potential of task-sharing to improve mental health support for women who are single parents on low incomes in Scotland

by Natalie Dewison-Koplinski

Chairperson of the Supervisory Committee: Professor Marion Henderson

This thesis explores opportunities to improve the mental health support available to women who are single parents on low incomes who experience disproportionately high rates of mental health problems and multiple practical and perceptual barriers to mental healthcare. It responds to calls for research looking at how to maximise peer roles within health contexts in Scotland. Focusing on the concept of 'task-sharing', I consider the ways in which people with 'lived experience' (community health workers) have been recruited into health and social care systems to make mental health support more accessible, feasible and meaningful for marginalised groups. Given the emphasis on 'community', and the acknowledgment of broader contextual issues causing health inequalities, such approaches have been situated under a social model of health. This presents challenges within health settings which are underpinned by hierarchical staffing structures and continue to privilege biomedical knowledge. I argue that this has led to practices better described as 'task-shifting' due to the emphasis on 'unburdening' health professionals and limited opportunities for knowledge sharing.

Drawing on examples from the global literature, this thesis explores opportunities for people with lived experience to apply their knowledge and skills in new ways, namely, shaping the design and delivery of talk therapies. Working alongside a small group of women and wider stakeholders, this study addresses a gap in participatory research on the subject area which both centers lived experience and involves health professionals. Through a series of workshops, research participants drew on their experiential knowledge in critical discussions about the feasibility of concepts and tools within interpersonal counselling (IPC) and the place of peer support in its delivery. Findings point to the existence of knowledge hierarchies within the field of mental health that threaten to limit the transformative potential of 'task-sharing' and warrant further investigation.

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Glossary of key terms

Cognitive Behavioural Therapy (CBT) - CBT is a short-term, structured therapy which can help people with anxiety or depression as well as other mental health issues such as obsessive-compulsive disorder (OCD) (NHS, 2020). It is designed to help individuals understand how their thoughts may be influencing their feelings and actions and work to address 'unhelpful' thought patterns. It is a practical, goal-oriented approach, typically conducted over 8-16 sessions by a trained practitioner, focusing on present-day issues.

Community Health Worker (CHW) – CHWs are individuals recruited from marginalised communities to extend and, in some cases, improve the feasibility of health-related services for community members. CHWs often share the same social and/or cultural background to community members (e.g. ethnicity, language, socioeconomic status, life experiences). The responsibilities of CHWs vary but can include information sharing, advocacy, signposting, counselling and building community capacity to address health inequalities.

High income countries (HIC) - The World Bank classifies countries and territories into four categories based on their gross national income (GNI) per capita; low, lower-middle, upper-middle, and high-income. This term refers to countries in the 'high-income' category. A full list of country classifications can be found here.

Interpersonal counselling (IPC) - IPC is a reduced form of IPT (see below), typically conducted over fewer sessions (six), which are usually shorter in length (30-45 minutes) (Kontunen et al., 2020). It is manualised for use by professionals without a background in mental healthcare (e.g. youth workers) and was developed in response to the pressure placed on mental health services to meet the growing demand for psychotherapy (Weissman et al., 2014). The focus on interpersonal problems related to difficult life transitions, disputes, bereavement or social isolation remains the same. IPC has predominantly been used to address symptoms of distress, depression and anxiety. A more detailed overview can be found in chapter 2 of this thesis.

Interpersonal therapy (IPT) - Much like CBT (above), IPT is a time-limited structured therapy, focusing on present-day issues, typically conducted over 8-16 sessions with a trained practitioner (Weissman et al., 2014). It draws on a range of tools and strategies to address current interpersonal problems related to difficult life transitions, disputes, bereavement or social isolation. It was originally

developed to treat depression but has since been used to address other mental health issues such as eating disorders.

Lived experience - In the context of this research study, 'lived experience' (or 'lived expertise') refers to the knowledge, understanding, insights and perspectives gained through first-hand experience of marginalisation (see below). Within this thesis, I break down the concept of lived experience further, distinguishing between 'experiential knowledge' - knowing how to help people who have been through similar life experiences - and 'embodied knowledge' as something 'innate' within individuals/communities that can support connection e.g. phrasing or body language (Yoeli and Cattan, 2017).

Low- and Middle-Income Countries (LMIC) - The World Bank classifies countries and territories into four categories based on their gross national income (GNI) per capita; low, lower-middle, upper-middle, and high-income. LMIC thus refers to countries in the first three of these four categories. A list of LMIC is compiled and reviewed every three years by the Organisation of Economic Co-operation and Development and can be found here.

Marginalised groups – Marginalised groups (also referred to as 'marginalised communities' or 'marginalised populations') refers to people who are systematically excluded from social, economic and/or political life and/or experience discrimination based on characteristics such as gender, class, religion, race, disability and employment status. These characteristics can be perceived to deviate from the 'norm' in mainstream society, for example, single parenthood.

Racially minoritised groups – this term refers to people who have been marginalised because of the colour of their skin or other religious or cultural factors within a White majority system. I choose to use the term 'racially minoritised' instead of 'Black and Minority Ethnic (BAME)' as it draws attention to the socially constructed nature of these categorisations, the active minoritisation by others as a social process and avoids making assumptions about self-identification (Milner and Jumbe, 2020).

Task-sharing – In the context of this study, 'task-sharing' refers to the collaborative completion of tasks by workers and volunteers in different parts of health and social care systems.

Task-shifting – This commonly used term is defined by the WHO (2008) as the redistribution of tasks amongst healthcare teams. More specifically, the transference or delegation of tasks from highly qualified health professionals to

those with fewer qualifications and/or limited training, including CHWs (see above).

Women who are single parents on low incomes - I use this term to describe the participant group for this study, as women who are no longer in a relationship with the other parent of their child(ren) and are on a low household income. It includes women who co-parent and those who have no contact with ex-partners/ex-partners are not involved in their child(ren)'s lives. Whilst participants agreed that there was no 'ideal' term to describe their situations, given issues related to stigma explored throughout this thesis, the term 'single parent' was preferred.

RESEARCH CONTEXT AND SETTING

Poverty, single parenthood and mental health in Scotland

In 2018, the mental wellbeing of adults in Scotland was reported to be at the lowest level since 2008[1] (Scottish Government, 2019). Longitudinal data gathered by the Scottish Government revealed further deterioration in mental health and wellbeing following the COVID-19 pandemic (Wetherall et al., 2021). At the time of writing, rates of reported anxiety in Scotland are yet to return to pre-pandemic levels (MHF, 2023). The reported levels of depression and anxiety in the most deprived areas are double that of the most affluent parts of the country (JRF, 2017). There is growing evidence that COVID-19 and the cost-of-living crisis exacerbated existing inequalities in mental health, leading to disproportionate levels of anxiety amongst single parents due to financial stress (Bambra et al., 2021; Scottish Government, 2023a). The bi-directional relationship between destitution and mental health has been well documented; a range of structural and individual factors including unstable employment, debt, housing issues and relationship breakdown can result in mental health problems which can cyclically compound these issues (MHF, 2020). The experience of poverty is shaped by other marginalising characteristics contributing to our social identities which in turn affect our health (Seng et al., 2012); there is a call for more research looking at the ways in which factors such as gender, race, ethnicity, economic background, and disability intersect to better understand the complexity of experiences (Bixby, 2024).The Scottish Government acknowledged the potential value of 'intersectionality' to support a more nuanced understanding of these interlinkages within the latest mental health and wellbeing strategy (Scottish Government, 2023b). Introduced as part of the Black feminist movement to better understand the multiple dimensions of Black women's oppression, the concept 'account[s] for the multiple grounds of identity when considering how the social world is constructed' (Crenshaw, 1997: 1244). There has been growing interest in 'intersectionality' as a framework for understanding and actioning on health inequalities, yet uncertainty around how to apply this in policy and practice (Holman et al., 2021). The concept of intersectionality is central to this thesis and is introduced as a key theoretical framework later in this chapter.

[1] Based on the mean score of adults and teenagers measured through the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

Single parent families are twice as likely to live in poverty than couple parent households (OPFS, 2021). Data suggests that just over one in five households with children in Scotland are single parent families; around 90% of these are headed by women (Scottish Government, 2019). Whilst the number of single parent families has remained 'fairly constant' in recent years, the National Records of Scotland (NRS) projected that the proportion would rise from 6% of all households in 2016 to 22% by 2041 (NRS, 2018: 23). In an analysis of longitudinal data on the maternal mental health of mothers gathered through the 'Growing up in Scotland' (GUS) study, the Scottish Government found that single mothers were more likely than mothers in couples to experience periods of poor mental health including both brief (23% compared to 16%) and repeated episodes (27% compared to 11%) (Marryat and Martin, 2010). Graham and McQuaid (2014) emphasise the importance of a multivariate analysis to understand the range of factors associated with poorer mental health within this household type. This includes social isolation, loneliness, domestic abuse, low confidence and self-worth, relationship problems (for example dealing with an ex-partner or introducing a new partner), time poverty and childcare issues, all of which are heightened by the experience of poverty and unemployment (Graham and McQuaid, 2014; Jun, 2018; Anderson, 2019). There is also said to be an above average proportion of single parents in Scotland who have disabilities (Taulbut et al., 2016).

One of the biggest challenges for single parents is the lack of continuous, secure employment heightening vulnerability during periods of austerity and welfare reform. In a survey of 1000 Scottish parents commissioned by Parents across Scotland (PAS) in 2015, 33% of single parents had fallen into debt with some bills or credit commitments in the last year compared to 11% of those in couples. Glasgow and Edinburgh have some of the highest rates of one parent families of all Scottish local authority areas, combined with some of the lowest employment rates for this group (Taulbut et al., 2016). Comparative analysis of survey data has found that single parents in Scotland experienced greater worry about financial concerns during the pandemic than other groups in potentially vulnerable situations (Cameron et al., 2021). Single parents engaging with OPFS reported losing access to support networks due to the rules around shielding, yet 'feeling increasing pressure' from the Department for Work and Pensions (DWP) to look for employment, which they felt did not account for their personal circumstances (OPFS, 2021). Women escaping situations of domestic abuse during lockdown found themselves isolated in new locations, with limited access to services (Brooks-Hay et al., 2022). In a poll of 4196 people in Scotland, the Joseph Rowntree Foundation (JRF) described the 'crushing impact' of continued poverty and the cost-of-living crisis on single parents on low incomes, the majority reporting negative impacts to their mental health and social lives, placing them at greater risk of isolation (JRF, 2022).

For people seeking help with mental health problems in Scotland, primary care is normally the first point of contact and GP practices have been described by the Scottish Parliament as the 'heart' of the Scottish healthcare system (Burgess, 2019: 4). Given the higher prevalence of mental illness, we might expect to see an increased number of services in areas of deprivation. However, as resource allocations within NHS services are based on population size rather than need, primary care services in these locations tend to be overstretched, resulting in a poorer quality of service (McLean et al., 2015). This was a trend first identified as the 'inverse care law' by Tudor-Hart (1971) who concluded that the differential health outcomes for NHS patients stemmed from inadequate resourcing of GP practices targeting low-income populations, creating increased pressure on staff and poorer outcomes for patients. In a large-scale piece of research studying NHS patients and GPs across Scotland, Mercer and Watt (2007) found that patients in the most deprived areas were given shorter appointments despite having more issues to discuss; GP stress levels were higher and patient satisfaction levels were lower (*See also* Audit Scotland, 2012). In a more recent study gathering service data from 956 Scottish GP practices, McLean et al. (2015) concluded that funding did not match clinical need, meaning practices were more likely to add to rather than mitigate health inequalities. In fact, the universality of the 'inverse care law' in explaining the socioeconomic patterning of health outcomes has been confirmed through research in a wide range of contexts including the USA (Ram, 2011), Brazil (De Lima, 2002), Australia (Furler et al., 2002), Greece (Tountas et al., 2005 *cited in* Connell, 2010) and sub-Saharan Africa (Moosa et al., 2014).

However, the availability of health services is not synonymous with accessibility (White et al., 2009); there are also many potential practical barriers that could prevent low- income populations broadly and single mothers in particularly, from reaching the point of engagement with primary healthcare including the ability to afford time off work, childcare and the de-prioritisation of personal need (Dermott and Pomati, 2016; Butler, 2019). Perceptual barriers also play an important role; in a One Parent Families Scotland (OPFS) study of 129 single mothers in 2014, 74% of respondents reported experiencing negative attitudes or stigma in the last two years, 60% of which had happened 'in the community at large' (OPFS, 2014). In a research briefing produced by the same organisation, many members felt that they were regarded as 'a drain on society' and that such views were increasing (Davis, 2016). Single mothers on low incomes can be fearful of appearing unable to 'cope' in case they are labelled a 'bad mother'; a wealth of research has evidenced the stigmatisation of single mothers in receipt of benefits as part of 'anti-welfare' rhetoric within popular culture (Tyler, 2008; Jun, 2019). Research suggests that other perceptual barriers include causal beliefs about mental health symptoms (e.g. that they are a normal response to material stress) (Stack and Meredith, 2018). For women who are single parents on low incomes from racially minoritised groups,

there may be other factors which prohibit engagement such as language barriers, cultural competency and a lack of trust in health professionals or the UK health system as a whole (Sime, 2014; Ajayi, 2021). There are broader consequences to untreated mental illness; it is estimated that those with life-long poor mental health are likely to die 15-20 years prematurely due to physical illness (Scottish Government, 2017*a*).

Recent academic research documenting the specific experiences of women who are single parents in Scotland once they engage with mental health services does not appear to exist. However, as services struggle to meet demand, there can be long waiting times for mental health services, and this only accounts for those engaging with provision (Scottish Government, 2017*a*). It is estimated that only 1 in 3 people who would benefit from treatment for mental illness actually receive it (Scottish Government, 2017*a*). In recent qualitative research with marginalised groups across Scotland, participants expressed a desire for low-level, non-clinical support for mental health problems that was readily available within communities and companionship through support groups (Support in Mind Scotland, 2018: 5).

Focus and outline of this thesis: why 'task-sharing'?

I had become aware of the issues described above whilst working as a researcher evaluating homelessness prevention programmes. I met women who were single parents on low incomes experiencing various forms of structural and cultural marginalisation, whose mental health had been worn down by the relentless struggle to 'make ends meet' yet faced multiple barriers to accessing appropriate mental health support. I was struck by the strength of these women as they bore the weight of financial strain and handled challenging encounters within complex systems, all whilst working to protect their children from these everyday realities. I later came across a PhD studentship with the broad aim of exploring the potential of 'task-shifting' for mental healthcare in Scotland, and the role of stigma in the implementation of the approach. There has been growing interest in the concept of 'task-shifting' as a means of improving access to, and the availability of healthcare (Hoeft, 2018). Task-shifting is defined by the World Health Organisation (WHO) as:

'… the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications.'

(2008:2)

Funded through an international strategic partnership (ISP) between the University of Strathclyde, NHS Lothian and City University of New York (CUNY), this project sought to explore what could be learned from existing work on 'task-

shifting' and how this might be applied to the Scottish context. I successfully sought permission to focus this project on the potential of 'task-shifting' to improve the mental health support available to women who are single parents on low incomes. The concept of 'task-shifting' has a long history (*See* Perez and Martinez, 2008) and has involved the reallocation of tasks within the medical profession, for example from doctors to nurses (Drennan et al., 2018) and between professions, such as upskilling frontline staff working in social care (Ayer et al., 2018). However, it also includes the recruitment of members of the public, often representing marginalised communities, who are trained to deliver aspects of healthcare previously reserved for those with recognised qualifications (Harris and Haines, 2012). Given the emphasis on supporting people from marginalised populations, I was particularly interested in the potential of this latter approach to improve the support available to women who are single parents on low incomes and sought to find out more about the type of tasks that are being, and have been, reallocated within mental healthcare. As will be discussed in the following chapter, this approach is frequently framed around what people recruited through 'task-shifting' initiatives can do to alleviate the burden on health professionals and wider services by taking on 'less technical' tasks. I go on to argue that this not only fails to acknowledge the value of lived experience to enhance the quality of existing provision but the need for mental health teams to work together, collaboratively, in new ways. It is for this reason I opt to use the term 'task-sharing' over 'task-shifting', reflecting the 'sharing of care' by people with varied and complimentary expertise (Hoeft et al., 2018).

Outline of thesis

Chapter 1: *Introduction* In the remaining sections of this introductory chapter, I outline theoretical frameworks relevant to the topic of 'task-sharing' in mental health care as conceptual context for this study. I begin by considering dominant and alternative models for understanding mental health and mental illness. I draw on the work of systems theorists who conceptualise the medical profession as a dynamic structure which must work to maintain its position of power and influence. Finally, I introduce the multi-level, intersectional feminist framework guiding this project from the outset. These ideas were foundational in understanding the context for 'task sharing' in mental health care and in making sense of the literature review and fieldwork findings supporting this thesis. I move on to apply these ideas to the Scottish landscape for mental health policy and practice as the research setting. This chapter ends with a reflection on recent developments in mental health policy that feel relevant to the topic of 'task-sharing', namely the integration of health and social care, a commitment to addressing health inequalities and the interest in building a peer workforce.

Chapter 2: *Literature review* Within this chapter, I review the existing literature on 'task-sharing', justifying the focus on the work of community health workers (CHW) and the potential of such approaches to improve the mental health support available to people from marginalised groups. I begin by outlining the search strategy adopted to establish the relevance and quality of sources. I then examine literature from different time periods and settings, distinguishing between CHW approaches involving 'task-shifting' in that they emphasise the unburdening of health professionals and examples of 'task-sharing' characterised by more participatory approaches to research and practice. Reflecting on the themes of power structures, knowledge hierarchies and lived experience as a resource in mental health care, I conclude by summarising the research gaps and opportunities presented for this research study.

Chapter 3: *Methods*. I begin chapter 3 by outlining the research questions guiding the fieldwork. I then outline the ontological and epistemological underpinning the research design, return to the multi-level intersectional feminist framework for analysis and justify the decision to adopt a participatory approach. Given the iterative and reflexive nature of the research process, I provide a detailed account of the initial, proposed approach and the subsequent changes informed by the input of advisory group members and research participants. In addition to describing the processes for data collection and management, I reflect on what I perceive to be the successes and limitations of the fieldwork methods adopted.

Chapter 4-7: *Findings*. Fieldwork findings are presented and discussed over four chapters. These bring together the qualitative insights gained through workshop discussions and activities with research participants, interviews with wider stakeholders and my own research diary, situating these findings in the wider literature on task-sharing, mental health care and 'single parenthood'. Applying the multi-level, feminist, intersectional framework, chapter 4 focuses on discussions around identity, establishing the meaning of 'lived experience' in the context of mental health to the women involved in this study. Chapter five maps out women's experiences of navigating the mental health system and their perspectives on what matters when it comes of mental health support, identifying areas for improvement. I move on to discuss the findings from workshops exploring the potential of interpersonal counselling (IPC), as an evidence-based method made available to those 'outside' the mental health profession. I explore participants' perspectives on the feasibility of concepts and tools and their ideas about how these might be adapted to feel more meaningful and practicable to women who are single parents on low incomes. The last findings chapter focuses on the topic of 'peer support' in relation to 'task-sharing' and the challenges and opportunities presented by new types of peer roles.

Chapter 8: *Conclusion*. Chapter 8 outlines three conclusive arguments in response to the research aim and questions, the implications of research findings for mental health policy and practice in Scotland and opportunities for future research.

THEORETICAL FRAMEWORKS FOR EXPLORING TASK-SHARING IN SCOTLAND

Defining mental health and illness

Understanding the dominance of the biomedical model for mental illness: theorising the professions involved in mental healthcare

To understand the landscape for mental healthcare provision in Scotland today, it is first helpful to consider the role of the medical profession as a 'professional system' in shaping ideas around what mental health is and how it should be responded to. The theme of 'ownership' explored below will become particularly pertinent to the central topic of task-sharing. The medical profession has upheld a dominant position defining health and treating illness in higher income countries, in ways that are largely accepted by the general public and endorsed by political parties (Abbott, 1988). There are a group of theorists however that conceptualise the profession, not as a static fixture within Western societies but as a dynamic structure, continually working to maintain its status and influence as part of a wider system. Highlighting the power inherent in professional knowledge systems, Freidson argued:

'The profession bases its claim for its position on the possession of a skill so esoteric or complex that nonmembers of the profession cannot perform the work properly. On this basis, nonmembers are excluded from practice and evaluation."

(1972: 45)

From this perspective, it is the knowledge systems built, managed, and protected by professions that justify operational autonomy in the eyes of the public; thus, 'abstraction enables survival' (See Abbott, 1988: 20). For the medical profession, initially limited to 'doctors', access to this abstraction of knowledge has required a university education. Writing in the 70s, Freidson emphasised that this meant physicians throughout the Western world were 'predominantly middle class' (1972: 173). Almost fifty years on, it is striking to note recent research which found 60% of doctors in the UK are privately educated (*See* Kirby, 2016). As the medical profession expanded to include occupations such as 'nursing', the same authors posit that abstraction has limited the scope of practice for so-called 'paramedical

professionals', creating a professional hierarchy within which the superior status of physicians, clinicians and other specialists at the top has been fervently protected (Freidson, 1972: Abbott, 1988).

As the abstraction of knowledge for a general practitioner (GP) is less visible to the lay person than in the case of a 'hospital specialist', Freidson (1972) posited that their autonomy (and salary) was justified by creating for them an indispensable position at the forefront of primary care. Reflecting on the dynamism between professions within an 'ecological system', Abbott contends that 'the techniques themselves may … be delegated to other workers … [but]…control of the occupation lies in control of the abstractions that generate the practical techniques' (1988: 8/9). As outlined in the previous section, GPs remain at the centre of primary care in Scotland today and the first point of call for general health concerns, even if this involves a referral back to a community service (*See* Burgess, 2019).

It could be argued that the theories outlined here are overly critical; they fail to account for well-meaning drivers of primary care service design which prioritise the experience of patients and the constraining influence of budget cuts on decision making (*See* Rogers and Pilgrim, 2021). I will come to consider these structural constraints shortly. However, systems theories help us to recognise that the medical profession is a somewhat vulnerable structure, continually working to protect and justify its position in a broader system; this is an important framework for understanding the potential for 'task sharing' and the concept of 'professional threat' which emerges as a core theme of this thesis. This framework can also help us to understand the privileging of the arena of work controlled by the medical profession; this has been defined as the biomedical model, '…the pervasive assumption that ill-health equals individual pathology, and that health therefore consists of individual medical interventions...' (Harrison and Ahmad, 2002:131). I have already referred to the dynamism inherent in the system of professions; Abbott conceptualises professions as needing to adapt over time to maintain abstraction, 'redefin[ing] its problems and tasks, defend[ing] them from interlopers, and seize[ing] new problems' (1988:8/9). Mental health was argued to be a 'new problem' seized by the medical profession and thus initially experienced 'professional, organisational and even political isolation within psychiatry' (Abbott, 1988; Wahlbeck, 2015: 36). Foucault argued that psychiatry utilised the cultural legitimacy of the human sciences (positivism) to claim ownership over knowledge of mental illness; these discourses were then said to grant power to medical professionals (Foucault 1965; 1973). Foucault contended that the psychiatric discourses on mental illness were thus historical manifestations of cultural norms, values and political concerns in place at the time. The social construction of mental health as a medical issue, a biological phenomenon to be understood through objective science, is said to have led to the othering of people identified as being

'mentally ill', underpinned by the concept of 'public threat' (Burstow, 2018). Much has been written about the segregation and containment of people experiencing mental illness within mental hospitals, asylums and other institutions(Goffman, 1963; 1968; Foucault, 1967). Psychiatry has thus been described by those adopting critical standpoints as 'a vehicle for the medicalisation of problematic behaviours and the management of society through control of social risk and deviance' (Hewitt, 2008: 187).

Anti-psychiatry, neoliberalism and the development of the biopsychosocial model

The closure of mental hospitals in the UK following the Mental Health Act ([1983] 2007) was particularly significant in shaping contemporary mental healthcare provision and understandings around mental illness. This was said to be influenced by several factors, for example, concerns about the conditions within hospitals, the rights of service users and growing consensus that people would be best supported in their local communities (Beresford, 2012; Macdonald et al., 2018). Psychiatry faced critique for biological reductionism and the paternalistic, dehumanising treatment of patients (Pilgrim, 2002). Whilst cautious of rejecting the medical model and potentially denying the reality of people's distress, the service users/survivor movement was also involved in challenging the 'medicalisation of everyday life', advocating for a more holistic conceptualisation of mental distress which accounted for practical and social issues such as employment, housing, interpersonal relationships, and cultural identity (Beresford, 2012; Macdonald et al., 2018). This formed part of a broader effort to improve the rights, and respectful treatment of, people experiencing mental distress as equals (Beresford, 2012). The so-called 'anti-psychiatry movement' fuelled intellectual debate within the profession and the development of the 'biopsychosocial model' which maintained the conceptualisation of mental illness as a biological disease whilst also paying attention to psychosocial issues and the impact of social environment (Ghaemi, 2011). It is suggested that this presented somewhat of a compromise, intended to create opportunities for a more pluralistic and multi-disciplinary approach to understanding and dealing with mental illness (Benning, 2015). In practice terms, this period resulted in an increase in mental health care provided in communities with a greater role for social services (Tew, 1999).

However, returning to the theory of professions as systems of self-preservation, whilst the biopsychosocial model became a 'mainstay' within psychiatry, the positioning of this in the scientific domain is said to have upheld a positivist conception of the biological, psychological and social components and done little to challenge the dominance of the biomedical paradigm (Benning, 2015). Furthermore, to fully understand this period, sometimes described as the 'de-institutionalisation' of mental healthcare, it is also crucial to consider economic and political influences. The 1980's saw the rise of neoliberalism within UK politics,

characterised by fiscal austerity, limited government spending, deregulation and privatisation (Beresford, 2012). It is worth highlighting at this point that the closure of mental hospitals was in part motivated by the desire to reduce maintenance costs and the opportunity to sell old buildings (Beresford, 2012). The introduction of market principles to mental health policy reform under neoliberalism is said to have positioned those diagnosed with a mental health condition as individual consumers with a choice of mental health services, which were put into competition with one another to drive up standards however services were underfunded, poorly coordinated and low quality (Beresford, 2012). Rather than representing a shift from 'biomedical' to 'social' approaches, it has been suggested that psychiatry and community nursing in fact 'spearheaded' new treatments in the community, enshrining the medical model as 'the dominant discourse around which community services [were] conceived and constructed' (Tew, 1999: 434). As mentioned above, GPs were positioned as 'gatekeepers' to community services and the continued use of residential care units led some to question the notion of 'de-institutionalisation' (Macdonald et al., 2018). Social services (e.g. social work practice) by comparison are said to have adopted a weak position within the 'inter-professional arena (Tew, 1999). Carpenter refers to the development of a 'discursive environment within which 'human distress and difference were increasingly defined in psychiatric terms', through the development of the Diagnostic and Statistical Manual of Mental Disorders (2000: 615). This is said to have contributed to the greater focus on the treatment of common mental health disorders such as anxiety and depression (Carpenter, 2000). Ghaemi (2011) suggests that the biopsychosocial model has been used to justify a combined treatment model of psychopharmacological treatment (medication) for the 'biological factors' and psychotherapy for the psychosocial issues. Of particular relevance to 'task sharing' it is suggested that the emphasis on this combined treatment 'becomes a justification of psychiatry as a guild' as traditionally it was only psychiatrists who were able to prescribe (Ghaemi, 2011: 5). The emphasis on individuals, increased use of psychiatric medication and influence of the pharmaceutical industry are also said to have upheld a medicalised conception of mental illness and a 'neoliberal logic' that the problem resides in the individual, to the neglect of economic, social and cultural factors (Eposito and Perez, 2014). It is for this reason that Beresford describes the relationship between psychiatry and right-wing politics as an 'informal and possibly unintended alliance' (2020: 89).

One of the biggest criticisms of 'expanded medical models' like the biopsychosocial model is the lack of attention paid to subjective experience and the interpretation of reality by individuals and groups with reference to cultural, historical and societal factors (Butler, 2004). Culture, for example, is included within the social domain of the biopsychosocial model but is argued to be conceptualised through a positivist lens utilising quantitative measures that homogenise cultural groups without due consideration of whether these categorisations are meaningful (Hatala, 2012).

Similar arguments have been made towards the use of 'expanded medical models' in public mental health; Lynch and King advocate for greater acknowledgment of the limitations of knowledge and frameworks generated at the population level and more opportunities for dialogue to understand how macro-level factors are configured through the subjective experiences and politics of everyday life (2023:8). Questions have been raised around 'how mental illness is discursively constructed (and by whom)' (Tew, 2015: 72). This has arguably had implications for stigma; attempts by psychiatry to normalise mental distress as an illness like any other is said to have foregrounded 'illness' rather starting with individual identity, thus inadvertently 'reinforcing us and them thinking in the general population' (Tew, 2015: 72).

Activist movements and alternative models for mental illness

From a research perspective, the arguments above have been used to demonstrate the need for interpretive epistemologies and qualitative methodologies for enhancing understandings around the conceptualisation and appropriate treatment of mental health issues (Butler et al., 2004; Hatala, 2012). They also highlight the importance of mental health activist movements in addressing some of these concerns. I have already mentioned the service user/survivor movement which has been critical of the medicalised, individualised model of mental illness; their activities and thinking have paid close attention to the social, developing discourses that address personal, political, spiritual, and material issues (Beresford, 2012). Utilising an 'intersectional' lens, efforts have been made to highlight the internal diversity of service users/survivors' to enhance understanding of multiple, varied experiences of social exclusion and oppression (Beresford, 2012). The extent of influence achieved by this movement has been questioned; it has been criticised for failing to produce an alternative conceptual framework to challenge the biomedical model or the neoliberal discourses that fuel inequality (Beresford, 2020). It is also suggested that the movement occupies a somewhat lonely position as a critical partner to psychiatry, focusing on reform to the existing system (Beresford, 2020). Authors speak of lost alliances; this included social work due to its marginalised position in the mental health system (Tew, 1999) and voluntary organisations who are increasingly reliant on contracts from government (Beresford 2020).

Another perspective that has been of great interest to mental health policy and practice in the UK has been that of the 'recovery movement', also led by people with first-hand experience of mental distress. Central to this movement was the concept of personal and collective empowerment, allowing people to become 'agents of their own recovery, rather than passively waiting for professionals to 'make them better' (Tew, 2015: 77). The movement has sought to challenge the pathologisation (or 'writing off') of people with mental illness, supporting people experiencing mental illness to participate meaningfully in everyday life, with an

emphasis on reclaiming social identities, forming social connections, and inspiring hope (Tew, 2015; Beresford, 2012). Critics have argued that the movement is 'conceptually slippery' and thus open to 'colonisation' (Tew, 2015). The concept of 'getting better', for example, is said to have offered the medical model 'a new lease of life'; meanwhile 'recovery' can be used to justify the withdrawal of support and the blaming of individuals who do not recover within defined periods, thus supporting the neoliberal ideals of reduced public spending and active market participation (Beresford, 2012).

A final, slightly different example to mention is that of 'mad studies'; described as a 'movement, a discipline and a form of activism' (Beresford and Rose, 2023: 5). Also led by mental health service users/survivors, 'mad studies', rejects the biomedical model of mental illness and utilises the concept of 'madness' to illustrate how we can be made mad by society and our social circumstances (Beresford, 2020). There are two purported strengths when compared to the above movements; firstly it has focused on developing a theoretically coherent alternative to the medicalised conceptions of mental illness (Beresford, 2020). Secondly, it has adopted an inclusive approach to opposition, inviting a range of views from different disciplines and backgrounds (including mental health professionals), thus creating allies that have the potential to strengthen progress (Beresford, 2020). Contrasting the objective approaches to research traditionally associated with psychiatry, mad studies centralises experiential knowledge, prioritising reflexivity and making use of participatory, qualitative methodologies (Sweeney, 2016). Some have however critiqued the situating of mad studies within academia as 'elitist' and exclusionary (Beresford, 2020).

Intersectionality: the potential of a multi-level, intersectional feminist framework for exploring mental health and illness

So far, we have explored theoretical frameworks and ideas that are useful for setting out the historical, cultural, political and economic context upon which the mental healthcare landscape in Scotland has been built. Reflecting on these debates, there is a clear need for frameworks which account for social, cultural and economic factors historically neglected in individualised explanations of mental health and illness, but which allow for diversity in experiences and thus avoid homogenisation and othering. As described above in reference to the service-user/survivor movement, an 'intersectional lens' can help to capture this multiplicity in the mental health experiences of marginalised people whilst also identifying points of connection (Anthias, 2012). Given the purported potential of intersectionality here, and the fact that this project was guided from the outset by an intersectional feminist framework, informing the review of existing literature (chapter 2), methodology (chapter 3) and analysis of research findings (chapters 4-8), it feels pertinent to introduce in more detail.

'Intersectionality' emerged in response to the 'myopic' nature of first and second wave feminism which was felt to focus narrowly on the experiences of White, middle-class women (Bagshaw, 2019). The 'neologism' was central to the anti-racist feminist movement as a tool to challenge existing knowledge hierarchies and better understand how multiple social identities (such as gender, race, class, age…), interweave within systems of power and privilege, creating specific forms of discrimination (Crenshaw, 1991; Anthias, 2012). It has since been used in a plethora of ways to explore the multidimensional nature of social divisions and the diverse nature of women's (and others') lives. Theorists have adopted different philosophical lenses to conceptualise categories of experience (e.g. gender) and there has been much debate as to the relevance of social structures and of categories themselves (Davis, 2008; McCall, 2005; Nash, 2008). Given the varied and contested application of 'intersectionality' as a theory in recent years, authors have emphasised the importance of identifying which conceptualisation is being applied within research studies (Choo and Feree, 2010).

I was drawn to what are described as 'multi-level' intersectional feminist frameworks which '[locate] social categories and divisions within a broader social framing that attends to power, hierarchy and context – both spatial and temporal' (Anthias, 2012: 6). This begins by acknowledging that people are organised into social categories within society, for example, by government bodies for the purposes of auditing and policy making; being defined as belonging to a marginalised group can influence life chances and self-perception but these allocations may also not be recognised by individuals and thus form part of their identities (Anthias, 2012). I share Anthias' view that social categories are not fixed but dialectical; that the same categories of experience can be oppressive and empowering in different spatial and temporal contexts (Anthias, 2013; *see also* Kara, 2017). In this way, categories are retained as 'important elements of the social landscape' but are not assumed or essentialised (Anthias, 2012: 13). My decision to focus on women who are single parents on low incomes was influenced by my previous involvement in research projects which identified gaps in the availability of mental health support; this was solidified upon reviewing the wider literature (chapter 2). I was however aware of the diverse realities of women I was defining as belonging to this research population.

Women who are single parents on low incomes are frequently stereotyped within the media and public policy yet represent a broad range of backgrounds and perspectives. I was interested in exploring how factors such as gender, poverty, employment, and the status of a 'single parent' impacted upon the mental health issues experienced by women and how they engaged with support. However, I was also keen to create space for these categories to be discussed, contested, negotiated and for other aspects of significance to emerge.

Within 'multi-level' framings, identity categories exist across multiple levels of experience including the macro/structural (organisational systems and structures), the meso/representational (symbolic representations/discourses) and the micro/individual (individual/identities); these are not mutually exclusive but interact with and are shaped by the other (Winker and Degele, 2011). Identities and representations are therefore factors which create and maintain structures as well (Winker and Degele, 2011: 58). The comprehensiveness of this framework felt appropriate as it accounts for the way in which single motherhood has been problematised in health policy research (Dermott & Pomati, 2016) and for the overfocus on individual behaviours feeding moralisation discourses to understand health inequalities (Brown, 2018). This multi-level, intersectional framework ended up being an invaluable heuristic tool for me in navigating the research process and understanding the experiences and perspectives of the women involved in relation to mental health, mental illness and mental healthcare.

Implications for task-sharing in mental healthcare

Drawing on systems theory, the medical profession emerges as a system operating to protect its superior status in an eco-system of healthcare professions. I have sought to demonstrate how the dominance of the biomedical model reflects the ownership of abstract knowledge required to maintain power allowing psychiatry to define what mental illness is and how it should be treated. Authors have argued that the compatibility of biomedical responses with a market society and neoliberal ideology has provided the medical profession with political and economic alliances which have assisted in upholding the biomedical paradigm. This has arguably led to the downplaying of social influences and the marginalisation of professions dealing with these issues. The medical profession appears to have played a central role in designing the mental healthcare service landscape in the UK following 'de-institutionalisation'. Ultimately, the profession could be said to own the task of definition and thus determine the type of 'tasks' that might be available to 'share' within mental healthcare. In applying the ideas within systems theory in the review of task sharing literature (chapter 2) and to my own research findings on the potential of task sharing approaches for women who are single parents on low incomes (chapter 4-8), I make a unique contribution to knowledge. Doing so, fore fronted the significance of inter-professional power structures to the everyday experiences of people with lived experience providing and receiving mental healthcare and, I go on to argue, has important implications for future work.

The dominance of biomedical and 'extended medical' models appear to have limited opportunities for individuals to define their experiences of mental illness in the context of their own lives. This is particularly relevant given the interest within this thesis on the involvement of people with lived experience of mental health issues. Activist groups have worked hard to expand understandings of mental

health and illness, drawing attention to structural, political, material and personal issues. These movements have highlighted the internal diversity inherent in the population of people impacted by mental distress, challenging the stigmatising nature of a singular illness identity, demonstrating how individuals occupy multiple, intersecting locations in society which shape their experiences of social exclusion and oppression. It is important to acknowledge however that these movements have not provided a clearly defined 'social model for mental health'. I will use this term within this thesis to refer to these alternative approaches whilst remaining aware that the lack of clear definition is a limitation. Nonetheless, this draws attention to the potential of intersectionality as a framework for developing a nuanced understanding of the mental health experiences of people from marginalised groups and avoiding the homogenisation described above that can lead to othering. I chose to use a multi-level, intersectional, feminist framework as a heuristic tool throughout this project. This helped me to build a comprehensive picture of the current state, and future potential of, task-sharing in mental healthcare accounting for multiple levels of experience (structural/representational/individual) and led to a consideration of factors such as gender and social class which remain underexplored within the existing literature. I go on to argue that this theoretical framework, which allows for points of connection and divergence, could assist in the development of more nuanced understandings of the meaning of 'lived' and/or 'shared' experience in mental healthcare settings.

Having outlined these theoretical debates and ideas, I will now go on to explain how these relate specifically to the Scottish context as the research setting for this thesis.

Mental health policy and practice in Scotland

The broader context

The establishment of the Scottish Parliament and the Scottish Executive in 1999 led to the transferral of some political powers from Westminster[2]; this has included health and social care services where significant developments have been made in mental health policy and practice (Woods, 2004; Mitchell, 2018). The freedom granted to utilise UK-wide taxation (the 'block grant'), devolved taxes (e.g. income tax) and borrowing powers have allowed the Scottish Government to make decisions about resource allocation (UKGov, 2020). This provided an opportunity to take health and social care in a distinctively 'Scottish' direction, supported by a set of national ambitions which have remained fairly constant over the last two

[2] Following the independence referendum of 2014, where a small majority of the Scottish population voted to remain part of the UK, the UK Parliament set up the Smith Commission granting the Scottish Parliament new powers which included income tax, welfare and benefits.

decades (Dayan and Edwards, 2017) and are particularly relevant to task-sharing. This includes an emphasis on communities and the integration of health and social care.

Firstly, MacIntyre (2018) speaks of a specifically 'Scottish' reconceptualisation of mental health following the opening of the Scottish parliament, rooted in 'Calvanist' principles. This is described as a human-rights, 'whole population' approach, which emphasises the role of local communities (MacIntyre, 2018). 'Communities' has since featured heavily within mental health policy as part of a commitment to addressing deep seated social issues (Scottish Government, 2011). The emphasis on 'community' is regarded as part of an effort to acknowledge the value of social care, perhaps reflected in the introduction of the living wage for the social care workforce in Scotland (Dayan and Edwards, 2018). When compared to other parts of the UK, local and national third sector organisations in Scotland receive significant investment and are said to be acknowledged as 'key players' in the delivery of mental health care (Gordon and Bradstreet, 2015: 162; Dayan and Edwards, 2018). The development of Health and Social Care partnerships (HSCPs) is perhaps the most significant policy development in this regard; since 2016, 31 HSCPs have been developed, with the purpose of integrating NHS and council led services (*See* Scottish Government, 2019). HSCPs have been designed to overcome organisational silos, encouraging medical and social care professionals to work as part of the same system towards shared national objectives (Scottish Government, 2019). It was hoped that this would make the system more accessible to individuals and communities whilst also addressing social inequalities, leading to more preventative mental healthcare (Scottish Government, 2011).

However, Scotland has not been immune to impacts of austerity and the influences of neoliberalism which appear to have hampered the realisation of these ambitions (Cairney et al., 2016; Pearson et al., 2018). Whilst there are now higher than average levels of expenditure on public services in Scotland, health boards already owe large sums of money (Dayan and Edwards, 2017). The prospect of decreases in the level of funding available to the Scottish Government to meet ever increasing demand for health services has raised concern about the sustainability of current fiscal arrangements (Mitchell, 2018). Whilst not perceived to be as severe as other parts the UK, the neoliberalist introduction of market principles to achieve greater efficiency during times of austerity left its mark on the Scottish mental health service landscape. This is said to have included the fragmentation of services into multiple specialisms cutting across different sectors, creating an 'economy of services' (MacIntyre, 2018). The emphasis on 'short-term' interventions for cost-efficiency, arguably compounded by the commitment to 'piloting' innovation in Scotland (Dayan and Edwards, 2017) and insecure funding mechanisms, has resulted in so called 'short-termism' (Scottish Government, 2011). This appears to be reflected in a system characterised by complexity and volatility (Scottish

Government, 2011). A lack of investment in the infrastructure required to support partnership working (e.g. IT systems) and increased workloads, limiting the capacity of the workforce for relationship building are cited as additional consequences of austerity, impacting the development of HSCPs (Pearson and Watson, 2018). Furthermore, despite the repeated reference to 'rediscovering community' within government policy, the emphasis on the 'personalisation' of care as a means of cost-saving 'has tended to push services in the other direction' (Ferguson, 2018: 50).

Finally, it has been suggested that insufficient consideration was given to addressing the relational power dynamics between professions involved in HSCPs (Pearson and Watson, 2018). Returning to the conceptualisation of professions as systems, Abbott postulated that 'as social work …become[s] [a] collegiate profession, medicine has become postgraduate' (1988: 9). It thus follows that the medical profession will always seek to maintain a dominant position within professional hierarchies. Reflecting on the development of HSCPs, Eccles urges us to remain open to the possibility that unequal power dynamics continue to play out at the relational level:

'…the ability of social work to voice its distinctiveness in collaborative working is not straightforward, as power relations and assumptions about status come into play…the exercise of organisational power, and the power by individuals within organisations is not always apparent…not all power is observable when it is being exercised, and 'non-decision making' (for example, which issues do or do not arrive on the agenda for discussion) may exist in collaborative forums… traditional biases in power (for example, towards a medical model rather than a social model of understanding problems and potential solutions)…will have to be negotiated. There is a need for more research on this issue.'

(2018: 87)

The contextual factors outlined here provide an important starting point for understanding both the potential of 'task sharing' but also possible challenges in implementing such approaches.

Mental health-specific policy and practice in Scotland

Turning to recent developments in policy and practice related specifically to mental health, there does appear to be a shift away from medicalised, individualised models for understanding mental health and illness, an increased emphasis on collaboration and greater acknowledgment of lived experience. The COVID-19 pandemic prompted a renewal of what should have been a ten-year mental health strategy published in 2017 (Scottish Government, 2017*a*). The Scottish Government acknowledge that 'the current system is not as we would wish despite the efforts of thousands of dedicated and skilled people across Scotland' (2023:

15). A new mental health and wellbeing strategy was published in 2023 (Scottish Government, 2023*a*); as reflected in the title, this appears to focus more on wellbeing and less on 'achieving parity of esteem between mental and physical health' (Scottish Government, 2017*a*: 7). Terms that might be associated with a biomedical model for mental illness, such as 'clinical', 'illness' and specialist', feature more heavily in the earlier document (Scottish Government, 2017) whilst the latest strategy pays closer attention to the social determinants of mental health, such unemployment, poverty, housing, stigma and inequality. There is a commitment to adopting a more nuanced approach to understanding the mental health experiences of people from marginalised groups, drawing on the concept of 'intersectionality' (not featured at all in the previous strategy):

'We also recognise that underlying factors, inequalities and types of disadvantage affect certain groups of people who may suffer disproportionate impacts on their mental health. We must learn from evolving evidence about intersectionality by recognising that people are multifaceted and that different experiences or aspects of their identity can interact and combine to affect their mental health in ways that are not the case for everyone.'

(Scottish Government, 2023*a*:2)

Of particular relevance to the subject of this thesis, 'lived experience' features strongly in the 2023 strategy and delivery plan. For example, the Scottish Government commit to ensuring that 'mental health policies, support, care, and treatment are better informed and shaped by people with lived experience of mental health issues and staff practitioners, with a focus on high quality provision that is recovery orientated' (2023*b*: 12). There is also a commitment to working alongside people with lived experience 'to identify and share evidence of the benefits and impacts of peer support and the settings where this will have the most impact' (Scottish Government, 2023*b*: 14). Peer support workers are recognised as part of the 'core mental health and wellbeing workforce' and peer support is listed as part of the emotional dimension of a 'whole systems' model for prevention and early intervention alongside families and carers, emphasising the importance of support provided locally within communities (Scottish Government, 2023*a*: 36).

There has been growing interest on the role of peer work within Scottish mental health policy and practice over the last twenty years (Bradstreet and Mcbrierty, 2012). This has been heavily influenced by the Scottish 'recovery movement'; as discussed in broad terms in the previous section, this has sought to improve the experience of people accessing mental health services, challenge the stigmatisation of mental illness and divisive 'us and them' attitudes (Christie, 2016). The Scottish Recovery Network (SRN) has spearheaded the development of peer principles, providing a framework for peer work values based around 'sharing personal

experiences of recovery in a way that inspires hope', 'offering help and support as an equal' and 'developing mutually empowering relationships', (SRN, 2020: 3). Peer work has thus featured within mental health policy since 2003; marking their commitment to the development of the peer support role within mental health services, the Scottish Government began to invest in a range of peer initiatives (SRN, 2020). One such initiative, developed in partnership with SRN, was a pilot scheme seeking to pioneer formalised peer support across a range of service areas (including NHS teams and community services) and geographical settings in Scotland (McLean et al., 2009). The evaluation concluded that the roll-out of peer support roles would not only be beneficial to service users but also peer support workers and mental health teams (McLean et al., 2009). However, challenges were identified in terms of defining and implementing these roles and there was substantial variation in terms of pay scales and the types of activities that were involved which tended to be tailored to the specific setting (McLean et al., 2009).

In response to the perceived need for greater 'standardisation', the SRN facilitated the development of a 'robust accredited award' - The Professional Development Award (PDA) in Mental Health Peer Support – which aimed to support the creation of a 'recognised employment and career pathway' for peer support workers (SQA, 2010: 1). However, whilst the Scottish Government endorsed the development of this work, local authorities continue to exercise decision making control as to the extent to which they incorporate peer work into their mental health services (Gordon and Bradstreet, 2015). It is argued that this lack of accountability has prohibited the systemic changes required to support the effective integration of peer support into mainstream mental health services (Gordon and Bradstreet, 2015). This is said to include the development of new competencies and practices by mental health professionals focused around supporting and empowering individuals in addition to providing care (Bradstreet and McBrierty, 2012). The same authors have advocated for a greater 'shift in power and responsibility from service providers to communities and citizens' (Bradstreet and McBrierty, 2012: 67). Authors in the field stress the compatibility of peer roles and community-based settings, suggesting that the availability of tools and resources have allowed community-based approaches to become more structured and intentional (Bradstreet and McBrierty, 2012). However, this is not consistent, and developments have been limited by the absence of long-term funding (Bradstreet and McBrierty, 2012). Furthermore, the role of peer work for marginalised groups, and the experience of poverty, seems to have been neglected within existing research (Llewellyn-Beardsley et al., 2019; Moran, 2020).

Introduction

Approach taken to literature review

Having developed an understanding of the research context for this study, I sought to build my knowledge of approaches involving 'task sharing' (or 'task shifting' as it is commonly described) and identify any gaps in the existing academic literature. 'Task shifting' is a broad subject which includes various approaches such as the reallocation of tasks between different types of professionals. As described above, I was particularly interested in the involvement of people with marginalised populations with 'lived experience' (see glossary for a definition of this). An initial search on Google scholar using the key words 'task shifting' OR 'task sharing' and 'Scotland' indicated that academic literature on the subject specific to single mothers on low incomes and the Scottish context (respectively) was very limited. As this study adopted an intersectional framework and the purpose of intersectional research is to identify 'patterns that are complex and contingent across groups, contexts, and time' (Hughes and Dubrow, 2018: 81), I therefore chose to adopt an open and exploratory approach to conducting this literature review as is reflected in the inclusion and exclusion criteria below. The research question guiding the literature review process was therefore:

What research is currently available on the topic of task shifting (or 'task sharing') to improve the mental health and wellbeing of marginalised groups? Are there any recurring themes and gaps in knowledge?

I sought to consider what might be learned from examples of 'task shifting' or 'task-sharing' in various historical and geographical contexts, involving different groups (albeit with an emphasis on women), identifying relevant patterns and themes. The process of literature searching was iterative. During the initial search, reflecting the interest in 'lived experience', I focused on terms related to 'peer support', yet added other terms (e.g. 'community health workers') as I became more familiar with the literature (this is discussed further in the following section). Similarly, I began by exploring a few well-known journals relevant to the subject (e.g. The Lancet; Journal of Social Science and Medicine; Journal of Community Mental health), however the topic of 'task-shifting' (or 'task-sharing') covers a wide range of disciplines and professional fields and key word searches identified papers from a plethora of academic journals which were eventually included. I wished to develop a sense of the overall research landscape for 'task-shifting' and 'task-sharing' involving marginalised groups to both situate this study and to inform the methodological design. Thus, whilst I was particularly interested in qualitative approaches involving marginalised groups (especially those that were participatory

in nature) a more diverse range of studies were included in the literature review including randomised control trials, which often had a qualitative component.

Task-sharing	**Group**	**Setting**
task-shift* OR task shift* OR task-shar* OR task shar*	single parent* OR single mother* OR lone mother* OR lone parent* OR solo mother* OR "solo parent*"	Scotland OR Scottish
peer support OR peer support work* OR peer volunteer* OR peer role*	women	Edinburgh OR Glasgow OR Dundee OR Inverness OR Perth OR Dunfermline
Community health worker* OR lay health worker* OR paraprofessional*	marginalised OR disad* OR low-income OR poverty	high* income countr* OR developed countr* OR west* countr*
lived experience OR lived expertise	mental health OR mental health issue OR mental health problem OR mental wellbeing	low income countr* OR low and middle income countr* OR developing countr*

Table 1: Terms used during literature search

Example search-string: ALL (("task-shift*" OR "task shift*" OR "task-shar*" OR "task shar*") AND ("single parent*" OR "single mother*" OR "lone mother*" OR "lone parent*") AND ("marginalised" OR "disad*" OR "low-income" OR "poverty")AND ("mental health" OR "mental health issue" OR "mental health problem" OR "mental wellbeing") AND ("Scotland" OR "Scottish" OR "Edinburgh" OR "Glasgow" OR "Dundee" OR "Inverness" OR "Perth" OR "Dunfermline" (LIMIT-TO (AFFILCOUNTRY , "United Kingdom")

Inclusion criteria

• must be relevant to the topic of task-shifting or task-sharing in health and social care • must relate to common mental health disorders (e.g. anxiety; depression) • must involve the recruitment of people from 'marginalised populations' (i.e. by nature of their social/economic/cultural background and/or having a health condition/disability) • must involve the experiences of women • must be written in English
Exclusion Criteria
• not relevant to the topic of task-shifting or task-sharing in health and social care • focusing on serious mental illness (e.g. schizophrenia) • not involving the recruitment of people from 'marginalised populations' (as detailed above) • essays and opinion pieces; textbooks; news articles; book reviews • only relating to the experiences of men • not written in English

Table 2: Inclusion and exclusion criteria used during literature search

I established the search criteria outlined above to support a systematic process of establishing relevance. I purposefully chose not to exclude articles based on date of publication as I had an interest in exploring approaches spanning different time periods. Scopus, ProQuest, Google scholar the University of Strathclyde's own search engine SUPrimo were used for the initial key word searches. Once the key word searches returned relevant journal articles (established using the inclusion and exclusion criteria above), I was able to engage in a process of 'reference harvesting', identifying other relevant papers and research journals from citations and reference lists. The other method used to identify literature was through contacts working in relevant academic fields. For example, 'task-shifting' and 'task-sharing' appear to be relatively recent terms. The key word search results therefore did not identify papers from earlier periods in recent history (i.e. pre-2000). I was able to connect with someone specialising in the history of health and medicine, mental health and psychiatry who helped me to identify the literature discussed in the first section of this chapter. I was then able to adopt the same approach, using these sources to find other relevant papers from this period.

I adopted a thematic approach to reviewing the literature, working to identify recurring themes from the literature across different time periods and geographic settings. To support this process, I created a 'reference book' on Excel, organising references into separate sheets first by topic area or setting and then by later by theme. I have included a screen shot of this document below.

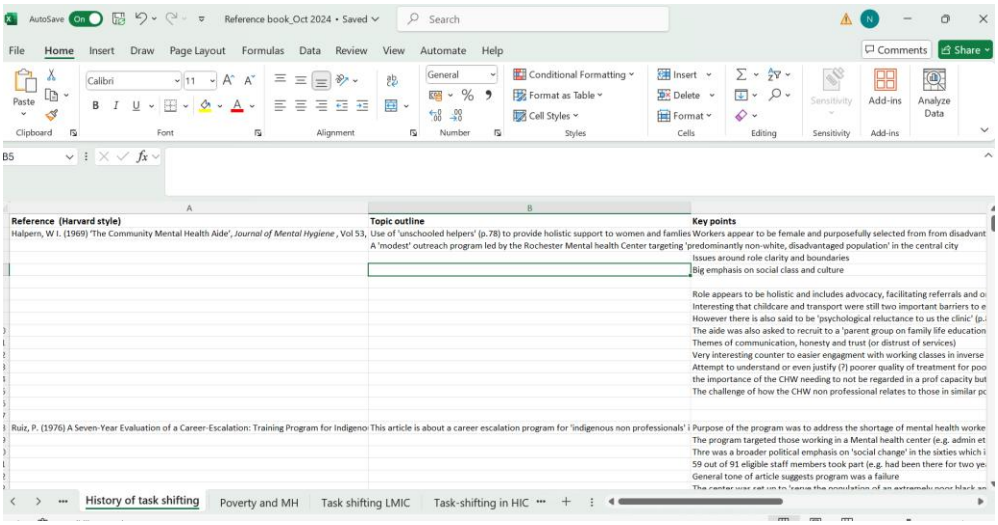

Figure 1: A screen shot of the reference book created on Excel to support literature review process

Overview

Task shifting has been heralded as a means of addressing the growing demand for mental health care and shortage of professional capacity as part of a global effort to achieve 'universal health coverage' (Javadi et al., 2017: 2). However, as we established in the previous chapter, service capacity does not impact all groups proportionately (McLean et al. 2015; *See also* Chew-Graham et al., 2002). Rather than representing a ubiquitous shift in health care provision, there is an emphasis within the literature on 'low resource settings' where there are high levels of unmet need (Joshi et al, 2014). The majority of programmes involving task-shifting or task-sharing have therefore been implemented within low and middle income countries (LMIC) but also, as we go onto discuss, marginalised populations within higher income settings (Barnett et al., 2018). The approach most commonly discussed within the available literature is the recruitment of individuals from 'communities', defined both in geographical terms and in relation to interest groups

(such as having a particular health condition), often with limited education and professional training, to work as 'community health workers' (referred to throughout this thesis as the CHWs). Whilst authors have tried to distinguish between 'CHWs' and 'peer workers' (*See* Jack et al., 2020), given the extent of overlap and the prevalence of peer principles within CHW programmes and initiatives, for example 'offering help and support as an equal' (SRN, 2020), CHWs are conceptualised as a type of peer role within this thesis that can test the boundaries between peer and professional. In some cases (e.g. when reflecting on overall findings), I use the term 'CHW' for clarity and consistency where another title may have been given within the programme, for example, 'Indigenous Health Care Workers'. Notably, whilst a wide range of CHW models are described in the available literature, the individuals filling these roles are most often women who live and work in the communities targeted by interventions (Najafizada et al., 2015; Hoeft et al., 2018).

Adopting a critical standpoint, I go on to argue that much of the global policy literature on 'task-shifting' conceives of the concept through an operational lens, by which I mean identifying tasks that can be feasibly 'shifted' onto CHWs to 'reduce the burden' on mental health professionals who are able to dedicate more time to 'specialist' work (Philip and Chatervedi, 2018). This hierarchical perspective, more prominent within higher income settings, focuses on what CHWs can do *for* the healthcare system by extending existing services or acting as a bridge to marginalised populations so that they can access preventative (and more cost-effective) care. Less attention appears to be paid to how mainstream structures, systems and processes could and should be adapted to better support CHWs and the populations they represent. Contrastingly, in low- and middle-income countries, where seemingly empty service landscapes appear to have created opportunities for 'disruptive innovation', CHWs have been involved in the design and delivery of services, adapting 'Western' approaches to be more accessible and appropriate for target communities. In the absence of human resources, CHWs have demonstrated that they can successfully identify mental illness and deliver psycho-therapeutic interventions (Menezes, 2015).

Whilst there is a wealth of evidence documenting the positive impacts achieved through interventions for marginalised populations globally, there is surprisingly little research focusing on the experiences and perspectives of CHWs; recent concern surrounding the motivations of CHWs has tended be framed operationally – a need to ensure 'low attrition rates' to support 'project sustainment' (Koskan et al., 2013). Adopting an intersectional feminist framework, I go on to argue that the CHW model (or similar) has the potential to address mental health issues in ways that are empowering to the individuals fulfilling these roles, wider networks and whole communities (*See* Harris and Haines, 2012). However, I posit that interventions should start with understanding the motivations of prospective

CHWs and be developed in a participatory way that is conscious of the potential for oppressive practice within hierarchical structures.

I go on to explore CHW models in different settings, beginning with a focus on low- and middle-income countries before moving on to look at more recent developments in countries such as the United Kingdom, United States and Canada. To build a deeper understanding of the opportunities for empowerment, the risk of exploitative practice and potential relevance of task-sharing initiatives like the CHW model for addressing the needs of women who are single parents on low incomes in Scotland, I will now go on to consider the development of this work over different time periods and settings. I begin by reflecting on the utilisation of CHWs as part of a policy programme to tackle poverty in 1960s America. As one of the largest national efforts to utilise CHW models to address health inequalities, it provides important historical context. However, it also enables us to develop a theoretical framework which can be used to identify patterns in the implementation of contemporary CHW interventions in higher income settings. Even where inspiration claims to have been sought from innovations in LMIC, recent models appear to align more closely with models of the past, raising questions about the pervasiveness of power structures, knowledge hierarchies and the extent of opportunity for transformative innovation.

'Task-shifting' during the War on Poverty in the United States

Policy context

Writing in 1970, Westheimer et al. suggested that the wealth of literature on the utilisation of 'nonprofessionals' in the United States published between 1965-66 reflected 'growing public and private concern with helping the poor' (1970: 626). In the preceding year, as part of a so called 'War on Poverty', the United States Congress had signed into law the Economic Opportunity Act of 1964 (EOA); this legislation responded to political concern around the increasingly high levels of poverty, unemployment, and racial discrimination evidenced in the 1960 census (Adler, 1994). The EOA set out eleven programmes, one of which is particularly relevant to the focus of this thesis in its apparent endorsement of the principles underpinning later examples of 'task shifting'. The 'Urban and Rural Community Action program' (URCAP) aimed to improve motivation and productivity levels, provide employment opportunities and improve the conditions for living, learning and working in target communities (*See* Boone, 1972).

Whilst an unprecedently high level of federal funding was made available, there were several stipulations. Each funded programme had to be delivered or coordinated by a non-profit agency, however more controversially for the time, programmes were to involve the maximum possible participation of residents

living in target communities (Caro 1981). Speaking at a conference during the implementation of the Act, the then Director of the Office of Economic Opportunity reflected on what appears to be a shift in thinking around dealing with poverty related issues:

"This is a major change in American methods of working with disadvantaged people. This is not help for the poor but help with the poor. We are no longer thinking about merely dispensing help from above. Rather, the poor are to be active participants in all phases of the new programs ranging from program formulation to basic policy decisions and actual operations."

(Berry, 1965)

Underpinning this approach appeared to be an acknowledgement that service provision and engagement could be strengthened by drawing on the knowledge, skills, and experiences of members of the communities being targeted. The EOA legislation was purposefully flexible to be adaptable to local contexts, however the vague wording is said to have led to alternative interpretations of the aims and responsibilities of programme leaders (Adler, 2014). The speed at which both the EOA and URCAP were implemented was also said to leave little time for state and local government, individual agencies and grass roots organisations to reach a consensus on the local principles of the URCAP resulting in, as I go on to discuss, two broadly different approaches to 'task-shifting' (Adler, 2014).

The implementation of URCAP led to the recruitment of community representatives without academic qualifications, most often described as 'non-professionals'[3], within a range of service areas including education, housing and, of particular relevance to this thesis, health. A wide range of roles were created for non-professionals within health care programmes, referred to as indigenous health care workers (IHCW), the majority of which were filled by women (Ramirez-Valles, 1998). Naples (1991) highlights that URCAP 'offered the first state-sponsored support for the community work of low-income women' which was previously unpaid and not recognised by those outside of their communities (1991:480). There are references to greater difficulty in recruiting males as IHCW (Ruiz, 1976); in part this is said to reflect the historic perception of healthcare as 'women's work' but some suggest that the low status and poor pay made it unappealing and impracticable for men who were often the main earners in the household (Ramirez-Valles, 1998). Racially minoritised groups were also disproportionately represented within the communities targeted by the programme which was regarded as part of a wider attempt to move beyond years of civil unrest resulting from the racial discrimination and abuse experienced by African Americans (Moynihan, 1969).

[3] A range of terms are employed within the literature published at the time to describe residents employed through the URCAP including 'non-professionals', 'paraprofessionals' and 'indigenous workers'.

Framing 'commonality' as a community resource

The framing of 'shared experience' as a community resource by the federal government led academics to explore the idea in more detail, defining the concept as either 'indigenousness' or 'commonality'*:*

'Indigenousness, ascribed as being from the same community and subculture, is assumed to represent a sharing of attitudes, values, and behaviours between the provider and client. This commonality is further assumed to foster a positive relationship between the provider and client.'

(Giblin, 1989: 362)

In recruiting IHCWs from target populations, health care agencies could begin to address the dearth of knowledge around the specific health needs of minority groups and gain access to communities that were not engaging with local health services or seen to be adhering to official health advice (Ruiz, 1976). Having grown up in relevant communities, IHCWs were likely to have a rich understanding of the cultural beliefs around health and an awareness of the barriers to service engagement, drawing on this to improve communication between professionals and prospective service users (Heath and Pelz, 1970).

IHCWs' position as a community member was argued to be conducive to relationship building, 'characterized by mutual trust and caring, reciprocity, and a respect for the priorities of the client' (Giblin, 1989: 362). Reflecting on earlier examples where non-professionals from middle class backgrounds, such as housewives and college students, had been recruited by mental health services to 'reduce the burden' on professionals by taking on basic tasks, Reiff and Riessman argued that those recruited had been regarded as an 'extension of the professional' (1965:5). The authors suggest that because non-professionals in earlier programmes had the 'same social background, the same attitudes and values, and to some extent, the same educational background', they were, in effect, an aide to the professional rather than the client (Rieff and Riessman, 1965). In contrast, as a result of their lower socioeconomic positioning, the perceived value of the 'indigenous nonprofessional' to health care services was that they were in fact *distinguishable* from professionals who were often seen to be subjugating, largely distrusted and even resented by the poor; 'commonality' in this context was perceived to be a 'special quality' which could be used to '[establish] communication across class lines' (Reiff and Riessman, 1965: 7; Halpern, 1969). Theories of social capital which, broadly speaking ' identif[y] how involvement and participation in groups can have positive consequences for the individual and the community' (Aldrich and Mayer, 2015: 256), provide a conceptual framework for understanding the function of 'commonality' here. Arguing that sociological definitions of social capital ignored the institutional context within which networks were embedded, Woolcock (2001) adopts a 'multidimensional' approach building

on prior distinctions between 'bonding capital' (relations between families, friends and neighbours based on mutuality) and 'bridging capital' (connections between people within communities that share some demographic characteristics but have less in common). He goes further, adding a third dimension to account for the vertical relationship between communities and those in positions of power – 'linking capital' is said to be 'the capacity to leverage resources, ideas and information from formal institutions beyond the community' (2001: 71). Understood in this way, IHCWs can draw on their bonding capital ('commonality') to access target populations and create both bridging and linking capital; in doing so they improve the reach and impact of healthcare services, support the system to achieve policy aims and link communities to services that could improve their health, employment opportunities and prospects for social mobility. In this sense, IHCWs possess a form of social capital inaccessible to professionals or the wider middle class, which *adds value to* rather than simply extending existing services.

However, as we go on to discuss, the extent to which 'commonality' was recognised by individual agencies appears to have varied. Whilst URCAP resulted in a proliferation of roles for IHCWs with wide ranging duties, Heath and Pelz (1970) were able to identify patterns in the approaches taken by different agencies, outlining three broad role typologies: the 'routine aide', 'program aide' and 'policy aide'. These role depictions can also be applied as broader models employed by agencies adopting alternative interpretations of URCAP policy aims; each of these models will be discussed in turn below.

An integrated approach to task shifting: The 'routine aide'

The 'routine aide' is said to have been employed by agencies generally motivated by concerns over manpower shortages and/or cost containment (Giblin, 1989). Ruiz (1976) for example speaks of the difficulty of employing mental health professionals that were willing to work in the urban ghettos. Under this model, the emphasis appears to have been on providing access to careers within the health care system through further education and 'fast-tracked' qualifications (Rogawski, 1971). Routine aides were generally said to be closely supervised within a vertical staffing structure; they were assigned specific tasks with clear instructions and little room for initiative (Heath and Pelz, 1970). As the role is said to be 'task-oriented', there is perceived to be little need for the involvement of the aide in agency policy; mirroring the phrasing used by Reiff and Riessman (1965) in their depiction of middle-class non-professionals, the routine aide is regarded as an 'extension of the professional' (Heath and Pelz, 1970: 768). For example, the language used by Collins and Cavanaugh in their evaluation of a tailor-made mental health training programme for 'those who might not have completed high school, but were interested in a career as a health worker' in newly established neighbourhood health centres, is very telling (1971: 368). Didactic elements of the course are discussed in detail and the authors discuss the possible functions of IHCWs 'with adequate

training'; there is no mention of how the students may add value to the programme as a result of their social position and lived experience; instead there is a focus on 'integrating them into the clinical activities' within health care settings (1971:368-370).

Similarly, discussing a 'model career development program' in mental health led by the University of Carolina, Rogawski (1971) outlines the core program elements which initially included training in a clinical setting supervised by nursing staff, didactic seminars and remedial or supplementary education. 'Non-credentialed' students recruited from poor (mostly 'Mexican-American' and 'Black') neighbourhoods were quickly taught the 'ground rules of working in an institutional setting' and the roles and functions of mental health workers compared to professionals in mental health were covered as a module in the training curriculum (1971:21).

Whilst Rogawski (1971) does highlight that students helped staff members to better understand the specific needs and barriers experienced by local neighbourhoods, 'commonality' appears to be something of an additional benefit rather than a core, functional aspect of their role. For example, the author talks about the 'highly valued' and 'long needed' services provided by Mexican-American graduates who were able to interpret for patients, make home visits and even conduct counselling sessions in Spanish, yet this was said to be 'initiated' by IHCWs themselves once they had graduated[4] (Rogawski, 1971: 26).The evaluation emphasises the importance of ensuring that students received well-rounded training[5] and that all graduates, described as 'new careerists', were offered employment within human services upon completion.

Interestingly, in a later phase of the programme, the agency employed a new Training Director who is described as having 'the advantage of being a Black professional' and said to act as a role model to students demonstrating the types of senior roles that may be available to them when they 'achieve similar levels of competence' (Rogawski, 1971: 30). Task shifting in these settings appears to be focussed on *capability*, on the type of basic tasks that can be offloaded from busy professionals whilst providing access for IHCWs who, through a process of education and professionalisation, can build a career. 'Commonality' is an added benefit which can support communication between target communities and professionals, 'humanise' a service and plays an aspirational role focussed on visibility rather than systematic change (Braun, 2001). There is of course a question

[4] Rogawski refers to the high proportion of IHCWs that chose to continue their education even after completing the programme and finding employment.

[5] There was a 'rotation system' in place for students to ensure that they gained experience of difference aspects of the service.

as to whether Giblin's (1989) definition of 'commonality' is still applicable here given the emphasis on behavioural change in order to 'pass' within institutional settings; we will go on to explore this in more detail in the following section.

Interestingly, the new Training Director mentioned above introduced several changes to the course:

'Our new Training Director wishes to "start where the trainees are at" to foster "learning by doing" and to encourage the trainees to draw on their personal experiences whenever possible. The aim is to help students not only to gain knowledge and techniques but to assist them in their personal growth. The charge in orientation and focus of the training is unquestionably influenced by the professional background and the personal characteristics of the Training Director.'

(Rogawski, 1971: 30)

Here, we see the influences of an alternative approach to utilising IHCWs; a model Heath and Pelz (1970) define as the 'program aide'.

A community-based approach to task shifting: The Program Aide

An alternative model for the IHCW can be seen in the recruitment of 'program aides'. Broadly speaking, agencies adopting this approach appeared to regard 'commonality' as central to the role and 'worked to utlilise this uniqueness to the fullest extent' (Heath and Pelz, 1970: 768). Discussing the use of IHCWs at the Santa Barbara County Health Department, Heath argues that the IHCW is recognised as 'a person with a professionalism based on a grasp of the culture and feelings of a group rather than on specific academic preparation' (1967: 610). Under this model, informal, on-the-job training is therefore felt to be more appropriate than a didactic method and medical knowledge is only to be acquired in that it can be relayed to clients in simple terms, supporting communication between professionals and target populations. In fact, as this approach focused on 'preserv[ing] the indigenous essence of the person', further education and qualifications were seen to threaten 'commonality' as they increased the distance between IHCWs and clients (Giblin 1989:364).

Reiff and Riessman reflect on the need to discourage staff members involved in recruiting IHCWs from favouring 'middle-class characteristics' during the interview process, as 'the "style" of the non-professional is significantly related to his effectiveness, because it matches the clients' (1965: 8). IHCWs' membership of target communities, something we have already defined as 'bonding capital' (Woolcock, 2001) means that they have 'no need to validate [their] presence'; this is said to place them at an immediate advantage over professionals (Brager, 1964: 8). Where professionals must draw on expert knowledge to validate their status in a process of 'self-actualization' said to be threatened by identification with the client, the IHCW uses shared identity as a source of motivation to achieve positive change for communities; their peer status means that this is likely to be recognised

by clients as a genuine willingness to help (Brager, 1964; Reiff and Riessman, 1965). Some go further arguing that the IHCW should not possess a 'special body of knowledge' as clients need to believe that they will be able to reciprocate the support being provided should circumstances change (Reiff and Riessman, 1965: 9).

Nonetheless, framed in this way, the professional, who has been trained to rely on the 'abstraction of knowledge' as a form of control, is disarmed (*See* Abbott, 1988). This sense of disarmament is further captured by Halpern as he reflects on the use of IHCWs to facilitate communication between doctors and clients at the Rochester Mental Health Center:

'The professional's confidence in his adequacy as the steward of psychologic or case work skills quickly wanes as he deals with the poor. Usually, he does not get the positive feedback that assures him he is on the right track.'

(1969: 82)

From this perspective, the justification for 'task shifting' appears to be less about what is possible through training and instruction and more about recognising that ICHWs may be better placed to deliver certain aspects of health care. This is endorsed by Giblin who argues that ICHWs should not replace professionals but compliment them 'since each has a separate and important contribution to make toward achieving a common goal' (1989:24).

In terms of functions, whilst the 'program aide' may be required to complete some internal duties in support of professionals, authors were clear that the aide 'is not a handmaid to the professional' and should therefore not be performing 'menial tasks' they wished to avoid (Heath, 1967:610). Instead, there is an emphasis on interpersonal skills which moved beyond interpretation and included advocacy, health education and liaison between various services required by the client (Health, 1967). There are many references to IHCWs as providing a 'human link' supporting clients to 'negotiate the service jungle', moving between agencies and making follow-up visits to ensure the continuation of treatment or action (Reiff and Riessman, 1965: 13-14; Halpern, 1969). As a 'human bridge', providing a buffer between clients and services, the program aide was said to hold a challenging position; there are reports of IHCWs struggling to balance their role as community and agency representative (Halpern, 1969). Here, it could be argued that ICHWs were being exploited as creators of 'linking capital' (Woolcock, 2001), buffering the impact of service-related issues and masking the need for systemic change.

The language used in depictions of this model is heavily politicised and combative; program aides are described as 'missionaries', 'militantly oriented to changing social conditions' (Heath and Pelz, 1970; Brager, 1964: 5). As 'change agents', program

aides were involved in the planning, implementation, and evaluation of programme delivery; recognition of a new professionalism earned through lived experience meant they were to enter staff teams as respected colleagues in a horizontal team structure and trusted to work autonomously 'out in the field' (Brager, 1964; Heath and Pelz, 1970). As part of this broader approach, some agencies also created opportunities for IHCWs to feed into policy making decisions and invited community representatives to sit on the board of directors, a role Heath and Pelz (1970) define as the 'policy aide', however this was said to be a lesser used function of the IHCW.

The consensus within programme evaluations is that the use of IHCWs as program aides, whilst resource-intensive, encouraged engagement with health care services and adherence to treatment (Reiff and Riessman, 1965). However, the voices of clients appear to be missing from the literature and those of IHCWs are limited to an occasional case study or references to case notes.

The risk of exploitation and opportunities for empowerment

Distinguishing between task-oriented approaches ('routine aide') and those encouraging IHCWs to work autonomously ('program aide'), prioritising the needs of clients, Giblin argues that the former involves 'minimal' and the latter 'significant' levels of empowerment (1989: 362). Here, empowerment is also measured by the extent to which IHCWs are involved in policy and programme development; to achieve a higher level of empowerment 'indigenousness' must be recognised as 'an important criterion to ensure that the community for whom a program is provided is represented' (Giblin, 1989: 362). In promoting recognition and conscious inclusion, this viewpoint aligns with that of feminist theorists, who posit that the success of poverty programmes 'largely depend[s] on whether the poor are encouraged to identify their own needs and priorities and are 'able and entitled to make decisions" (Wong, 2003: 317/318). According to this definition, the 'program and policy aide' could be more empowering roles for IHCWs than that of the 'routine aide' discussed above. However, as we go on to discuss, potential flaws in the implementation of the program aide model within this context appear to have limited opportunities for meaningful participation and lead us to reconsider potential strengths of a more 'routine' approach.

There are references to the burnout experienced by program aides due to the holistic, informal and more 'emotional' nature of the role (*See* Reiff and Riessman, 1965). This might be another example of the exploitation of 'linking capital' previously discussed (Woolcock, 2001). We could speculate that this is less likely to have been an issue for 'routine aides' whose task-oriented role, whilst arguably limiting, provides boundaries that might have prevented overworking. Furthermore, there are numerous accounts of IHCWs being treated poorly by other staff members; the concerns of 'sanitarians' that IHCWs would 'lower their

professional status'; the initial reluctance of nurses to trust IHCWs with duties; the frustration of social workers who felt that IHCWs were 'stepping on their toes' (Heath, 1970: 612; Halpern, 1969). Whilst integration with existing staff teams appears to have been a challenge for both 'program' and 'routine' aides, the emphasis on role clarity in the latter appears to have reduced the risk of 'overlapping functions' and be drawn upon to ease status anxiety where this did occur; discussing the reactions of ward attendants who felt threatened by the recruitment of IHCWs, Rogawski emphasised the importance of clear roles and functions and talked of imbuing IHCWs with a '*supportive* role identity' (Italics added, 1971: 23). The focus on preparatory training and skill development with the routine aide model, particularly when dealing with severely mentally ill patients, is linked to addressing the anxieties of IHCWs and building confidence (Rogawski, 1971).

The program aide may have been designed to recognise 'commonality' and encourage respect for IHCWs, however Giblin's apparent assumption that this translates into practice, arguably fails to acknowledge, as feminist theorists have, that empowerment is 'a multidimensional and complex process' influenced by societal structures and realised through social interaction (Wong, 2003: 315). IHCWs may attend planning meetings but this does not mean that they feel able to contribute or are listened to by colleagues. Caro highlights the lack of technical knowledge amongst IHCWs needed to understand programme governance and the absence of 'stylistic skills' required to make effective contributions at board meetings (1981:79). In fact, critics have argued that the emphasis on maintaining commonality within the program aide furthered othering, protecting professionals from having to adapt their practice to communicate more effectively with minority groups (*See* Moynihan, 1969).

Part of the problem appears to be that program aides were working as 'agents of change' in a hierarchical system that failed to keep pace; supervisors, for example, were advised to ensure program aides understood that 'administratively, there is always a vertical relationship' (Heath and Pelz, 1970: 768). There is an emphasis on the 'experimental' and thus temporal nature of the program aide model which were largely outreach programmes added on to existing services (Braun, 2001). Program aides might have the special skills to thrive 'out in the field' but it seems that they were not equipped with the tools they needed to be heard when they returned to the office. Caro also highlights agencies that did involve program aides in the evaluation process tended to adopt a top-down approach, for example outlining objectives and developing tools used by IHCWs; as evaluations were often required by management to evidence ambitious performance targets, there was concern about 'authorizing evaluations that might reveal serious program weaknesses' (1981: 80). He concluded that the only way to avoid such shortcomings in future

programmes was to invest heavily in meaningful participatory methods, led by citizens and consumers.

Broadly speaking, the program aide model relied on the 'peer status' of the IHCW who appear to have been discouraged from furthering their education and gaining qualifications. There are references to the financial insecurity of ICHWs whose salaries were not always guaranteed and vulnerable to delays and changes in programme funding (*See* Naples, 1991). Whilst this is likely to have affected both program and routine aides, the latter were more likely to move into salaried, secure employment (Rogawski, 1971). In the 1970s the political context and federal funding priorities shifted; whilst citizen participation was still an expected feature of services for low-income groups, a growing culture of cost containment and performance management meant the program aide model lost appeal (Caro, 1981; Naples, 1991). There is much debate about the impact of URCAP, but ultimately it did not result in the permanent acceptance of program aides as 'professionals through experience' nor did it eradicate poverty:

'Many disadvantaged persons invested substantial time and energy in the planning and governance of anti-poverty programs with the expectation that their contributions would make an important difference. Some were bitterly disillusioned when they discovered that critical decisions regarding program funding were made at a federal level without the immediate participation of the poor.'
(Caro, 1981: 78)

Thus, whilst Braun (2001) argues that URCAP did eventually lead to additional and more appropriate services for low-income populations, this 'outcome-focused' perspective posits that program aides were failed and even 'betrayed'. Socialist or radicalist thinkers within the field of community work prioritising economic inequality (a viewpoint popularised in the 60s and 70s) may have argued that routine aides, who had been integrated into the health care system, better able to advance their careers and increase their household incomes were more 'empowered' in the long-term (Popple, 1995). However, others in the field would contend that this places too much emphasis on poverty and the vertical relationship with resource holders, undermining the importance of the 'micro' (Popple, 1995: 34). Many years after URCAP, Naples (1991) completed in-depth interviews with forty-two predominantly African American and Puerto-Rican women who had worked as community workers during the period. They found that most of the women, did not see their work as 'political' but as a 'civic duty' (Naples, 1991). Where funding was lost, they had continued to do their community work unpaid, finding other means of getting by. Participants 'constantly challenged the authority of city and state agencies … maintain[ing] a close watch over the actions of elected officials to ensure the interests of their communities were served'; they protested against racism and other forms of discrimination. For these women, who had

turned down opportunities to enter higher paying, more secure employment, poverty was a reality and therefore not something to fear (Naples, 1991: 479).

Crucially, Naples concluded that the women regarded 'their own empowerment and that of other community residents to be more significant to them than career advancement' (1991:483). Seemingly, the women in Naples' study not only appear to have exchanged the prospect of economic capital for social capital (Woolcock, 2001) but also endorse the assignment of meaning by feminist theorists to process over outcome (*See* Wong, 2003). In a similar qualitative study of female leaders of a coalition in low-income areas of New York, DeSena concluded that 'women were empowered by their participation…and developed a critical consciousness regarding politics, race relations and feminism' (1998: 311).

In fact, the notion that economic mobility is synonymous with empowerment has been criticised for adopting the value judgments of White, affluent men and undermining the agency of low-income women (DeSena, 1998). The empirical examples above support the view held by some neighbourhood work theorists that community work should '[equip]…groups and individuals for effective participation'; from this perspective an experimental approach is valuable if it educates, builds capacity and awakens political consciousness (Popple, 1995). This standpoint acknowledges the importance of social interaction, the value in strengthening social networks and creating of roles and functions which are personally significant (Shaw and Martin, 2000). However, this approach has been critiqued for failing to account for the structural factors shaping experiences and overestimating 'agency' (Popple, 1995).

The 'neighbourhood' is said to have historical significance for women given the dominance of roles within the domestic sphere and the greater involvement in community work; however, as we established in discussing the example of middle-class wives in France above, the nature and meaning of community work can vary according to economic positioning (Reiss and Reissman, 1965). Neighbourhood can however take on different meanings for communities in poverty, either as a site for injustice or as resource networks (Gilchrist, 2009). Gilchrist's suggestion that 'communities of resistance' can 'coalesce around experiences of systematic discrimination and exclusion' such as civil war and migration feels particularly pertinent here (2009: 5). Culture also plays a role; in the evaluation of a career escalation program (routine aide model) targeting low-income communities, Ruiz reflected that whilst Puerto-Rican women were likely to drop out due to their commitment to responsibilities at home, 'Puerto Rican men and Black women tend more than other groups to see view education as a ladder to career achievement', highlighting that Black women tend to 'seek leadership roles' (1976: 225). These examples remind us to avoid reductionist conclusions about the motivations of low-income women to fulfil CHW roles. It also serves to highlight

the value of adopting an intersectional feminist framework which acknowledges the way in which factors such as gender, class, race, ethnicity and culture interweave within a 'web of domination', meaning that 'that women from marginalized groups are often situated in multiple groups that pursue conflicting agendas' (Hughes and Dubrow, 2018: 81).

Summary of findings from the historic literature on task-shifting

In this section, I reviewed a rich body of literature from a period in recent history reflecting on the recruitment of people from marginalised populations into healthcare systems as part of a government funded programme in the United States (the 'war on poverty') seeking to address health inequalities. In so doing, I uncovered a number of themes that will continue to hold relevance in other time periods and settings; namely the significance of commonality (or 'lived experience'), social capital and power structures within health systems. It is also striking to note that most of the CHWs involved in the approaches explored thus far appeared to be racially minoritised women on low incomes; research findings point to a gendered conception of the CHW role given the emotional labour involved and the low pay. I identified two broad approaches to utilising CHWs; a pattern that will re-emerge when reviewing current examples from higher income settings later in this chapter. On the one hand, the 'routine aide' represented an attempt to integrate CHWs into the healthcare system creating career advancement opportunities through clearly defined roles. Yet, I have argued that the emphasis on developing medical skills and training meant that commonality was viewed merely as a way to humanize or extend existing provision rather than a mark of merit; routine aides therefore entered at the bottom of vertical hierarchies with little autonomy. I would suggest that this approach therefore fits the definition of 'task-shifting', emphasising the reallocation or delegation of simple tasks to unburden health professionals.

In the second approach, program aides and policy aides were encouraged to draw on their lived experience in a critical capacity, engaging in advocacy work and even feeding into decision making processes. They worked more autonomously on an outreach basis and it is suggested that they operated in horizontal staffing structures; this arguably better recognises commonality as a form of social capital not accessible to most health professionals and could be described as 'task sharing' in that it sought to merge different expertise. However, the purported difficulty of policy aides to contribute to board meetings in a meaningful way indicates that 'horizontal structures' may have been more of an ideal than a reality and the 'outreach' nature of the program aide role might also be interpreted as existing on

the fringes of the mainstream system. This raises questions about how far program and policy aides had the power to influence change. It is for these reasons that Caro (1981) called for greater consideration of the components required to achieve meaningful participation.

Finally, I considered debates related to extent to which those involved in each model might have been exploited or empowered. Underscoring the relevance of intersectional feminism to this subject area, this highlighted the heterogenous nature of women involved in this programme whose perspectives on what it meant to be 'empowered' were likely informed by other axes of social organisation (e.g. race, ethnicity, religion and so on) (Hughes and Dubrow, 2017). This body of literature thus points to the value of qualitative research in better understanding the perspectives, values and specific experiences of CHWs, of which there is surprisingly little for this time period, save for a small number of studies conducted decades after the programme ended (e.g. Naples, 1991). Within the global literature on 'task-shifting' (or 'task-sharing') initiatives recruiting people from marginalised groups, this programme represented an early wave of activity; the next wave of activity I identified was within low and middle income countries (LMIC). Following a chronological structure, I will now go on to review this body of literature, returning to more recent developments in higher income settings later in the chapter.

CHWs in Low- and Middle-Income Countries (LMIC)

Section overview

In the previous section, I explored evaluative literature on the use of lay workers during the 'War on Poverty' in the United States. I argued that the concept of 'commonality' is useful in highlighting the importance of shared experience within 'task shifting' initiatives and how this might signal weaknesses in traditional, professional approaches to health care provision. I also considered how 'commonality' can be used to distinguish between different models of 'task shifting', the impact on the women recruited under these alternative approaches, the potential for empowerment and the risk of exploitation. To gain a deeper understanding of the concept of 'commonality' within task shifting and the opportunities and risks for low-income women, I will now look at low and middle income countries (LMIC) where task shifting has been utilised extensively as a cost-effective solution to addressing treatment gaps in health care provision. I will also consider the extent to which programme providers in LMIC settings have adopted the participatory methods and qualitative research argued by Caro (1981) to have limited the impact of the interventions described above.

Policy Context for LMIC

Since the 1960s, national governments within low and middle income countries (LMIC) have been encouraged to implement community-oriented programmes to improve access to primary health care; funding has been provided by NGOs for pilot projects with additional sponsorship from institutions such as universities and churches (*See* Ofosu-Amaah, 1983; WHO, 1989). Lay members of local populations have been trained as Community Health Workers (hereon CHWs) and have played an important role in providing access to health care in communities, particularly in rural areas, where residents had previously been unable to afford the costs associated with travelling to larger towns and cities. Whilst there was an initial emphasis on physical illness, particularly as part of the response to the HIV/AIDS epidemic (WHO, 2008), there has been a gradual acknowledgement of the need to address the treatment gap for non-communicable disease including common mental health problems such as depression and anxiety (Verdeli et al., 2003; Barnett et al., 2018). The already restricted resources for mental health care do not tend to be 'optimally distributed' within LMIC settings; tertiary care services tend to receive the bulk of funding and trained professionals are generally located in psychiatric hospitals (Menezes et al., 2015: 324).

Global health organisations have played a leading role, drawing on the research produced by a burgeoning academic research community to build a case for the universality of common mental health problems and evidence the impact of treatment gaps on economic inactivity and growth (WHO, 2012; Bolton. 2019). The findings of programme evaluations have been used to build a set of frameworks and what appears to be a 'best practice' model which has been implemented in a wide range of LMIC settings (WHO*a*, 2008; WHO*b*, 2008).

The stepped care model and functions of CHWs

The model commonly adopted within LMIC settings is one of 'stepped care'; community health workers (CHWs) are trained to treat less severe mental health problems at the community level in a 'circumscribed' role using psychosocial interventions; those showing signs of more serious mental illness are referred to a medical professional for more specialist support as part of a 'stepped care' supervisory staffing structure (Patel et al., 2010; Honikman et al., 2012; Ngo et al., 2014: 4). As I go on to discuss later in this chapter, the 'stepped care' model in mental healthcare is common in higher income countries (HIC) such as the UK where it refers to the delineation of low-intensity and high-intensity treatment options to make more efficient use of resources (Martin et al., 2022). Individuals in HIC accessing these services may be offered low-intensity approaches such as guided self-help before being referred to a mental health specialist if their symptoms persisted (van Straten et al., 2015). However, what appears to

differentiate stepped care models within HIC and LMIC is the nature of 'task-shifting' underpinning these. Where models in HIC appear to focus more on 'inter-professional' task-shifting (the involvement of different types of health and social care professionals) and self-help approaches, models in LMIC tend to involve the recruitment of CHWs from local communities who deliver aspects of mental healthcare usually reserved for mental health professionals (Jack et al., 2020). Multiple randomised control trials have concluded that Western approaches to mental health care, namely the prescription of evidence-based drugs by health professionals and/or psychosocial interventions delivered by lay people, can be effectively implemented in LMIC settings if adapted for use by CHWS and shaped in response to specific cultural beliefs and values (*See* Patel et al., 2003; Bolton et al., 2003; Araya et al., 2003). Programme providers have developed tools that simplify diagnostic processes and have tended to opt for therapeutic methods such as Cognitive Behavioural Therapy (CBT)[6] and Interpersonal Psychotherapy (IPT) that can be simplified and manualised (Verdeli, 2003; Peterson et al., 2012 Nyatsanza et al., 2016). Thus, in addition to screening, psychoeducation, health promotion, adherence management, signposting and befriending, CHWs have been responsible for delivering simplified versions, or aspects of, talk therapies such as CBT (e.g. behavioural activation and problem solving) and IPT (e.g. interpersonal counselling)(Patel, 2008). In apparent acknowledgement of the ethical risks associated with this type of intervention, there has been an emphasis within the literature on continuous supervision from a trained professional that is available to the CHW (i.e. someone who lives and works close to the targeted community) to provide support and guidance and monitor quality (Patel, 2012). This marks a shift from early guidance suggesting that supervision and training could be time limited (Patel, 2012).

Returning to earlier discussions of professional hierarchies (see chapter 1), CHWs with limited education and no qualifications have been given access to a method previously 'off limits' to non-professionals; an argument framed around ethical concern and quality assurance long supported by the medical profession (Menezes, 2015). Authors have reflected on the disruptive potential of programmes in LMIC settings where 'patients and providers with no access to mental health services have few incentives to retain the status quo'; this is said to have created pressure to innovate within mental health care (Menezes, 2015: 326). The correlation between the absence of resources and CHW responsibility is further supported by a study comparing the use of CHWs in different socio-demographic contexts in Kenya which found that those working in nomadic settings provided a greater range of

[6] Please see glossary for definitions of CBT and IPT

curative services due to the scarcity of resources and distance from other health facilities (*See* Ochieng et al., 2014).

The findings of large-scale reviews assessing the impact of these interventions not only evidence that trained CHWs with limited education can accurately identify common mental health problems (e.g. depression and anxiety) but that they can also successfully deliver preventative care and complex treatment options including psychoeducation and counselling; there is widespread agreement that programmes have been effective (Joshi et al., 2014; Barnett et al, 2017). Programme success ('effectiveness') has generally been measured on the basis of treatment completion and symptom improvement. Vikram Patel, a leading figure in the field of global mental health, argued that these trials have 'thrown open the door of opportunity for task sharing to virtually anyone in the population'; beyond achieving programme aims, they have shown what is possible when evidence-based methods are democratized (2012:9). Whilst outcomes have been promising, this has been at a minimal scale and there has been a focus within recent literature on overcoming the challenge of expansion and sustainment (Naimoli et al., 2014; Menezes et al., 2015). The issue of sustainment will be discussed at greater length later in this section.

The concept of 'feasibility' in LMIC settings

Many interventions have been led by NGOs; there has therefore been an emphasis on feasibility and the need to encourage ownership at both the national and community level. The stepped care model relies on collaboration between different agencies, requiring a broader multisectoral 'systems' approach, building on the existing or infrastructure or developing anew (Peterson et al., 2011). As common mental health problems are not recognised either conceptually or as a health priority within many LMIC settings where mental health can be heavily stigmatised, programme providers have had to invest substantial amounts of time engaging policy makers, leaders, and funders as well as local and national stakeholders, to support implementation and the continuation of services past the pilot stage (*See* Ngo, 2014). The unwillingness of funders and existing service providers to commit resources has been cited as a challenge relying on broader campaign work to raise awareness of the importance of mental health and justify investment (Ngo, 2014).

To ensure 'feasibility' at the community level, a period of formative research appears to have been integrated into the stepped care model to understand local conceptualisations of mental health, the role of stigma and discrimination and any practical issues which could serve as barriers to engagement (Verdeli, 2003; Peterson et al., 2014). Programme providers have used qualitative methods such as interviews and focus groups to engage with a wide range of stakeholders; this has included gathering the views of prospective CHWs on planned approaches (*See*

Atif et al., 2019; Chibanda, 2019 b). Findings appear to have been used to shape the design and implementation of interventions. This has led to adaptations which have altered the functions of CHWs in different settings; examples include the preference for group therapy in settings where the 'self' was not recognised as a concept (Verdeli, 2003; Ngo et al., 2014), the use of prayer in Zimbabwe (Chibanda et al., 2017) and yoga techniques in India (Patel et al., 2008). In now globally recognised Zimbabwean project called the 'Friendship bench', mature women, described as 'custodians' of wisdom and culture, have been recruited as 'community grandmothers' and trained to provide simplified versions of talk therapy outside on wooden benches (Chibanda et al., 2011; Woolston, 2020: para 1). The Friendship Bench was originally referred to as the 'Mental Health Bench'; community grandmothers that suggested changing the name, arguing that nobody would want to come (Chibanda, 2019 b). Given the high levels of mobility amongst people in Zimbabwe, community grandmothers also proposed extending the first meeting, and shortening subsequent sessions (Chibanda et al., 2017). Despite requiring a 'major shift in session content' and challenging Western convention, this adaptation was 'necessitated by the [community grandmothers'] desire to ensure that the client takes home a solution…after the first visit' (Chibanda et al., 2017: 149/150). These developments are the result of ongoing engagement with community grandmothers, who are encouraged to share their reflections during regular meetings with the wider programme team.

Formative engagement has also played a pivotal role in strengthening the 'problem solving' component of the models; providers have sought to understand local triggers of common mental health problems and participants have been encouraged to suggest culturally appropriate solutions or coping strategies. Solutions have sometimes challenged Western values, for example the suggestion of trainees in rural Uganda that a useful response for a women who could not have children is to ask another female family member to marry her husband and raise children as a wider unit (Verdeli et al., 2003). Findings have then been used to co-design tools with and for CHWs such as vignettes which can be used as part of the problem-solving element of therapeutic sessions to encourage reflection and stimulate discussion (*See* Verdeli, 2003; Peterson et al., 2012; Nyatsanza et al., 2016). In a programme aimed at women experiencing perinatal depression in Pakistan, the team developed card games to supplement vignettes containing illustration representing personal wellbeing messages which were used to challenge thought patterns and encourage positive thinking; CHWs reported being able to apply the strategies covered during sessions they delivered to overcome difficulties in their own lives (Atif, 2019). Where this approach has been taken, CHWs have reported feelings of satisfaction in being able to offer practical and realistic support to service users (Atif, 2019).

Formative research has also enabled providers to understand the role of stigma and discrimination and discuss potential barriers to both engagement and impact with community members. This has included agreeing the appropriate location for therapy sessions to reduce suspicion amongst community members and the potential for stigmatisation of participants (Balaji et al., 2012; Nyatsanza et al., 2016). However, it has also presented opportunities for CHWs to work with families, neighbourhoods and in some cases whole communities to improve understandings around mental health through 'psycho-education', ease fears and challenge discriminatory practice (Balaji et al., 2012; WHO, 2015).

In committing to this approach, programme providers appear to have adopted some of the founding principles of participatory action research (PAR); an acknowledgement of 'other ways of knowing and making sense of the world', conducting research *with* rather than on community members and creating opportunities for CHWs and service users to play a leading role in developing solutions to address local issues (Baldwin, 2012: 468). According to methodological literature, PAR generates information that is locally relevant ensuring outcomes are useful; the examples of tool development above show how providers have 'enhanced the possibility of problem-solving action using research findings' (Baldwin, 2012; van Rooyen & Gray, 1995). This method has also been shown to give communities a sense of ownership increasing the likelihood that outcomes are empowering and sustainable (Baldwin, 2012). Thus, we perhaps see qualitative methods being used in the way that Caro (1981) argued was much needed and absent from task shifting initiatives in the US. It is worth noting however that, whilst the use of formative research is discussed within programme evaluations which explain how findings have been incorporated, there appears to be little published information on the design of formative research methods and even less on how the process was experienced by participants.

The endorsement of two other principles of PAR, the importance of ongoing reflection and adaptation and working towards transformational social change, is also less consistently apparent. Firstly, whilst there are examples of CHWs being encouraged to reflect on their experiences with supervisory teams and make adaptations to their approach where they feel necessary (*See* Chibanda et al., 2017), it does not seem that CHWs on other programmes have had such autonomy. Programmes that adopt approaches that are heavily manualised, using scripts and relying on close supervision have been justified on the basis that this improves consistency, assures quality and prevents CHW burnout (*See* Verdeli, 2003; Atif, 2019). Interestingly, CHWs in the former example were permitted to provide ongoing support to service users within the community, through phone calls and home visits. The arguments made for and against 'boundaried' roles here, in some way reflect the debated ideas in the utilisation of 'routine' and 'program' aides in

the previous section. The second factor – the extent of transformational social change - requires more detailed exploration.

Poverty and gender disadvantage: opportunities for transformational change

A starting point for exploring the extent to which mental health programmes utilising task shifting in LMIC have achieved 'transformational' change must start with an acknowledgement that PAR methods are most often used to target marginalised and oppressed groups (Baldwin, 2012). Patel (2012) argued that developments in mental health care have relied on the acceptance of common mental health problems as a universal condition and evidence confirming the global significance of the association between mental disorders, poverty and gender disadvantage[7]. Thus, the higher levels of poverty and the lack of resources within LMIC settings has a direct impact on the experience of common mental health problems; this includes higher rates of co-morbidity than in HIC (individuals dealing with both physical diseases and mental health issues) as well as a higher number of people dealing with multiple mental health conditions (Bolton, 2019). Furthermore, as previously discussed, global research has shown that women, who experience greater levels of economic deprivation, isolation and exploitation than men, are more likely to experience common mental health problems during their lifetime; this gendered patterning is particularly stark in LMIC settings (Fisher et al., 2012; Steel et al., 2014). There are two broad reasons why these findings are significant to this study; firstly, in highlighting the universality and global patterning of common mental health issues in relation to gender and poverty, they demonstrate the potential relevance of approaches developed in LMIC to the Scottish context and possible opportunities for shared learning. Secondly, they illustrate the additional challenges facing providers in these settings, arguably adding merit to the outcomes achieved by models we go on to discuss.

Earlier mental health programmes utilising task shifting appear to have focused interventions around what is deemed feasible to achieve by and within the targeted community; an example frequently cited within the literature is a project in rural Uganda which made the decision not to provide any financial support to CHWs and participants or focus directly on poverty within therapeutic sessions:

'The trainees frequently brought up poverty as a trigger of depression and we debated whether it should be added as a new problem area. Many aspects of poverty are not interpersonal (e.g., malnutrition) and the adversities associated with it can be chronic and cumulative rather than 'here-and-now' and relatively circumscribed like the other problem areas of IPT. We decided to

[7] There is also evidence to show the global significance of violence, conflicts and disasters and mental disorders (Patel, 2012) but these topics are beyond the scope of this thesis.

conceptualize poverty as a risk factor for depression rather than a trigger, and instead focus on discrete interpersonal events associated with it (change in role/ status, disputes and grief). Thus, we were hoping to focus on the aspects of poverty that are within a person's control to act upon, while acknowledging the numerous ones that are not.'

(Verdeli et al., 2003: 117)

Over recent years, there has been growing concern about the sustainability of outcomes where poverty is not appropriately addressed as a causal factor and the potential for CHWs to be exploited, thus furthering the experience of oppression (Daniels et al., 2012). Broadly speaking, the basic requirements for CHWs have been ability, availability, and willingness (Surjaningrum et al., 2018). It has been argued that this partly explains why the majority of CHW positions within LMIC settings are filled by women who are less likely to be in employment and more willing to engage in voluntary or low paid work (Surjaningrum et al., 2018). The general preference for female CHWs has also been associated with that fact that attributes desired by service users, which include being caring, empathetic, a good listener and good at problem-solving, are qualities traditionally associated with maternalism (Ramirez-Valles, 1998); the absence of literature exploring this is somewhat surprising.

Finally, the focus on addressing the gendered pattern of common mental health problems has meant that task shifting has been utilised heavily within women's health and, by association, children's health (Surjaningrum et al., 2018). For example, the success of large-scale government funded programmes in India and Pakistan where 'lady health workers' (*See* WHO, 2015) receive extensive training have been paid a small allowance to support women with perinatal depression has led to a proliferation of programmes targeting maternal mental health; more recent examples have begun to incorporate the delivery of adapted versions of CBT[8] and IPT (Rahman, 2008; Shipton et al. 2017). Authors have highlighted that the preference for women by service users within such programmes, who are both from the same community and have experience of pregnancy (Surjaningrum et al., 2018), leading to the recruitment of large numbers of female CHWs (WHO, 2015). Here we see how the concept of 'commonality' discussed in the previous section, which conceptualises the value placed on shared background and experience, could be said to have created opportunities for women within LMIC settings. I will return to the role of commonality later in this chapter. These developments have been underpinned by global health policy development highlighting the potential of the CHW role to empower women who would likely otherwise be completing unpaid care work in the home (*See* WHO, 2015).

[8] Please see glossary for a definition of CBT and IPT

Programme evaluations, which increasingly involve a qualitative component, report many positive benefits experienced by female CHWs, including improved confidence and self-esteem, status in the community, wider social networks and the ability to treat their children with the money left over from allowances (Shipton et al., 2017), however there has also been concern over the risk of exploitation. Reports of mistreatment in Africa for example led to the development of national policy guidance on the rights of CHWs which is said to have adopted a 'gender lens' (Daniels et al., 2012). In very low resource settings, CHWs have not been given adequate medical supplies and in some cases have had to find ways of supplementing this themselves (*See* Ochieng et al., 2014). The issue most frequently discussed within the literature however is that of renumeration; whilst providers adopt different approaches, CHWs in LMIC have generally operated on a voluntary basis, received gifts in kind from community members or worked for very low pay; in one study CHWs saw their role as a religious calling for which renumeration was deemed to be inappropriate (Surjaningrum et al., 2018). The challenge of maintaining the 'peer status' of CHWs felt to be important in maintaining trust between the CHW and client whilst also creating career pathways is frequently discussed (another example perhaps of protecting 'commonality') (*See* Atif, 2019).

However, the status of 'peer' does not appear to be valued in all settings. In qualitative research conducted in Kenya, CHWs in rural areas explained that accredited training, badges and uniforms would help to achieve greater levels of respect from community members who would then recognise them as 'experts'; those in peri-urban settings also expressed a desire to develop skills that they could sell (Ochieng et al., 2014). Further demonstrating the value of qualitative research, following longitudinal, ethnographic research with CHWs in Ethiopia and Mozambique, Maes and Kalafonos (2013) concluded that motivations were complex, including relationships with beneficiaries but also the desire to escape poverty and better support their families. This also serves to remind us of the value of an intersectional feminist framework, helping us acknowledge the unique experiences and perspectives of women from different cultures, in different locations and help us to avoid assumptions that empowerment is synonymous or reducible to economic gain, 'particularly…when social capital is understood in terms of the horizontal networks and associations' (Geleta, 2014: 421).

Whilst authors have argued that blanket guidance on renumeration may risk dismissing cultures where CHWs are motivated by factors such as religion and community status over financial gain, there is widespread agreement that livelihood support should be incorporated into models of task shifting in LMIC settings and that failure to do so threatens the sustainability of intervention outcomes, limiting opportunities for transformational change (Kakuma et al., 2011; WHO, 2015). This approach was adopted in a recent programme led by Basic Needs Vietnam and the

Women's Union, wherein group therapy sessions led by CHWs involved behaviour activation and problem-solving aimed at resolving depression and poverty issues (Ngo, 2019). Groups considered barriers to income generation and budgeting strategies; participants were given small micro-finance loans and were supported to develop savings plans (Ngo, 2019). The intervention was found to be effective in alleviating the symptoms of depression for participants and their families and achieving increases in economic activity.

The importance of 'commonality' and the 'collective' in LMIC settings

Before concluding this section and considering more recent developments in higher income settings, it is important to return to the concept of 'commonality' and the relevance of the 'collective'. Whilst we have already discussed the preference for 'maternal' qualities in CHWs, the skill most frequently cited within the existing literature is communication (Surjaningrum et al., 2018). The recruitment of CHWs from local communities in 'task sharing' initiatives is described as a way of 'providing locally relevant treatment by people from the same community, culture and language thereby making the intervention more culturally appropriate' (Nyatsanza et al., 2016:2). There is an emphasis within the literature not only on what is said (i.e. supporting clear and comprehensive explanations) but also *how* topics are broached and discussed (*See* Chibanda, 2019b). In a perinatal mental health programme in Indonesia, community membership constituted 'previous experience'; one mother using the service stated that 'CHWs do not need to improve communication skills because, -as village people living in the same area as users, they know how to talk to neighbours' (Surjaningrum et al., 2018: 4). Yoeli and Cattan's conception of 'embodied knowledge' as 'knowledge which has never needed to have been dis-covered or generated, [but] ... inherent within an individual human body or within the structure of a community and its ritual', feels relevant here (2017: 1745). This level of communication is said to be crucial to the CHW's duty to both educate and persuade (Yoeli and Cattan, 2017)). Here, community membership facilitates the acceptance of CHWs as someone who can be trusted to advise and guide. This supports Giblin's conceptualisation of 'commonality', wherein shared cultural background 'fosters a positive relationship between provider and client' (1989:362). It also provides another example of CHWs as holders of social capital, not accessible to those outside of the community (Woolcock, 2001). It has been argued that the delivery of mental health care by members of communities in LMIC has the power to normalise common mental health problems and remove the stigma associated with psychiatric hospitals where such issues can be conflated with more serious forms of mental illness (Mascayano et al, 2015; Bolton, 2019).

Findings from a study conducted by Patel et al. (2008) in Goa provides further evidence demonstrating the relevance of 'commonality' within mental healthcare programmes in LMIC settings. A randomised control trial piloting a stepped care intervention for the treatment of common mental health problems delivered by a CHW was conducted in both public and private primary health care facilities; the team concluded that the minimal difference between the trial and control arm within private settings was due to physicians already performing a similar role to that of the CHW (Patel et al., 2008). In a piece of qualitative research with service users supplementing trial findings Shinde et al. (2013) found that the most common complaint amongst those in the public health arm was that doctors did not listen to them. Whilst greater time limitations within public settings where doctors have a higher number of patients is likely to have been a factor here; findings of this qualitative research were said to imply that there was a 'paternalistic and distant' relationship between physicians and clients with an emphasis on what and how information was exchanged (2013: 51). This was found to be in stark contrast with those in private clinics who generally felt that doctors made the effort to learn about their lives, cared about finding the right treatment and treated them with dignity. If we assume that those able to afford private health care are likely to be closer in social position to the physicians they are visiting (unfortunately demographic data is not made available), this provides another example of the perceived value of 'commonality' amongst low-income groups. The communicative approach adopted by the CHW, who helped patients to understand their illness before discussing coping strategies, was said to be conducive to building a 'good interpersonal relationship' (2013: 50).

Another pattern related to 'commonality' is the recruitment of CHWs with lived experience which has been found to increase empathy with service users (Nyatsanza et al., 2016). This has been defined in a broader sense, as with the example previously discussed of CHWs with experience of marriage and pregnancy on perinatal mental health care programmes (Surjaningrum et al., 2018). In some cases, however, this has been specific to the health condition, as with the recruitment of CHWs with experience of HIV on a programme for depression in Zimbabwe (*See* Chibanda et al, 2017). Contrasting Western approaches to delivery, under this programme, CHWs were encouraged to share their own experiences during therapy sessions; as encapsulated by the reflections of the participant quoted below, this appeared to build rapport and encourage openness:

"When the counselor (CHW) told me that she too was living with HIV I felt an instant relief (kusununguka) and felt I could open up to her about my husband and his not wanting to use protection during sex".'

[Client on the 'Friendship Bench' programme]
(2017: 149)

The apparent role of 'commonality' here in gaining trust, privileging wisdom over academic qualifications and addressing stigma, may also explain the apparent feasibility of group therapy formats in some settings. There are accounts of participants drawing on their own experiences of poverty to suggest useful coping strategies, using their contacts to find employment opportunities for other group members and continuing to provide peer support following programme completion (Verdeli, 2003; Ngo, 2019). The positive impact of enhanced social networks for both service users and CHWs following interventions, particularly those who previously experienced isolation, has been emphasised within the literature (*See* Atif, 2019). The formation of these networks however first relies on consistent attendance at sessions; authors refer to the value of formative research to ensure services *feel* accessible, increasing the likelihood of repeated engagement (Nyatsanza, 2016; Chibanda et al., 2017; Chibanda, 2019b).

The success of task shifting initiatives in addressing common mental health problems within LMIC settings has received global attention (WHO, 2008). Some argue that the CHW models applied in LMIC have challenged Western practice demonstrating the importance of formative research, the potential of lay workers and the effectiveness of a simple intervention to address multiple conditions (Kakuma et al., 2011; Bolton, 2019). The examples cited within this section arguably acknowledge the mutuality of structural and interpersonal causes of common mental health issues and the value in collective rather than individual approaches to addressing these, resulting in positive outcomes for service users, CHWs and wider communities. This has led Menezes et al. to conclude that innovative practices developed within LMICs 'have the potential to transform and improve care in more advantaged settings' (2015:236). The implementation of task shifting in recent years within higher income settings and the extent to which this learning has been applied will be explored in the next chapter as well as gaps in the existing literature.

The implementation of CHW programmes in higher income settings

Section overview

Within this section, I move on to consider recent literature on the recruitment of CHWs within higher income countries (HIC). In the first section of this literature review, I explored a period in American history which involved a wave of activity regarding recruitment of people from marginalised populations. Whilst not as prominent as within LMIC, there has been a proliferation of CHW programmes and interventions in HICs over more recent years as part of efforts to reduce health inequalities, in times of austerity, respond to health crises and as a means of managing spiralling healthcare costs (South et al., 2012; Yoeli and Cattan, 2017).

The majority of these appear to be in the US, but examples can be found in a wide range of countries including Canada (Torres et al., 2013), Australia (Bartik et al., 2007), Belgium (Vanden Bossche et al., 2021), Sweden (Wrede et al., 2021), the Netherlands (Hesselink and Harting, 2011) Hungary (Kósa et al., 2020) and Spain (López-Sánchez et al., 2021). Whilst there has never been a formal CHW programme in the UK, I was able to identify several relevant examples of task shifting involving lay people in similar roles.

There are a wide range of models and titles, yet CHWs in HIC are most often lay people recruited to help improve the accessibility of health services for marginalised groups, particularly low-income populations and racially minoritised groups (Hoeft et al, 2018). In general, CHWs are 'from the community they serve or have similar living conditions and experiences as the service population' (Najafizada, 2015: 160), suggesting that 'commonality' is an integral aspect of the CHW role, maintaining relevance in different time periods and geographical settings. A central theme driving the need for CHW roles is a continued distrust in health professionals amongst marginalised populations. In the pages below, I consider examples from various HICs and identify two broad models for CHWs which closely resemble the historical examples of the 'routine', 'program' and 'policy' aides previously identified. In the first model, CHWs appear to be used to extend existing mainstream health provision and have thus been described as 'extension agents' (Hodgins et al., 2021). In the second model, the 'change agent', CHWs tend to be situated in the third sector (Hodgins et al., 2021). The role appears to be more 'political' in nature, with a bigger focus on advocacy, sometimes challenging biomedical or western conceptions of mental illness, mental health and wellbeing. I go on to question the persistence of this polarised model for CHWs in higher income settings and the absence of innovations apparent in low- and middle-income countries. I argue that 'culturalist' frameworks for interpreting the work of CHWs, which overemphasise 'difference' to the mainstream population, have led to an underestimation of their significance and value. Furthermore, findings point to the existence of knowledge hierarchies in fields of practice and research related to 'task-sharing' which threaten to limit the potential for transformative innovation.

The integration of CHWs into primary care teams: CHW as extension agent

EXAMPLES FROM THE US AND CANADA

One way that CHWs have been integrated into existing systems is as members of primary care teams, either within health centres or on an outreach basis. Roman et

al. (2007) for example piloted an intervention in Michigan targeting low-income pregnant women with poor mental health. In a multi-site randomised control trial, 'culturally diverse and bilingual' CHWs were recruited to work alongside registered nurses with the aim of increasing face-to-face contact time with clients, who had a history of rejecting home visits from nurses, combining nurse care with 'intensive social support' for the duration of the pregnancy up to the first year of the child's life (Roman et al., 2007: 246; *See* Richer et al., 2018 for a similar intervention in Canada). This draws on a peer model emphasising commonality:

'CHWs have an authentic presence grounded in life experiences similar to those of their clients, and may be able to reach women who have difficulty forming relationships, are fearful of professionals, experience language or cultural barriers to care, or are engaged in risk behaviors... '
(Roman et al., 2007:243)

While nurses focused on physical health issues and parenting, CHWs received didactic and 'practicum' training and used their 'experiential and cultural knowledge and skills' to 'bridge' access to care, translating health information for women, their friends and families and addressing 'environmental' issues by helping clients to navigate services (2007: 246). They also employed 'empowerment strategies', using peer activities to build life skills and encouraged social interaction to address isolation (2007: 246). Results showed significant increases in contact time with women facing barriers to engagement[9], thus 'favouring' the approach but evidence was limited on whether support directly correlated with improved mental health (Roman et al., 2007). In an earlier trial also comparing home visits by nurses and CHWs to 1178 low income, pregnant women in Colorado, initial outcomes suggested that there was no difference in maternal mental health outcomes (*See* Olds et al., 2004). However, two years later, those that had been visited by the CHW reported experiencing improved mental health, increased responsiveness and sensitivity towards others and a greater sense of 'mastery' (Olds et al., 2004). Returning to the intersectional feminist conception of 'empowerment as a process', we see here why Cleaver contends that there can be an incompatibility between more participatory approaches focused on capacity building and project frameworks which are 'by definition, a clearly defined set of activities, concerned with quantifiable costs and benefits, with time-limited activities and budgets' (1999: 598).

Notably, neither evaluation includes the specific experiences and perspectives of CHWs and it is therefore difficult to establish working conditions. In Colorado, CHWs are tellingly referred to as 'paraprofessionals' (Olds et al., 2004). The outreach nature of the work may have meant greater autonomy for CHWs, however CHW roles in Michigan are clearly defined within month-by-month

[9] Women with addiction problems were the only group for whom this was not effective

clinical guidelines and nurses in Michigan, described as having 'extensive knowledge and skills', appear to be responsible for completing all 'medical' tasks including screening and monitoring as well as having supervisory responsibility for CHWs (2007: 243). Whether these arrangements were experienced as supportive or restrictive is difficult to ascertain without qualitative insight. However, as the issue of burnout in CHW models has been well documented (*See* Hoeft et al., 2018) it is concerning to note that CHWs in Michigan appear to have large caseloads (30-35 clients each) (Roman et al., 2007).

In another multi-site study providers tested the use of 'promotoras' (hereon CHWs for consistency) to address the contextual sources of depression amongst low-income clients (Waitzkin et al, 2011). In this model, CHWs were based within primary care health centres, where it was argued primary health practitioners (PCPs) 'often do not recognise mental health disorders, do not provide adequate treatment, and report difficulties in responding to patients' psychosocial needs' (Waitzkin et al., 2011: 316/17). When patients attending appointments flagged a 'contextual issue' (e.g. housing insecurity), CHWs offered to help. CHWs were given a 'resource directory' developed by the centre which included details of relevant services, foodbanks and church run organisations; CHWs used this to make referrals, following up with clients and organisations by phone (Waitzkin et al., 2011).

The quantitative patient outcome data collected revealed little difference to the mental health of patients or contextual issues through the intervention. However, the findings of semi-structured interviews and job shadowing were positive; patients felt that CHWs, who they viewed as peers, gave them more time and listened more 'attentively' than PCPs (2011: 322/325). The value of the model in overcoming language and cultural barriers was emphasised by CHWs and other staff members at the centre. Interestingly, CHWs also highlighted their ability to diagnose depression whilst staff focused on the 'increased comfort' of patients in discussing difficulties' and the better awareness of depression amongst staff members (2011: 325). As these were not measures of effectiveness per say, the authors could only make a recommendation for further research. The authors also reflected on some challenges, for example 'turf wars' between CHWs and medical assistants (MA) who 'felt threatened by the promotora' (2011: 322). As a result of this tension CHWs were said to spend 'considerable time doing favours for the MAs, such as bringing patients into exam rooms, translating, or retrieving charts' (2011: 322). Anthias argues this type of scenario is where intersectionality 'comes into its own', allowing us to see how the organisational hierarchy leads to multi-level power structures which are realised inter-subjectively; through their hostile behaviour, MAs 'inferiorise' CHWs who appear to respond submissively ('doing favours'), thus cementing their lower status (2012: 10).

These examples suggest that there are qualitative benefits to recruiting CHWs into primary care teams helping to improve the reach of mainstream provision for marginalised populations, however impacts are difficult to capture, in part due to the methods used to assess effectiveness. It also reveals the seemingly hierarchical nature of staffing structures within primary care teams with implications for CHWs who attain 'entry level' roles, clearly distinguished from those of the 'professionals' they work alongside, comprised of prescribed tasks that sit outside of the 'biomedical' field.

Recognising the need to evidence impact, a broader CHW initiative was led by 'Duke Medicine', the largest employer for the Duke University Health System in North Carolina, which sought to gather fiscal and outcome data on the savings made to acute care services, in part as a response to reluctant physicians who were not convinced that CHWs were either valuable or affordable (Anderson and Boubjerg, 2013). In this model, CHWs work alongside nurses, social workers and health educators as part of clinical care teams, operating as care coordinators for marginalised groups, whilst also providing some basic health information (Anderson and Boubjerg, 2013). As with the examples above, their roles are outlined on a step-by-step basis. Notably, CHWs are also described as 'paraprofessionals' who *assist* professionals in care teams with service delivery; this involved changing the model already in use in some geographic networks where CHWs had initially worked autonomously but now worked 'supportively' with nurses, 'enabl[ing] the nurses to focus on tasks that require nursing capabilities' (2013: 22). As was the case in LMIC (see previous section), CHWs working in rural areas were said to have more autonomy. The information on salaries is nebulous; CHWs in one stream are said to receive '$16 per hour after 8 years in post' (2013:24). To provide CHWs with career progression opportunities, a higher level CHW role was created for CHWs with more capabilities and experience (Anderson and Boubjerg, 2013). This approach has been criticised for creating hierarchies amongst CHWs (Ibe et al., 2020). Given the emphasis placed on 'commonality' and the horizontal nature of relationships between CHWs and the people they support, this point feels pertinent.

A similar approach has been adopted in Canada where large numbers of 'indigenous paraprofessionals' (hereon CHWs), have been recruited to work alongside 'non-indigenous professionals' in a range of roles to achieve both 'clinical and cultural competence' in healthcare delivery to First Nation populations (Minore et al., 2009). Mirroring the case in North Carolina, the initiative revised roles already held by indigenous people in rural locations who, in the absence of medical provision, had been providing 'hands-on' treatment and initiating clinical interventions since the 1960s; the removal of these functions from CHWs was said to cause 'consternation amongst community members' (Minore et al., 2009: 4). As visiting doctors and nurses lacked understanding of CHWs' role, they were said to

lack confidence in their skills and training, fail[ing] to acknowledge paraprofessionals as colleagues with separate but equal knowledge who can make a valuable contribution to the team' (2009: 4). The authors contend that this had led to the underutilisation and marginalisation of CHWs within care teams limiting the impact of interventions (Minore et al., 2009). They concluded that an accreditation and certification programme for CHWs that mirrored that of professionals could help to address some of these issues. However, as we go on to discuss, the development of such systems in the United States appears to have led to a new set of problems.

As CHWs played an increasingly important function in health systems across the US, efforts to formalise the role have included the development of certification or credentialing systems. In 2010 the US Department of Labour included 'CHW' as a classified job category (Najafizada, 2015); at the time of writing nine States have formally instituted certification processes involving didactic training through a standardised curriculum with six States introducing a 'grandparent' clause legitimating very experienced CHWs (Ibe et al., 2020; London et al., 2016). Proponents have argued that certification acknowledges CHWs as a profession, provides clarity over desired competencies, consistency in provision and can help to secure more sustained funding streams (Eyster and Bovbjerg, 2013). Certification programmes have been developed at state level resulting in some variation, however there appears to be unanimous endorsement of CHWs as a 'bridge' to marginalised populations, providing 'culturally appropriate health education and information as well as informal counseling and social support … [whilst] also link[ing] individuals and families to needed resources and advocat[ing] for individual and community needs' (Ibe et al., 2020: 1). There has been concern that CHWs must take a leading role in the implementation of such programmes (Ibe et al., 2020); a comparison of developments in Texas and Minnesota arguably illustrates why.

The 'Texas Certification System' was largely led by State legislators, with early input from a national group which included CHWs (Richardson and Ormond, 2013). CHWs complete 160 hours of training costing between $500 - $1000 and were expected to recertify every two years (Richardson and Ormond, 2013). In a small-scale evaluation, CHWs reported that 'certification shifted costs to them' rather than employers, arguing that this meant both money and time were significant barriers to participation (2013: 8). CHWs also raised that training was not bilingual and researchers were said to be 'surprised to discover that many practicing CHWs have experienced Texas' credentialing program as a burden, rather than a benefit' (2013: 8). Furthermore, employers were said to be put off hiring CHWs due to the perceived expectation of higher pay (Richardson and Ormond, 2013).

Conversely, the Minnesota Community Healthcare Program is said to be a response to demand from grassroots, CHW-led organisation [seeking recognition] and developed in collaboration with the Healthcare Education Industry Partnership (HEIP), which included a full range of stakeholders including, government, service providers and CHWs (Ormond and Richardson, 2013). HEIP successfully pushed through state legislation which authorised Medicaid reimbursement of CHW services; the cost of the programme was therefore 'frequently borne by the student's employer' and only provides a 'foundation' upon which employers were expected to provide knowledge specific training (2013: 14). A 'distance learning' option was introduced to improve access for CHWs in rural areas and a peer network was set up for informal support (Ormond and Richardson, 2013). It therefore appears that co-production led to greater accessibility and reduced opportunities for exploitative practice.

In both cases however, certification does not appear to have resulted in significant changes to working conditions of CHWs; stakeholders interviewed in Texas 'noted the lack of direct connection between certification and improved pay, working conditions, or career prospects' (Richardson and Ormond, 2013: 9). A 2012 survey found that CHWs in Minnesota were variable and often paid hourly; concerns were raised around the sustainability of funding (Hardeman and Gerrard, 2012). Asked about the benefits of certification, CHWs in Texas referred to 'heightened credibility, recognition, and acceptance in the medical community' and in Minnesota, the certification system was said to be increasingly recognised as a 'proof' of the skills required to be successful (2013: 14).

More recently, authors of a large-scale review concluded that certification increases the credibility of CHWs and positively affects compensation (Najafizada, 2015: 160). However, certification is now required by funders in some areas (London et al., 2016). As it appears CHWs are often required to cover training costs (Hardeman and Gerrard, 2012), this may prevent access to jobs based on affordability (Ibe, 2020). Furthermore, there is said to be little evidence that certification has impacted on service delivery in a meaningful way for CHWs and the people they support with some arguing that the process undermines the 'intrinsic qualities' related to relationship building which are so integral to the CHW role (Ibe, 2020). These debates raise questions as to the main beneficiaries of this regulatory practice; CHWs and their communities or health professionals who gained solutions to operational problems and reassurance that this required no challenge or threat to the status quo?

Examples from Europe

In 2004, reportedly 'inspired' by the CHW role in the United States, 'health trainers' were introduced to NHS Primary Care Trusts (PCTs) 'to promote behaviour change amongst socially disadvantaged communities in England and Wales' (Gardner et al., 2012: 1178; Najafizada, 2015). Addressing inequalities and improving mental health and wellbeing were listed as priorities within The Public Health White Paper *Choosing health: making healthy choices easier* (Department of Health, 2004). This has been described as one of the most innovative developments in UK public health policy (Hodgins et al., 2021). By 2009, 76% of PCTs had a 'health trainer' (Cook and Wills, 2012), regarded as the 'principle lay community health worker in the UK' (Harris and Haines, 2012:331). Whilst the initiative led to substantial regional variation in implementation, for the most part health trainers have been lay people, often from target communities or sharing other demographic and experiential characteristics that allow them to act as 'cultural brokers'; 'personal qualities' were said to be 'more important than formal training' given a central function of the role was to gain access to marginalised groups not engaging with mainstream healthcare (Cook and Wills, 2012: 221/222). However, as with the 'integrated' examples discussed above, an accreditation system was developed based on national guidelines which outlined duties and competencies and included a mandatory training curriculum and a data recording system to monitor impact (Cook and Wills, 2012).

Broadly speaking, health trainers were to 'assess health and lifestyle risks, reinforce motivation, build confidence and skills and collaborate with clients to set goals', with an emphasis on empowerment (Gardner et al., 2012: 1179). Part of the role involved building knowledge of existing services in the area, so that they can share information and signpost. The initiative is said to have been widely interpreted resulting in two broadly different approaches; health trainers have either been hired as NHS employees in PCT led programmes working at the population or group level or by enhancing existing roles within third sector organisations (paid or voluntary) on projects targeting specific health conditions or population groups (Cook and Wills, 2012). Whilst initially tasked with helping people to address 'health behaviours' such as smoking and exercise, evaluations indicated that it was only after trusting relationships had been developed with health trainers that individuals' 'true needs' were identified which 'frequently related to mental health, welfare or lifestyle issues' (Ball and Nasr, 2012: 28). Those receiving support from health trainers emphasised the importance their 'lay identity' in that they were able to understand and acknowledge their life worlds, translating professional

knowledge into practical support often related to poverty reduction (Van Iseghen, 2022). 'Experiential knowledge' developed through lived experience of similar life worlds has reportedly been utilised by health trainers in different ways, either by sharing their experiences directly or in understanding the type of support that an individual is likely to find helpful (Yoeli and Cattan, 2017). Fundamental to this was said to be the time health trainers could dedicate to deep listening, which was felt to be lacking in the engagement with 'clock watching professionals' (Allen-Collinson, 2019). It is worth noting that CHWs in another UK study also referred to time as an important element of their role (Beck-Taylor et al., 2018). However, as appears to have been the case in multiple CHW programmes discussed so far, it has been argued that service performance data gathered failed to adequately capture the impact of health trainers in the programme (Van Iseghen, 2022). Furthermore, the recognition of 'lived experience' (or lack of) within hierarchical staffing structures emerges as a recurring theme across qualitative studies of the programme. As Cook and Wills reflect:

'The PCT health trainers are more akin to a paraprofessional with a greater degree of formality in the role, lower levels of autonomy, considerable performance management in relation to outcomes, and adoption of more individualistic approaches. Although they do not necessarily see themselves as organizationally assimilated, and often described being outsiders and having a low status within the NHS, accountability is to their employer.'

(2012:226)

Whilst limited, qualitative research with health trainers highlights issues related to low pay and limited career opportunities (Gale and Sidhu, 2019). As with examples from other HICs, relational issues were also identified in a study of PCT health trainers in Northern and Central England who reported 'a marked degree of conflict between themselves and existing community workers, particularly health and social care professionals, who were perceived as 'feeling threatened' by health trainers (Ball and Nasr, 2011: 27). In another small-scale qualitative study, five PCT health trainers in London reported low pay, limited career opportunities and suggested that uniforms and badges might help to improve their 'credibility' (Cook and Wills, 2012). Reflecting on findings from a qualitative study of 25 health trainers in the Midlands (UK), Allen-Collinson et al. reflected that health trainers engaged in boundary work to navigate structural power relations, involving 'recognition and valorisation of [the] referral aspect' of their role (2019: 606). The soft skills and time-intensive caring work involved in the health trainer role were deemed secondary to the technical skills and esoteric knowledge valued within the medical field:

'Such sustained support work, whilst not accorded high status within the healthcare hierarchy generally, nevertheless may be vital in translating esoteric, scientific, bio-medical knowledge into

public and community understanding, in order to achieve lasting healthy-behaviour change amongst those most at risk of, and from, unhealthy behaviour and health problems, particularly in disadvantaged communities.'

(2019: 609)

It has thus been argued that the emphasis on referrals and the translation (as opposed to challenging) of 'professional' knowledge in fact reinforces occupational hierarchies in institutional settings (Allen-Collinson et al., 2019). This example feels relevant to earlier discussions theorising the medical profession as a system which relies on the abstraction of knowledge and the exclusion of 'non-members' to maintain its position and survival (Freidson, 1972; Abbott, 1988). Authors have questioned the situating of CHW programmes within hierarchical healthcare settings such as the NHS, emphasising the importance of a horizontal dimension in developing trusting CHW-client relationships (characterised by 'responsibility for' rather than 'power over') (South et al., 2012). It is argued that CHW programmes are best located within a social model for health as they 'offer a mechanism to build more resilient communities through both bridging and bonding social capital, which is in turn associated with positive health outcomes' (South et al., 2012: 666). It is interesting to note that, following public health reforms, many CHWs now work for local authority or third sector services (rather than the NHS) where there are argued to be 'fewer cultural or attitudinal barriers to valuing or utilising lay knowledge' (Yoeli and Cattan, 2017: 1744).

Similar themes emerge from studies of projects seeking to integrate CHWs into primary care teams in other parts of Europe. In a perinatal programme aimed at Turkish women living in the Netherlands, women with a Turkish background were recruited as CHWs to support midwives to overcome cultural and language barriers (Hesselink and Harting, 2011). Qualitative insights gleaned through observations and interviews indicated that CHWs successfully engaged women, translated Dutch health information into Turkish and tailored the programme to the culture of participants, however this appears to be focused on omitting information not deemed to be relevant rather than making substantive changes to the programme content (Hesselink and Harting, 2011). The Turkish background of CHWs was said to be 'vital' in overcoming a lack of interest and trust towards Dutch midwives amongst the Turkish migrant women involved (Hesselink and Harting, 2011). The researchers concluded that such programmes had the potential to strengthen migrant women's support networks. As with the NHS health trainers discussed above, the Turkish CHWs found the 'boundary work' involved in the role challenging, especially where they were asked by clients not to pass information onto midwives (Hesselink and Harting, 2011). Those that worked more closely with midwives (i.e. as integrated teams) were said to develop more positive relationships but there was some resistance from some midwives involved who did

not see the value of the CHW role or agree with culturally adapting mainstream practice (Hesselink and Harting, 2011).

In Hungary, health mediators from the local area who were from, or had experience working with, Roma communities in the region were recruited onto a programme seeking to 'bridge the gap between general practitioners and their socioeconomically vulnerable clients' (Kósa et al., 2020: 3). Most of those recruited were middle aged women from the local area who identified as Roma. In addition to health mediation training, those with the 'appropriate' level of education were offered 800 hours of vocational training in assistant nursing. Health mediators were responsible for encouraging people from Roma communities to attend health assessments as GP practices and conduct health education activities. Data on attendance at health assessments indicated that health mediators had successfully encouraged uptake although it was not possible to measure specific impact against that of other health professionals involved. The authors concluded that health mediators can reduce the workload of GPs but also increase patient satisfaction 'by bridging the physical and societal distance between health professionals and their disadvantaged patients' (2020: 7).

As previously mentioned, interest in CHW programmes appears to have intensified during periods of global health crises. During the Covid-19 pandemic, many primary healthcare professionals were said to overburdened, overwhelmed by the growing psychosocial needs of patients, particularly those deemed to be 'vulnerable' (Vanden Bossche et al., 2021). A randomised control trial (RCT) in Belgium sought to address the impact of physical distancing measures which was causing 'psychosocial suffering' amongst people with limited support networks (Vanden Bossche et al., 2021). 50 CHWs were recruited as volunteers at 21 primary healthcare practices; CHWs needed to be aware of what it meant to live in a 'vulnerable' context either through experience or background. CHWs received online training and provided 'presence', check-ins, information about COVID-19 regulations and signposting to relevant services over an 8-week period (one contact per week). The RCT tested the impact of this against 'care as usual' and found no significant difference in several psychosocial measures: fear and anxiety about COVID, emotional support, ability to participate in social roles and activities, and isolation. However, a significant improvement was recorded in participant's 'self-rated perception of change in psychosocial health', attrition rates were low and there were high levels of satisfaction (Vanden Bossche et al., 2021: 11). Interestingly, the authors reflect that the outcome measures defined (e.g. isolation) were not realistic for CHWs to influence within an 8-week period in the context of an ongoing pandemic. Furthermore, the methodological requirement for comparative measurement was said to limit the autonomy of CHWs to respond to the unique needs of the individuals. It is suggested that the involvement of CHWs at an earlier point in the planning stages of the programme could have led to better

outcomes. The authors also reflect that outcomes were more effective when CHWs were more closely integrated into primary care teams; it is argued that this way the knowledge built through the CHW-client relationship could be maximised.

Interestingly, a realist qualitative study went on to explore the nature of the relationship between CHWs and participants in the programme (Vanden Bossche et al., 2022). The findings of in-depth interviews and focus groups with CHWs and clients are strikingly similar to the examples in other settings already discussed. Participants emphasised the importance of empathy, compassion and time and the adaptation of approaches to support the individual needs of clients. Relationships with professionals were conceptualised as being 'distant' as they are unlikely to share the same background as clients. By comparison, the CHWs were 'closer' to clients socio-demographically and able to foster a sense of connection and belonging by sharing their own experiences. Contrasting the hierarchical relationship conceived of between healthcare professionals and clients, the CHW-client relationship was said to be based on equality. The authors suggest that the interpersonal trust developed between CHWs and clients could contribute to institutional trust.

Finally, a similar approach was taken in 5-week health promotion programme in Sweden seeking to improve the subjective wellbeing and prevent common mental health disorders amongst migrants and asylum seekers (Wrede et al., 2021). Participants were invited to join weekly group sessions (2-3 hours) which covered signs and symptoms related to mental health and wellbeing, information about the Swedish healthcare system and provided opportunities to discuss their experiences with peers. As with the studies described above, sessions were led by 'health communicators' with migrant backgrounds in participants' native language; health communicators were said to have some form of health education (e.g. nursing) and received additional training relevant to the programme contents and delivery. The migrant background of the health communicator was intended to 'bridge linguistic and cultural barriers between refugees and health workers' and support 'trust, empathy, and connection with the target group' (2021: 5). The sessions were intended to be a 'safe space' for participants to reflect on and share their experiences. According to assessment data gathered at the start and end of the programme, fewer participants had symptoms of adverse mental health at the end of the sessions. The authors concluded that whilst identification (with health communicators) and empathy are not enough on their own to create clinical change, this type of social interaction can motivate individuals towards 'co-creating positive change' (2021:5).

Researchers evaluating the programme hypothesised that sociodemographic factors (e.g. gender, age, education, years residing in Sweden) would influence mental health outcomes, but this was not the case. The authors postulate that these

findings could reflect the successful adaptation of the programme by health communicators to participant's individual needs and the pragmatic, flexible approach to delivering group sessions. However, the limitations of this inference, and the need for further research, are acknowledged.

Community-based approaches in higher-income countries: CHW as change agent

So far, I have explored the literature describing efforts to integrate CHWs into healthcare services to extend or enhance provision. There are also community-based approaches which exist on the peripheries of healthcare systems; these interventions appear to align more closely with models in LMIC discussed earlier in that they focus on *adapting* mainstream provision using more 'collective approaches', for example seeking to strengthen, or diffuse health messages through, social networks (partners; families; wider communities). This arguably contrasts the more individualistic approaches (e.g. individual treatment) that characterise mainstream mental healthcare provision (Griner and Smith, 2006; Cook and Wills, 2012).

In a meta-analysis of 76 studies, Griner and Smith (2006) evidenced the effectiveness of adapting mental health interventions to be culturally meaningful, yet expressed frustration that not enough was done in this area; this included the specific cultures of racially minoritised groups but also broader approaches, such as the use of folk stories when working with children. Community-based interventions, often led by academics and delivered through charitable organisations, have tended to target marginalised groups with a particular focus on cultural minorities. Of particular relevance to this research study, initiatives frequently involve women on low incomes and the subject of motherhood (*See* Green et al., 2012; Tran et al., 2014). These approaches appear to share a commitment to participatory methods which actively involve CHWs in the design and delivery of interventions, distinguishing them from the integrated models previously discussed. However, as I go on to discuss, such approaches tend to be short-term and poorly funded, prompting concerns around the exploitation of people from marginalised groups and the sustainability of outcomes.

EXAMPLES FROM THE US

There are a small number of community-based CHW interventions that appear to be formally linked to mainstream health systems. Take for example the 'Screening, Education and Empowerment (SEE)' project targeting low-income, female caregivers (mostly from racially minoritised groups) attending family centres in New York whose children experienced mental illness and were themselves

showing signs of depression. The intervention was borne out of requests from 'family peer advocates' (hereon peers) already supporting this group (*See* Cavaleri et al., 2010) for mental health training to better identify and engage mothers (Acri et al., 2014). Providers gathered screening tools used in non-clinical settings and worked closely with experienced peers to develop four manualised modules. These covered screening, educating mothers about depression, the mainstream services available and activities encouraging mothers to take control of treatment decisions (Acri et al., 2014). Interestingly, peers proposed removing clinical language such as 'depression' as it could be stigmatising and prevent engagement; they also advocated for the removal of hierarchical structures:

'…family peer advocates felt some of the language and techniques were hierarchical; for instance, having the peer administer and score [the assessment for depression] …was potentially disempowering and created an imbalance of power between peer and parent… peers …sought to empower parents to be equal partners and take charge of their mental health. As a result, collaborative language was built into each module… Even the space between family peer advocates and parents was constructed in a way to foster a partnership, as demonstrated by the peer sitting next to, rather than facing, parents, whenever possible.'

(Acri et al., 2014: 841)

The authors concluded that the equalisation of power 'resulted in a more feasible, relevant, and acceptable intervention for mothers' (2014: 840). Challenging 'professional' approaches the involvement of 'empathetic' peers who shared their own experiences was said to reassure women who had negative previous experiences with mental health services. Despite concern from providers that strategies would be 'too confusing' (Acri et al., 2014), a follow-up evaluation indicated that peers effectively detected those at risk of depression, completed screening, psychoeducation and successfully delivered empowerment strategies which were deemed to be acceptable by parents (Acri et al., 2017). Findings prompted the authors to call for more research into the use of a peer-led mental health intervention for low-income mothers (Acri et al., 2017). However, the characteristics of piloting an 'evidence based' intervention appear to have negatively impacted peers who reported struggling to manage the additional work (e.g. bureaucracy) on top of their other duties; the project therefore "added more stress" (2017: 346). They also expressed frustration at the lack of responsiveness from the mental health clinic (the main referral agency) leading to feelings of discouragement amongst parents (Acri et al., 2017).

Many of the community-based CHW interventions which seem to sit further away from mainstream systems have targeted racially minoritised groups such as Latino populations. These have tended to draw on more creative methods. One example is the development of an intervention targeting 142 immigrant Latinas, mostly mothers on low incomes, deemed to be at risk of depression but not engaging with

support (Hernandez and Organista, 2013). In addition to cultural barriers including health literacy and language, other factors preventing service engagement were said to be 'stigma, a need to prioritize basic life needs, conflicting time commitments [and a] lack of childcare' (Hernandez and Organista, 2013: 224). It is worth highlighting at this point that these experiences correlate with those found to be experienced by single mothers on low incomes in the UK (Dermot and Pomati, 2016; Stack and Meredith, 2018; Morris and Munt, 2019). Previous studies using a 'fotonovela' as a depression literacy tool achieved significant improvements in depression related knowledge, reduced stigma related to mental health and antidepressants (Unger et al., 2012). It was also more likely to be shared with family and friends than other formats, thus increasing community reach (Unger et al., 2012). The 'fotonovela' is a dramatic story told through a booklet with pictures and captions developed through qualitative research with low-income Hispanic adults (Cabassa et al. 2007; 2008). Following recommendations that the fotonovela be used in conjunction with more intensive support from promotoras, providers opted to pilot this approach (Cabassa et al. 2007). The results of a randomised control trial showed 'significant patterns of pre to post gains for the experimental group as compared to the control group in depression-related knowledge, self-efficacy to identify the need for treatment, and reduced stigma towards antidepressant medication (Hernandez and Organista, 2013: 231). The authors emphasised the integral role played by promotoras who recruited participants, organised childcare, and read the fotonovela out loud in a group format to ensure inclusivity, thus helping participants to overcome multiple barriers to engagement (Hernandez and Organista, 2013). Community partners were also running 'promotora-led' support sessions for clients which identify 'maladaptive communication patterns between immigrant parents and their US born children and offers techniques for its improvement' (Hernandez and Organista, 2013:227).This indicates that, as with the example above, providers recruited CHWs already employed by partner agencies; it also suggests that CHWs here played a leading role in the delivery of programmes, working with more autonomy than those recruited through the integrated models previously discussed. Underpinning this approach is the concept of 'network diffusion'; time is invested into gaining buy-in from community members that the fotonovela is an important resource and one worth sharing amongst family, friends and other contacts.

In the example above, promotoras were recruited from existing programmes to support delivery. In another well-known project, promotoras were recruited and trained on a temporal basis as the intended delivery agents *and beneficiaries* of the intervention. Aiming to reduce pre-clinical depression and anxiety amongst this group, 'Amigas Latinas Motivando el ALMA (ALMA)[10], a grant-funded initiative led by academic centres and community partners in North Carolina, recruited

[10] The English translation is 'Latina Friends Motivating the Soul' (Green et al., 2012)

Latina immigrants to complete a 10-session training curriculum in preventative mental health (Green et al., 2012). Cultural values were integrated into training components including playing 'Loteria', a Mexican version of 'Bingo', to reinforce examples of coping strategies and developing 'inclusive' sessions for partners in response to the emphasis on familial relationships (Green et al., 2012). Promotoras were asked to draw on their own experiences, mental health priorities and share personal strategies during training which were incorporated into resources. Adopting a peer-based methodology, promotoras, described as 'natural community leaders', were given 'comfort baskets' containing the various resources and asked to share these and learned strategies with their networks, receiving monthly booster sessions for 9 months to reinforce concepts (Green et al., 2012: 2).

Unique to this intervention was the emphasis on improved mental health outcomes for *promotoras*; a pre and post-test intervention analysis found that promotoras had improved knowledge related to stress management, decreases in perceived stress and depressive symptoms and increased coping responses (*See* Tran et al., 2014). Of relevance to the target group of this study (single mothers on low incomes in Scotland), ALMA was underpinned by the principle that 'in order to care for others, one must first care for oneself', recognising promotoras as 'mothers but also grandmothers, caretakers, respected community elders, and key social figures' with the capacity to make intergenerational impact (Green et al., 2012). The authors emphasised improved perceived social support levels as a particularly significant outcome, given the preventative connection with mental health:

'ALMA's intent was to build the social support infrastructure for these women. As anticipated, some of the ALMA promotoras' social support networks grew stronger as a result of participation in the intervention. Certain promotoras reported continuing to interact after the intervention ended, engaging in activities such as creating a cycling club, celebrating special events, taking classes (English or computer) at the community college, and/or meeting monthly for coffee.'

(2012: 285/6)

Participants in this study are reported to come from a range of educational backgrounds and the majority (54%) were already employed, however some did state that more support related to employment opportunities would have been helpful (Green et al., 2012).

Examples from Europe

Whilst there are many initiatives involving 'service-users' in projects to redesign or evaluate health services in the UK and elsewhere in Europe, examples involving community health workers (CHWs) that are also related to mental health and wellbeing, appear to be less common.

In a previous section, I discussed an NHS programme integrating Lay Health Trainers into Primary Care Trust services (PCT); in some areas, providers opted to deliver this through third sector services. As with the example in New York above, this has often involved recruiting members of target populations who were already working for community organisations who take on the role in addition to their existing duties. Compared to their PCT counterparts, those based in the third sectors were said to have more informal, flexible roles spending more time engaging with communities; there was said to be greater emphasis on 'build[ing] social capital' by running events with groups rather than individuals aimed at strengthening networks and creating more supportive environments (Cook and Wills, 2012: 226). Where community engagement was used as a means of promoting mainstream provision in the PCT model, here, community engagement was a seen as 'a purpose in its own right' (Cook and Wills, 2012: 226).

However, health trainers across both models reported feeling 'ill-equipped' to deal with the mental health needs of people within communities and had requested counselling training; this has not been incorporated into either model, which continues to focus on 'signpost[ing] to other agencies and professionals' (NHS, 2020). As appears to be the case for peers in New York, this model is designed to link in with mainstream provision and aspects of mental healthcare provision seem to be off bounds.

A community-based participatory research programme (CBPR) in Sweden aiming to promote 'health equity' amongst low-income populations recruited lay 'health promoters' from relevant neighbourhoods (*See* Rämgård and Avery, 2022). Health promoters were involved from the beginning in designing the programme and their own roles. An important aspect of the health promoters' role was thus to mobilise and integrate local knowledge. They encouraged residents to participate and worked alongside community members and local stakeholders from various sectors (public, private, academic) in workshops ('co-creative labs') to develop programme objectives and structures. Speaking to the recurring theme of 'commonality', interviews, meeting notes and focus group sessions with the health promoters and local stakeholders indicate that the position of health promoters as members of the community (i.e. live in the area and understand the culture) was important in guiding their work, building trust with, and engaging, residents. Interestingly in this case, the extent to which their personal stories resonated was said to be more important to residents than ethnic background.

During workshops, residents raised personal, sensitive issues related to mental health and family situations; mental health problems were therefore identified as an urgent matter. According to qualitative research findings, health promoters had a sense of responsibility towards their community and the personal nature of

interactions led them to offer emotional support and practical help in addition to facilitating workshops. Much like examples from other settings discussed in this chapter, this led to difficulties finding balance in the role and health promoters described feeling 'overstretched' (2022: 8). Another challenge reported also aligns with earlier findings – that of managing power dynamics. There were said to be tensions between the interests of health promoters/residents and expectations of institutional stakeholders; the CBPR approach (health promoters were trained in participatory methods and the process was supported by academic partners) was said to enable health promoters to manage this and supported mutual learning. According to the authors, health promoters involved in the programme came to regard their 'tacit knowledge' as part of their own power which could also be used to empower the community (2022: 9). It is suggested that continual joint reflection also helped to ensure that the power dynamics between health promoters and citizens were also carefully considered throughout. The programme resulted in a new local association for health promotion (LindängenPower) led by health promoters and residents.

Summarising the findings from contemporary literature on CHWs in higher income countries

In reviewing the literature on CHWs within higher income settings, I identified a polarisation in approaches which appears to mirror that described in earlier literature [LINK]. I have summarised what I perceive to be the main features of these two models, based on the available literature, in the table below. It is important to note that not all examples fit neatly into these categories and can involve aspects of both (e.g. advocacy). Instead, the summary reflects a pattern within the literature, and I go onto reflect on the potential significance of this for this research study.

Feature	**CHW as 'extension agent'**	**CHW as 'change agent'**
Sector	Predominantly public sector	Predominantly third/charity sector
Nature of role	Paid, formal position in existing team	Some paid, formal positions but mostly voluntary, short-term initiatives
Main functions	Linking into healthcare services; signposting; translating	Advocacy; adapting healthcare messages and tools; informing policy
Dominant model of health	Biomedical model; individual treatment	Social model; emphasis on social networks

Dominant research methods	Randomised control trials (RTC) measuring individual outcomes with qualitative component	Participatory research methods
Environment	Vertical staffing structures	Horizontal structures

Table 3: Summary of two different approaches to recruiting CHWs identified within the literature on higher income settings

THE 'EXTENSION AGENT'

According to the available literature, CHWs recruited into mainstream health systems (e.g. primary care teams) in HIC enter low status, low paid roles in hierarchical staffing structures. Qualitative research findings have found that senior staff may not see the value of the CHW role and those in similar positions (i.e. salary bands) can feel threatened. Qualitative insights suggest that this plays out inter-subjectively through interactions in the workplace which can leave CHWs feeling that they do not belong, overworking to justify their employment and continually negotiating the boundaries of their role to avoid 'overstepping'. In making sense of these findings, authors have pointed to a potential incompatibility/tension in the situating of CHWs, representing a 'social model of health', and mainstream Western, health systems which, it is argued, continue to be underpinned by a biomedical model (Smith, 2013; Wade and Halligan, 2017). Returning to theories of professional systems, we understand that the privileging of esoteric knowledge functions to justify the medical profession, its power and influence. Advocates of the 'extension agent' model for CHWs emphasised the creation of employment opportunities for people from marginalised populations within healthcare settings. However, the low pay and status associated with the extension agent role arguably reflects the greater value placed on esoteric knowledge (here the 'lack of') over lived experience in healthcare settings. The nature of tasks 'shifted' onto CHWs tend to be simple with the explicit aim of 'unburdening' highly qualified health professionals. The introduction of training and certification systems appears to be more about evidencing value to colleagues (beyond CHWs' embodied knowledge); the importance of this to communities is not clear from the available literature. There are seemingly limited opportunities for CHWs to draw on their lived experience to influence the system. Instead, it might be argued that the emphasis on bridging and translation represents the exploitation of social capital (held by CHWs) to counteract inadequacies in the system for marginalised groups, such as the lack of trust in health professionals and

the complexity of health information. This again prioritises what CHWs can do for the system, rather than considering how the system needs to change to better meet the needs of CHWs and those they support.

Another justification of the extension agent model when compared with community-based approaches which tend to be short-term, is the potential sustainability of impacts for CHWs who formally enter staffing structures and can carve out careers in healthcare settings (Richardson and Ormond, 2013). However, the quality of opportunities created for CHWs has also been challenged. Koskan et al. (2013) purport that such models threaten to *limit* the economic and social mobility of CHWs who are tied to low status positions; the creation of a second level post for CHWs in the Texas certification system discussed in earlier in this chapter is perhaps a case in point. Another recurring theme pertaining to the hierarchical nature of this model refers to the relationship between CHWs and the people they support. There is much debate about the significance of payment for CHWs on what some have argued should be a peer relationship with their clients, yet there is strikingly little research exploring this issue with CHWs and communities. What is clear from programme evaluations is that CHWs working as 'extension agents' can struggle to balance their position as representative of both the system and the marginalised populations they support, not necessarily feeling they belong to either. This appears to contribute to the emotional labour involved in the role and could increase the risk of burnout. Finally, the prevalence of the biomedical model also appears to be reflected in the research methods employed to evaluate CHW programmes. It seems that providers often choose to conduct randomised control trials (RCT) focusing on individualised health outcomes which are quantifiable. It was striking to note similar frustrations across studies in different locations in HIC that the outcomes relevant to the work of CHWs (e.g. self-esteem; connectedness to services/communities) were either not included or not given the adequate time required to evidence impact. The lack of participatory approaches also appears to limit opportunities to explore with CHWs and communities which outcomes feel relevant and meaningful, and how these should best be captured. This again feels like a failure to recognise the value of the lived experience and a sidelining of the social model of health.

THE 'CHANGE AGENT'

The other model I identified within the available literature was that of the 'change agent' which, like the historical examples (program and policy aides) discussed at the beginning of this chapter, tended to be situated in the third sector and include short-term initiatives involving partners such as academics and policy professionals or link into mainstream health services. I have argued that the emphasis placed on 'collective' (e.g. group work; network strengthening and diffusion) rather than

individualised approaches suggest that this model is underpinned by a social model for health (Cook and Wills, 2012). The leveraging of 'embodied knowledge' seems to be central to the 'change agent' role which can include challenging conceptions of mental health and wellbeing dominant within mainstream healthcare drawing on creative methods. The prevalence of participatory methods which seek to dismantle knowledge hierarchies and empower CHWs to shape their own roles, and processes, contrast the 'extension agent' model and arguably reflect a greater value placed on lived experience. There also appears to be a greater interest in gathering outcomes related to the impact of initiatives on CHWs' health and wellbeing (as opposed to the service) (*See* Koskan et al., 2013). It has been suggested that such initiatives, which create opportunities for collaboration and dialogue with influential figures, can be empowering for CHWs and act as a 'springboard' for future employment opportunities:

'…promotoras [CHWs] gained knowledge and skills that improved their future employment opportunities. Through their community engagement and outreach, promotoras [CHWs] expanded their social networks, were introduced as community leaders to influential individuals within their communities, and some promotoras [CHWs] received job offers from their new contacts. Participants also reported they had introduced trained promotoras [CHWs] to future employers with the intent of creating opportunities for the promotoras [CHWs] to move on to better paying positions.'

(Koskan et al., 2013: 8)

However, it is important to avoid idealising third sector organisations and acknowledge the potential of exploitation. The third sector tends to be poorly resourced, meaning CHW (change agent) roles tend to be voluntary (Nkonki et al., 2011). Authors have been critical of mental health organisations that do not pay participants in 'co-produced' initiatives suggesting that this is in fact a condition of their involvement (*See* Grey, 2017). It is somewhat alarming to note that similar concerns to those raised by Caro (1981) regarding the limited involvement of program and policy aides in so-called 'participatory' approaches in the 1960s (see beginning of this chapter) have been expressed towards mental health organisations in more recent years, which some contend can be more 'participatory' than agenda setting (*See* Gillard et al., 2010). Indeed, I identified a gap in literature detailing participatory methods and evaluating how processes were experienced by CHWs, for example, how far CHWs felt able to contribute. Grey (2017) argues that the 'neo-liberal economic context' within which organisations must compete for funding, the marketisation of 'co-production' has led to tokenistic attempts. Moreover, the pressure on organisations to maintain a public image is said to have encouraged the inclusion of health benefits to participants within impact evaluations; whilst this may be well intentioned, Grey argues that this can reinstate the rhetoric that services 'be *therapeutic* (for them) rather than *transformative* (for others, for systems)' (2017:250). In a process defined as 'benevolent othering', the

impact made by participants, who are positioned as passive beneficiaries, may be overshadowed by findings aimed at reinstating the image of the organisation as 'benevolent giver' (Grey, 2017). This provides more critical lens for interpreting the inclusion of benefits to CHWs mentioned above. We are reminded here that power structures also exist within third sector organisations and initiatives which may be motivated, in competitive funding landscape, towards positive bias in reporting.

CULTURALISM AND OTHERING

Following the theme of othering, the emphasis across both CHW models in higher income settings on racially minoritised groups demands further attention. In their ethnographic study of the experiences of South Asian women in Canada, Johnson et al. refer to the utilisation of 'culturalist frameworks' by healthcare providers which provide guidance around cultural sensitivity but can also be used to 'explain away' broader, systemic issues:

'*…cultural descriptions…can also create groups as "outsiders." From this viewpoint, patients' problems with access, communication, and compliance are seen as occurring because customs and traditions conflict with mainstream medical practices. The focus on cultural difference thereby masks issues of power and control in health care contexts…The ease (and eagerness) with which cultural explanations are taken up to explain differences (or similarities) between groups is referred to as culturalism. In response to access barriers, there is a tendency to attribute the problem to the cultural beliefs and practices of the underserved group… rather than to discriminatory attitudes and practices of health care practitioners that act as barriers to health care. Culturalism, racism, and othering are thereby overlapping processes that reproduce and reinforce positions of domination and subordination, particularly when health care is provided by members of the dominant group to members of a typically subordinated or marginalized group. These overlapping processes affect a wide variety of underserved groups…*'

(2004: 256)

There are several ways in which the concept of culturalism can be applied to the existing task sharing literature which also serve to demonstrate the usefulness of the intersectional, feminist framework guiding this thesis. Firstly, the notion of 'culturalism' highlights the risk of essentialism in defining the racially minoritised groups being targeted by CHW programmes. Intersectional feminist theorists have argued that the utilisation of 'ethnic minority status' essentialises the populations being defined, undermining differences between people within these groupings and connections with people in the wider population (*See* Anthias, 2002). By invisibilising other points of connection (e.g. related to gender, class etc), the adoption of a 'culturalist lens' creates an essentialised 'other', positioned against the 'majority population' (itself a social construct). Consequently, approaches seeking

to adopt 'inclusive' strategies can actually facilitate exclusionary practices. Reflecting on an intervention aiming to improve access to mental health services for 'the Jewish community' in Salford, McEvoy et al. refer to the challenge of 'negotiating the accommodation of otherness' (2017:11). On the one hand, the project was said to signal that service providers were respectful of cultural otherness and recognised that belonging was an important buffer to mental health (McEvoy et al., 2017). However, the assumption of internal homogeneity led to an overestimation of cultural sameness between mental health workers representing the 'Jewish community' and those they were supporting, creating tensions between individuals and sub-communities (McEvoy et al., 2017). In this sense, the overemphasis on cultural difference (to the 'majority population') can lead to assumptions about 'shared experience' which perpetuate othering and threaten to limit the potential of services designed to support. The need to interrogate the meaning of 'lived' or 'shared' experience is an issue I go on to explore in more detail. For now, I seek to demonstrate the value of an intersectional feminist framework which recognises individuals as being positioned between multiple, intersecting locations (related to religion; ethnicity; class; gender; sexuality etc) meaning people can be simultaneously advantaged and oppressed (Anthias, 2012). This focus on points of connection as well as divergence helps to avoid minoritisation (which can lead to othering) within research and develop a more nuanced understanding of people's everyday realities.

The concept of 'culturalism' helps us to recognise that once a group has been essentialised based on cultural difference, this can be utilised by healthcare providers to defer attention away from broader issues with the system (e.g. communication; time), reinstating the purported adequacy of mainstream practice for the 'majority population' (Johnson et al., 2004). This can be seen in the literature on the 'extension agent' model (for CHWs), where potential issues related to the complexity, relevance and or communication of health information by professionals are reduced to 'language barriers' perceived to be overcome by CHWs who are able to translate. Even within the 'change agent' model, the situating of CHWs ('change agents') representing racially minoritised groups in the third sector, on the peripheries of wider health systems, can be perceived as an institutional form of othering, solidifying the position of marginalised groups as 'outsiders'. Whilst there are many positives to the culture and work of community organisations, they appear to hold a relatively weak position in relation to public and private sector bodies (to whom they are often reliant on funding). This arguably limits the abilities of community-based CHW programmes to challenge existing mainstream knowledge and practice, hampering opportunities to achieve transformative change. Again, this could be perceived as a form of exclusionary practice. These examples underscore the value of a *multi-level*, intersectional feminist framework in keeping structural (systems; processes) and representational (discourse) aspects of experience in the frame and thus facilitating the identification

of power (e.g. practices; relations) in these settings (Anthias, 2012). This can be further strengthened by drawing on the ideas within 'systems theory' which help us to recognise the medical profession as a system which must operate to maintain its own survival (Abbott, 1988).

The final point to make here regarding the concept of 'culturalism' relates to the contemporary literature reviewed. CHW programmes from HIC had more in common with (and appeared more likely to reference) the historic approaches in HIC than more recent examples from LMIC. I struggled to find any examples within the published literature of CHWs in higher income settings being involved in reviewing the feasibility of psycho-therapeutic methods (namely talk therapies) or delivering simplified versions of talk therapy themselves. Whilst various factors are likely to apply here, issues I go on to explore in later chapters, the lack of engagement in literature based on LMIC has been observed by authors in the research field. Harris et al. present qualitative evidence of bias against developments in low income countries, concluding that actors in HIC draw on 'flimsy national stereotypes' with confidence to make predictions about whether what works in one context would work in their own; this was said to 'occur with any context perceived to be different to one's own but is more apparent with low income countries because these were less familiar' (2015: 6). In a computer-based implicit association test distributed to health professionals and researchers, results showed moderately strong implicit associations between 'rich countries' and 'good research' (See Harris et al., 2017). More recently, Skopec et al. (2020) found evidence that indicates geographic bias against LMIC was impacting upon peer review and called for more research in this area. These findings thus point to the existence of a knowledge hierarchy within the academic research field on 'task-shifting', placing limits on opportunities for learning from innovations in LMIC to improve healthcare in more advantaged settings (Menezes et al., 2015). This also feels relevant to the issue of 'culturalism'; the overemphasis on difference (othering) to mask systemic issues, or here, opportunities for systemic change (Johnson et al., 2008).

Given the gap in research on higher income settings exploring the involvement of people with lived experience in shaping and delivering simplified talk therapy, I sought to understand the relevance of these approaches to women who are single parents on low incomes. The examples I had come across most frequently in the existing literature were modified forms of cognitive behavioural therapy (e.g. problem-solving therapy) and interpersonal therapy (e.g. interpersonal counselling). Before concluding the overall findings from the literature review, I have included the literature findings that contributed to my decision to explore 'interpersonal counselling' (IPC) in my fieldwork. As will be discussed briefly below and explained further in chapter 3, this was informed by various factors including the project partner's involvement in the development of IPC in Edinburgh.

A brief overview of Interpersonal Counselling (IPC)

This final section has the dual aim of providing an overview of IPC for the reader (if not already familiar) and to evidence the relevance of this approach to my research group. The literature included below was gathered separately to that reviewed so far through a combination of desk-based research using the search engines detailed earlier and articles shared by contacts in the field.

IPC is a 'brief, patient-centred approach to managing depression' which derives from interpersonal psychotherapy (IPT) (Weissman et al., 2014: 360). It is important to acknowledge that IPT is underpinned by the medical model as a conceptual framework (Law, 2011) yet recognises the 'universal centrality of relationships' and social roles to mental health and wellbeing (Ravitz et al., 2019: 165). Given my earlier critique of the medical model, the decision to focus on IPC warrants further explanation which is provided in the following chapter. IPT is based on the premise that depression can be a response to current interpersonal problems, often following or preceding from particular life events (Weissman et al., 2014). IPT is goal oriented - therapists adopt an 'active stance' drawing on a range of tools and strategies to help individuals to resolve the relevant issues, build social skills and develop support networks (Frank et al., 2014; Kontunen, 2020). The focus is therefore on 'here and now' issues rather than reflecting on events of the past, such as childhood trauma, as is common in more psycho-analytical models. Of particular relevance to this thesis, Toth et al. (2013) suggest that evaluative research on IPT was initially limited to the experiences of wealthy, White women. They contend that the emphasis on strengthening relational networks is particularly valuable for single mothers on low incomes given the increased risk of social isolation and need for social support (Toth et al., 2013; Stack and Meredith, 2018). Evidence suggests that IPT that has been adapted for mothers from economically disadvantaged as well as racially and ethnically diverse backgrounds, is not only effective in reducing symptoms of depression but outcomes may become stronger over time (Grote et al., 2009; Toth et al., 2013). Adaptations have included the incorporation of engagement sessions to address the cultural, psychological and practical barriers to treatment stemming from their socioeconomic circumstances, flexibility in the location for therapy sessions and partnering with bilingual staff (Toth et al., 2013; Beeber et al., 2007; 2009; 2013).

IPC was developed in response to growing demands for psychotherapy and accumulating pressure on primary care services (Weissman et al., 2014). It is a reduced form of IPT conducted over an average of six sessions (compared to 16 typically provided for IPT) (Kontunen et al., 2020). The sessions are also generally shorter in length (30-45 minutes), although the first session may be longer (Weissman et al., 2014). Importantly, IPC is manualised meaning it is 'easily taught'

to a wide range of professionals including nurses and social workers but also taught to people without a background in mental healthcare (Weissman et al., 2014: 361). It has been utilised to support people with mild to moderate depressive symptoms to enhance evaluation and triage processes, providing insights into issues for more effective signposting (Weissman et al., 2014). However, it has also proven to be effective as a standalone treatment to reduce depressive symptoms and improve psychosocial functioning, particularly for people who are experiencing depression for the first time (Badger et al., 2020; Kontunen et al., 2016; Menchetti et al., 2013).

Whilst cognitive behavioural therapy (CBT) focuses on thoughts and behaviours, IPC seeks to explore and respond to depression in an interpersonal context; as with IPT there is an emphasis on social roles and relationships (Ingram et al., 2021). As such, this aligns with a social model of health underpinning the CHW approaches of interest within this study. As depressive symptoms are often associated with particular interpersonal events, these form three of four focus areas in IPC:

- Disputes (e.g. arguments with a partner, family members or colleagues)
- Life transitions requiring a change in social role (e.g. having a baby; retirement) and;
- Grief (i.e. death of a loved one)

A fourth, less frequently used focus area ('loneliness/isolation') is included for cases where individuals are unable to pinpoint a specific event and instead struggle to form meaningful relationships. IPC is split into three phases, a beginning, middle, and end. In the beginning, IPC counsellors draw on a range of tools and strategies (discussed in greater detail below), working alongside individuals to link depressive symptoms to interpersonal events and agree which one of the four focus areas would be most relevant to the issues they are currently experiencing (Weissman et al., 2014). As IPC is a time-limited, highly structured approach, only one focus area is typically covered in the middle sessions. Given the interpersonal nature of issues, significant others may be involved in sessions if appropriate, thus leaning towards collective rather than individualistic principles of practice (Kontunen, 2020). Those receiving IPC will then be supported to prepare for the ending of sessions by reflecting on changes in symptoms and the tools and strategies they have learned. Typically, if an individual reaches the end of their IPC sessions and their symptoms have not been alleviated, they will be referred for more intensive, professional support. IPC has been adapted to be conducted in various formats, for different groups. It has been successfully conducted by practitioners from different backgrounds including mental health nurses but also junior mental health workers (Evans et al., 2021), youth workers (Wilkinson et al., 2018), community health workers with school level education (Masuzuka et al., 2017) and peer support workers (Fitzpatrick, 2018).

Conclusion

Within this conclusive section, I reflect on the overall themes to emerge from the literature review spanning different time periods and geographical settings. I go on to summarise the research gaps and opportunities identified through this process, focusing on potential implications for the research context (Scotland) and focus of this study (women who are single parents on low incomes). In doing so, I seek to respond to the initial question guiding this literature review:

What research is currently available on the topic of task shifting (or 'task sharing') to improve the mental health and wellbeing of marginalised groups? Are there any recurring themes and gaps in knowledge?

Overall themes

COMMONALITY, CONNECTION AND CONTEXT: CHWS AND THE SOCIAL MODEL FOR HEALTH

Evidence suggests that CHWs across the different settings and time periods explored have been able to make information and practice related to mental health, mental illness and wellbeing more accessible. Central to this appears to be the theme of 'connection'; research suggests shared or similar lived experience enables CHWs to connect with individuals from marginalised populations. This finding supports Woolcock's (2001) conception of trust as a *consequence* of social capital (here held by the CHW) allowing for the formation of trusting relationships. Following the theme of connection, CHWs may then connect the individual to projects or services (i.e. signposting). It might be said therefore that CHWs draw on 'bonding capital', using this to creating 'bridging capital' to the benefit of clients who are linked into services (Woolcock, 2003). The other aspect of connection relates to the connection of individuals to others in the community, strengthening and/or building social networks. This seems to be a more prominent feature of CHW models that sit outside of mainstream healthcare systems (i.e. primary care services), where a more individualised approach to mental healthcare is adopted (Cook and Wills, 2012). This includes initiatives led by community organisations, partnerships between third sector and public bodies, or in areas of low and middle income countries where there is limited infrastructure. Strategies such as network diffusion focus on the 'identification and mobilisation of community's pre-existing resources and relationships' and therefore have the potential to be self-sustaining; proponents support increased ownership of initiatives by community members who would no longer rely on the assistance of institutions and 'outside' organisations (Koskan et al., 2013:9). This model is based on the premise that mental health support becomes more accessible as it is embedded within

marginalised communities. It is argued that collective practices may lead to the reaffirmation of shared cultural identities; a greater sense of 'belonging' is known to have a positive impact on mental health and reduce feelings of isolation (Resmicow et al., 1998; McEvoy et al., 2017). There were repeated references within the available literature to the ability of CHWs in different settings to encourage a sense of belonging amongst the people they were supporting (McEvoy, et al., 2017; Vanden Bossche et al., 2022).

Another way in which CHWs appear to utilise their lived experience to develop trusting relationships is in the acknowledgment and understanding of people's life worlds and contextual issues that may impact their ability to access mental health support. It is notable that these issues often mirrored those reported to be experienced by women who are single parents on low incomes, for example, childcare, financial concerns and stigma (Dermott and Pomati, 2016). Authors have referred to this as 'experiential knowledge'; knowing 'how to help those who have undergone similar life experiences to themselves' (Yoeli and Cattan, 2017: 1745). The centring of social networks and contextual issues (or social determinants of health) have led some to reflect on the potential of CHW programmes to address the inequalities experienced by marginalised populations and empower communities (Ormond and Richardson, 2013). It is for these reasons South et al. argue CHW programmes 'should be located within a social model of health' (2012: 666).

Reflecting on the overall findings, there is another dimension to lived experience that supports mutual understanding and the development of trust; a recurring finding across different geographic settings and time periods was the importance of communication. This not only applied to *what* is said (i.e. the translation of health information into different languages) but *how* a CHW communicates that indicates 'commonality' (*See* Surjaningrum et al., 2018; Chibanda, 2019*b*). Whilst not always clearly articulated or specified (the subjective nature of this likely makes this challenging), this appears to relate to aspects of interaction such as word choice, phrasing and body language. This form of 'embodied knowledge' held by CHWs who are recruited from within closed communities is said to be 'innately ingrained within an individual or community' (Yoeli and Cattan, 2017: 1745). The intrinsic quality of these interactions, and the potential not only to improve understanding, but the viability of information related to mental healthcare is difficult to capture or evidence. This is one of several ways in which the work of CHWs appear to go under-recognised within programme evaluations in higher income countries (HIC). The lack of space (i.e. formative research) given to understanding the complexity and meaning of lived experience to CHWs and defined 'communities' within HIC had in some cases led to essentialism and threatened to impede the effectiveness of programmes (McEvoy et al., 2017). The available evidence suggests that the extent to which CHWs are able to draw on their experiential and/or embodied

knowledge to support marginalised communities depends largely on the CHW model, the degree of autonomy associated with the CHW role, opportunities for upskilling and the strength of partnerships (i.e. how easy it is to signpost).

A final point to mention here from the qualitative research with those supported by CHWs is the importance of 'deep listening', the carving out of space and time for people to share their concerns and experiences (Allen-Collinson et al., 2019). In some cases, participants referenced these qualities in contrast to their experience of engaging with health professionals, pointing to systemic issues, namely, the capacity of health professionals to dedicate the time required to build trust with clients, the use of inaccessible language within health services and limited opportunities to verify understanding (Visram, 2017; Vanden Bossche et al., 2022).

Power structures, knowledge hierarchies and the risk of exploitation

Looking across the academic literature from all settings and time periods, it is strikingly apparent that CHWs are mostly women on low incomes who exist within power structures which can leave them susceptible to exploitation and mistreatment (Surjaningrum et al., 2018; Hodgins et al., 2021). Given the gendered patterning of the CHW workforce, the emphasis on care work, and evidence of exploitation, surprisingly little appears to be written on the role of 'gender' within CHW programmes and initiatives (notable exceptions being Naples, 1991; Ramirez-Valles, 1998; Daniels et al., 2012). Exploitation and mistreatment appear to be particular issues in settings dominated by a biomedical model of health (i.e. mainstream healthcare systems in higher income countries) where hierarchical staffing structures are in place. The assignment of simple tasks and low pay can be taken as objective indicators of CHWs' low status within these models (i.e. routine aide; extension agent). It is my own reflection that evaluations of these approaches tend to emphasise opportunities for CHWs to 'unburden' health professionals who can 'shift' simple tasks (and focus on more technical work), rather than what they *bring* to the service in the form of their experiential and/or embodied knowledge and their ability to connect with people from marginalised communities. Authors have stressed how much health professionals have to learn from the knowledge and skills of lay health workers suggesting that such learning should be incorporated into training programmes (Yoeli and Cattan, 2019). The low status of CHWs also appears to be realised intersubjectively; the examples of mistreatment from colleagues in roles at similar levels seemingly anxious to assert their superiority and maintain their position on organisational hierarchies (Halpern, 1969; Heath, 1970; Rogawski, 1971; Ball and Nasr, 2011; Nkonki et al., 2011). Navigating these power dynamics and professional boundaries seemed to involve intense emotional labour for CHWs. The failure to recognise the value and impact of CHWs' work is arguably reflected in issues with evaluation measures, reported

across multiple studies, which tended to focus on short-term, individualised outcomes (Gale and Sidhu, 2019). This frustration also points to top-down decision-making processes and the limited use of participatory approaches to designing research methods within mainstream healthcare systems (Rämgård and Avery, 2022). On the experiences of health trainers (HTs) in the NHS in England, Allen-Collinson et al. write:

'*Whilst the time-consuming labour of 'deep' listening, working-with, helping and supporting clients sometimes over many months, may not be organisationally valorised as highly as esoteric knowledge and technical skills, it was this form of time-intensive work that was identified by HTs as so distinctive to their roles'*

(2019: 607)

The same authors posit that the NHS is upheld by an ideology of caring at the same time as denigrating caring work (Allen-Collinson et al., 2019). South et al. (2012) reflect that whilst lived experience is assigned low value within health settings, evaluative studies show that it is CHWs' 'lay status' that is valued by programme recipients. It is also worth noting the bounded nature of these CHW roles; the clearly prescribed tasks, limited opportunities for career progression and lack of influence (Eyster and Bovbjerg, 2013; Yoeli and Cattan, 2017; Gale and Sidhu, 2019). Returning to conceptualisation of professions as a 'systems', these findings might be regarded as attempts to maintain the low status of CHWs (representing a social model of health) to protect the superior positioning of biomedical knowledge within knowledge hierarchies (Abbott, 1988). This systemic function is after all said to be crucial to maintain the survival of the medical profession (Abbott, 1988).

Efforts to dismantle knowledge hierarchies appeared to be more prominent in the other CHW model I identified within the existing literature (the 'change agent' or 'policy aide') where participatory approaches were used more frequently, signifying a greater value of lived experience. There appeared to be greater investment in the mental health and wellbeing of CHWs, the strengthening of CHWs' own social networks and the development of confidence and self-esteem; this formed part of a 'springboard' approach aiming to improve career opportunities in a way that was argued to be more empowering to CHWs and their communities (Koskan et al., 2013). However, there is also evidence of power structures and the potential for exploitation within these settings. Whilst CHWs (and wider communities) may be invited to draw on their experiential and/or embodied knowledge within projects, positions were largely voluntary, and job outcomes were not guaranteed. The potential of payment to disrupt the peer relationship between CHW and those they support was used as a justification, yet there is surprisingly little qualitative research exploring the perspectives of CHWs and relevant communities on this issue. Such

approaches tend to be situated in the third sector which are said to hold relatively weak positions in broader health and social care systems, often reliant on organisations with more power for funding (Beresford, 2020). I discovered examples or claims of essentialism, tokenism and 'benevolent othering' by third sector organisations fighting for survival in competitive funding landscapes (Grey, 2017). These organisational power dynamics also appear to place limits on the ability of third sector organisations (and thus the CHWs recruited through them) to challenge or influence mainstream knowledge and practice. I noted very few cases where health professionals were involved in participatory CHW initiatives. This might be said to represent another form of 'task-shifting', in this case the offloading of responsibility to poorly resourced community organisations – as expressed by Rämgård and Avery:

'Underfunded organisations and institutions thus tend to exploit the engagement of health workers, perpetuating a situation where the burden and responsibility is placed on individuals working directly with people needing their support, rather than carried through adequately resourced structures.'

(2022: 10)

Power structures were also present in the literature on CHWs within low and middle income countries (LMIC), for example most of these programmes appeared to be led by NGOs and CHWs tended to be situated at the bottom of 'stepped care' staffing structures. Concerns have been raised about the exploitation of CHWs (mostly women) who can work long hours on a voluntary basis; there were also examples of CHWs paying for their own resources (Daniels et al., 2012; Surjaningrum et al., 2018; Hodgins et al., 2021). However, comparing the overall literature, it struck me that CHW programmes in LMIC appeared to incorporate aspects of the two different approaches to recruiting CHWs identified in higher income settings. To ensure feasibility in non-western settings, these approaches tend to start with participatory (formative) research which can involve adapting methods of treatment (commonly talk therapies e.g. cognitive behavioural therapy; problem solving therapy; interpersonal counselling) which have been developed by mental health professionals and thus might be said to belong to the medical profession. This has not only involved reviewing and adapting the content (e.g. language/terms) but also how it is delivered, to suit the needs of people in communities and account for potential barriers such as stigma. Furthermore, talk therapies have been manualised so that CHWs themselves can conduct sessions with the groups and individuals they support. I struggled to find any examples of this within the published academic literature on higher income settings. Crucially, CHWs in these programmes work autonomously (often due to circumstantial factors such as rurality/ the absence of infrastructure) whilst forming part of wider mental health teams who provide supervisory support and include mental health

specialists. The stronger examples (those I would argue exemplify 'task-sharing') appear to balance autonomy with a combination of professional and peer supervision (See Chibanda, 2017; 2019*b*). In this way, professional and lived expertise appear to be merged in a way I was not able to identify within the literature on HIC. The involvement of marginalised groups in the adaptation and delivery of talk therapies, such as interpersonal counselling (IPC), has been argued to democratise access to medical knowledge (Singla et al., 2023).

Research gaps and opportunities

Women who are single parents on low incomes

Reflecting on the available literature, the evidence included within this chapter demonstrates that the work of CHWs and CHW programmes is relevant to the experiences of women who are single parents on low incomes as a marginalised population in Scotland dealing with multiple perceptual and practical barriers to mental healthcare. This includes factors such as stigma, trust and childcare. The situating of CHWs within a social model of health speaks to the multiple contextual issues which have been found to influence the mental health of women who are single parents on low incomes such as financial pressures and social isolation. Whilst there are examples of projects involving or even targeting mothers, there does appear to be an emphasis on racially minoritised groups. Drawing on the concept of 'culturalism', and applying an intersectional feminist framework which accounts for multiple levels of experience (structural; representational; individual) and interconnection of multiple social locations (gender; class; religion etc), I have argued that an emphasis on cultural difference can other those ascribed to these groups and limit discussion of the implications for wider systemic change. Exploring the potential of CHW approaches to improve the mental health support for women who are single parents on low incomes, whilst maintaining awareness of the heterogenous nature of this grouping (more on this in the following chapter), could contribute towards discussions on the broader potential of this work and the significance of multiple social locations (such as gender, class, ethnicity etc.). Relatedly, there appears to be an opportunity to contribute to a gap in participatory research exploring the feasibility of CHW models with prospective CHWs/marginalised groups which prioritises discussions around identity and the meaning of lived experience. Doing so could help to minimise the risk of essentialism and top-down decision-making processes as identified within the existing literature.

Mental health policy and practice development in Scotland

Surprisingly little appears to be written on the subject of 'task-sharing' in mental healthcare within the Scottish context. However, the findings of this literature review feel very relevant to the aforementioned focus in developing the peer work

force within Scottish mental health policy and, more specifically, the gap in research exploring how to best integrate peer work roles into mainstream mental health services (Gordon and Bradstreet, 2015). Whilst there were some concerning findings related to the organisation structure and culture of the NHS, projects were based in England and it is not clear whether these would apply to NHS Scotland; this feels pertinent to explore. Findings evidenced the importance of effective partnership working in achieving positive outcomes for CHWs, targeted communities and wider stakeholders. Whilst not without its challenges (see Chapter 1), I would argue that this aligns with recent commitment to strengthening partnership working in Scotland through the development of health and social care partnerships (HSCP). It is suggested that CHWs are best situated within a social model of health; this feels compatible with the emphasis by the Scottish Government on working closely with communities to address the social determinants of mental health and health inequalities (Scottish Government, 2023*a*). Arguably, the innovative nature of this work also speaks to the purported desire of the Scottish Government to take mental health policy in a 'distinctly Scottish direction' (Dayan and Edwards, 2017). Finally, the attention paid to the multiple, intersecting social locations held by individuals in the research group (see following chapter), aligns with the most recent mental health and wellbeing policy strategy, which acknowledges experience as 'multifaceted', involving 'aspects of identity [which] can interact and combine to affect… mental health' (Scottish Government, 2023*a*: 2).

Academic research field on 'task-sharing'

The existing literature underscores the importance of participatory approaches to research and practice in its potential to dismantle knowledge hierarchies and acknowledge the lived experience of CHWs and the marginalised groups they are purported to represent. However, there were few examples of participants being involved in project design and a general lack of detail about the methods adopted; this is concerning given claims of tokenism within mental health organisations (Grey, 2017). It seems there is a need for more participatory research which details exactly *how* participants were involved, works to understand their experience of the process and provides appropriate compensation. The limited involvement of mental health professionals in participatory projects within higher income settings signifies a need for spaces that support mutual learning between people with different types of knowledge (e.g. experiential; embodied; empirical). A notable finding from the literature on LMIC was that CHWs were invited to discuss and shape adaptations of evidence-based methods (talk therapies) in a way not evident within the literature identified on higher income settings. Furthermore, I was unable to find examples wherein CHWs in higher income settings actually delivered simplified forms of talk therapy (as they do in LMIC) and very little appears to written about this within published, academic work. Given the themes to emerge from this review, namely power structures, knowledge hierarchies and professional

threat, this feels like an important finding to further explore. Doing so would also address a gap in research exploring the potential of innovation from LMIC for higher income settings.

In summary, the research gaps identified within this literature review, which this research study sought to respond to, were:

- A need for more research exploring ways to improve the mental health support available to women who are single parents on low incomes as a marginalised group in Scotland
- A gap in research exploring the potential of 'task sharing' in Scotland, accounting for the Scottish mental health policy and practice landscape
- A lack of research exploring ways to maximise peer roles within the Scottish health and social care system
- A need for more participatory research on 'task-sharing' which involves marginalised groups and health professionals and adequately details the research process
- A gap in research in higher income settings exploring the feasibility of involving people with lived experience in shaping the design and the delivery of talk therapy

In the following chapter, I move on to describe how these research gaps informed the development of my research questions and design of my fieldwork methods.

Introduction

This project began with the broad aim of exploring the potential of 'task sharing' to improve the mental health support available to women who are single parents on low incomes in Edinburgh. In the previous chapter, I reviewed the existing literature and identified important research gaps and opportunities which shaped the research questions I sought to address through my fieldwork.

My research questions were therefore:

1. How are mental health issues experienced, and understood, by women who are single parents on low incomes? What are their perspectives on mental health support?
2. How can people with 'lived experience' influence the design of an Interpersonal Counselling (IPC) intervention in ways that feels meaningful and supportive?
3. What opportunities (if any) do research participants see for peer roles in an IPC intervention?
4. What are the implications of participatory and collective approaches to mental health service provision for women who are single parents on low incomes, professionals and wider communities?
5. What are the wider implications of research findings for the potential of 'task sharing' in mental healthcare in Scotland, the UK and globally?

As this was a complex piece of fieldwork involving multiple components and changes, the infographics overleaf (fig 2; fig 3) are intended to provide an initial overview of the final approach. Within this chapter, I first outline the ontological and epistemological underpinning for the research design and discuss the decision to adopt a participatory approach. An iterative and reflexive approach was adopted and, as such, the project involved multiple changes. I therefore begin by describing the initial, proposed research methods, and the ethical considerations informing these decisions, before moving on to describe the actual approach taken to data collection, analysis and presentation. I have tried to include a detailed account of the ways in which advisory group members and research participants shaped these changes in direction. This responds to what I identified as a weakness within existing participatory research in the 'task-sharing' literature wherein a lack of detail made it difficult to ascertain the level of participation. I end the section reflecting on what I perceived to be the successes and limitations of the fieldwork process.

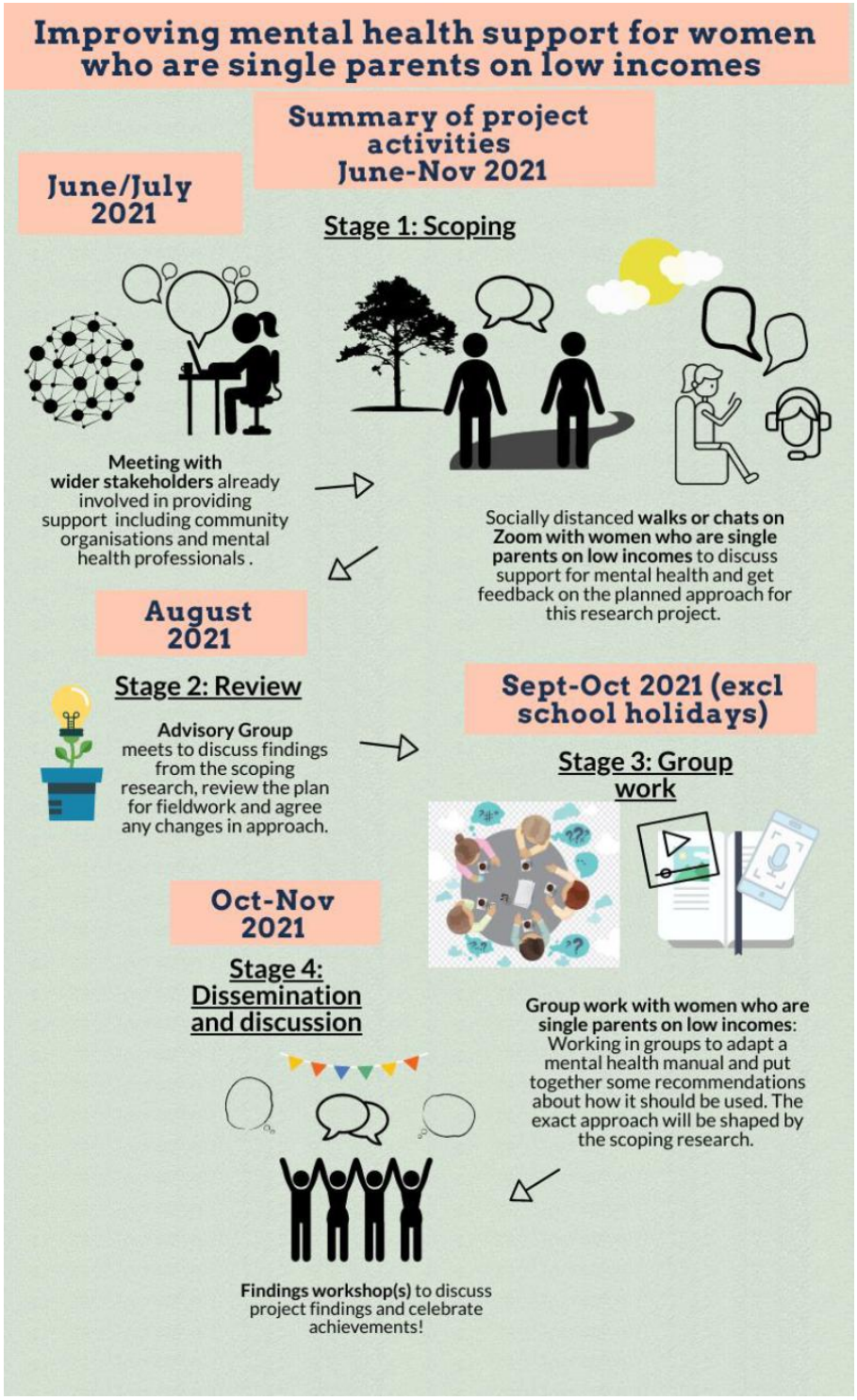

Figure 2: An overview of the main stages of fieldwork

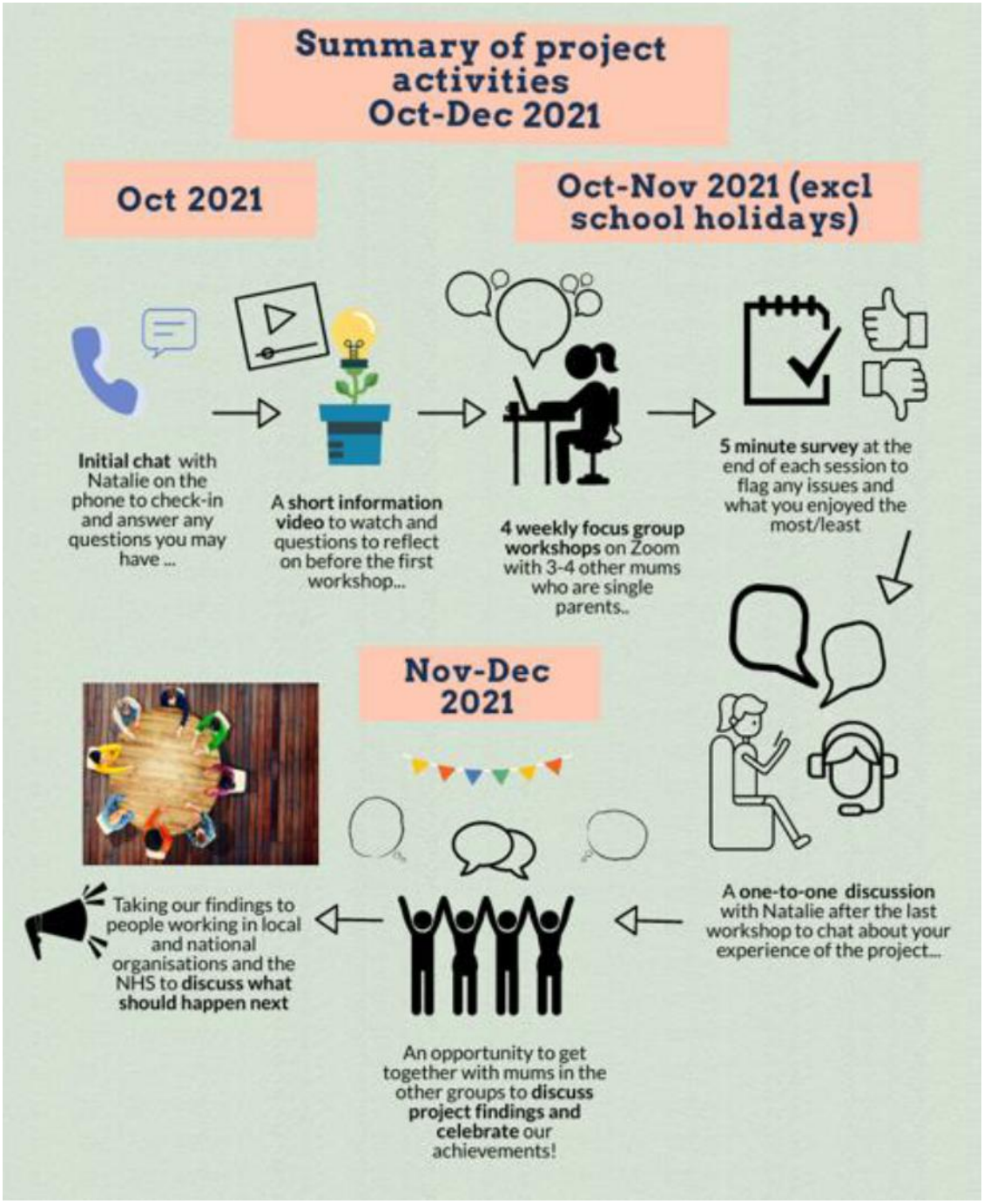

Figure 3: A more detailed depiction of the 'group phase' of fieldwork

Research Design

Ontological and epistemological underpinning

According to Beck (1979) the purpose of social science is said to be 'to understand the social reality as different people see it and to demonstrate how their views shape the action which they take within that reality' (quoted in Bracken, 2010: para 4). Outlining the ontological perspective, I assumed in designing my methodology is therefore 'a critical facet of the research process because it enables the researcher to uncover how their perceptions of human nature impact on the approach, they consciously adopt to reveal social truths' (Bracken, 2010: para 4).

As previously discussed (see chapter 1), this project was guided by a multi-level intersectional, feminist framework which conceptualises experiences as existing across multiple levels of reality including the macro/structural (organisational systems and structures), the meso/representational (symbolic representations/discourses) and the micro/individual (individual/identities) which shape and interact with one another (Winker and Degele, 2011). Social categories are thus located 'within a broader social framing that attends to power, hierarchy and context – both spatial and temporal' (Anthias, 2012: 6). Importantly, the maintenance of distinct levels of experience also helps us to recognise people can be assigned to a social category (e.g. racially minoritised) with material and social consequences but this may not align with an individual's self-perception and their own sense of identity (Anthias, 2012).

The project is therefore situated within the interpretivist paradigm whereby social reality does not exist independently of social actors but is composed of 'shared interpretations that social actors produce and reproduce as they go about their everyday lives' (Blaikie and Priest, 2017: 41). Everyday language and concepts are taken seriously and there is an emphasis on locating and elaborating meaning (Blaikie and Priest, 2017). My priority within this project was to understand how the women involved made sense of their experiences and needs, in their own words. The literature reviewed in the previous chapter revealed that evidence-based therapeutic methods are most often designed by professionals with limited input from participant populations. I sought to take the concepts used within interpersonal counselling (IPC) to participants, to see how they interpreted these in the context of their own lives.

Within this paradigmatic context, 'quality' (or validity) denotes authenticity rather than generalisability (Hiller, 2016). I thus required rich, in-depth (qualitative) data and the space for inductive ('open to surprise') and deductive ('theory led') inquiry even if this meant engaging with fewer participants (Winker and Degele, 2011: 57). In contrast to positivist approaches which position the researcher as 'distant observer', here my own lived subjectivity is an active ingredient in knowledge

creation and thus must be acknowledged and accounted for (Gaventa & Cornwall, 2015).

Deciding to do participatory action research (PAR)

Participatory action research (PAR) is 'multiform' (Swantz, 2008: 31), however PAR researchers do share the epistemological stance that 'power is embedded and reinforced in dominant (i.e. positivist) knowledge production' (Gaventa & Cornwall, 2015: 469). Intersectionality and PAR have been widely described as 'epistemologically coherent'; in a recent PAR project exploring health inequalities in Edinburgh for example, Kapilashrami and Marsden found that 'employing an intersectionality lens helped illuminate links between individual subjectivities and wider social structures and power relations' (2018:1). Acknowledging the value of lived experience, PAR seeks to dismantle knowledge hierarchies by involving communities in the research process, researching 'with' rather than 'on' participants to revise understandings and change practice (Reason and Bradbury, 2006). In this sense, the interests, experiences and perspectives of participants, who are often from marginalised groups, are 'the driving force' in the co-creation of new knowledge (Baldwin, 2012: 469). Reason and Bradbury (2008) argue that PAR is therefore *political*, as people are invited into decision making processes related to issues that affect them but also *empowering* as it supports people to recognise the value of their knowledge as well as other skills and abilities in achieving transformative change; participatory approaches are increasingly popular in health inequalities research (Felner, 2020).

In addition to its epistemological relevance and alignment with my personal values, there were several other factors influencing my decision to choose PAR. The first related to my positionality as a PhD student who was not a member of the research population. The emphasis within PAR on creating space to verify meaning and for participants to take the research in new directions felt conducive to my aim of maintaining the authenticity of accounts. Whilst positionality was always going to be a limitation of this project (this is discussed in more detail below), the focus on individual and collective reflexivity, offered another tool to establish depth in understanding and maintain awareness of how my own stance as a White, middle-class woman, at the time without children, may have been influencing the research process.

Secondly, I was keen to ensure that the knowledge co-created through the research project resulted in some form of action (rather than simply awareness raising). The broad aim of exploring how people with lived experience could be involved in the design and delivery of IPC was pre-defined having been informed by the 'task sharing' literature. Existing evidence highlights the crucial and often neglected potential of lived expertise but also the importance of partnership working. As I do not have a medical background, I wanted to ensure that what was being

proposed (e.g. adapting the language within IPC) was possible under clinical governance guidelines and that the safety and wellbeing of participants was protected throughout. It therefore felt imperative to involve a wider range of stakeholders including mental health professionals, community organisations and funders. I hoped that by doing this the project would be supported by the full range of relevant expertise and create a sense of shared ownership if the project were to be sustained beyond the period of my PhD. I also sought to contribute to a lack of participatory research in the literature on task-sharing involving professionals from health settings.

Thus, it is important to acknowledge that this project differs to more traditional conceptions of PAR whereby:

'…action against 'power over' relations implies conflict in which the power of the dominant classes is challenged, as the relatively powerless begin to develop their new awareness of their reality, and to act for themselves.'

(Gaventa & Cornwall, 2015: 469)

Conversely, I sought to create a research community of different stakeholders committed to mutual learning and a shared goal of improving the support available to women who are single parents on low incomes. This project was therefore underpinned by an 'extended epistemology in which experiential, practical and prepositional knowledge are equally valued' and this range of expertise is drawn upon to affect change (Chiu, 2003: 174). However, as Felner reflects 'the semantics of "participation" are insufficient to build a foundation for equitable participation among all partners' (2020: 550). My saying that all knowledge was equally valued would not have adequately addressed the potential for unequal power dynamics within and between the different stakeholder groups I sought to involve. As discussed in the previous chapter, the failure to consider how power relations might influence the research process has led to the tokenistic and sometimes exploitative involvement of lay people in health research described as 'participatory' leading to the misrepresentation of already marginalised populations and reinstatement of dominant thinking (Farrington, 2016; Grey, 2016).

It is also important to highlight the alternative constructions of reality that can occur between different professional groups (Baldwin, 2012). Unequal power dynamics within focus groups with health professionals have been found to negatively influence communication between participants, the ability to contribute and authentic expression (Tausch & Menold, 2016). In light of these examples, I tried to remain aware of power relations in the design and planning of my fieldwork. This began by abandoning the ideological inclination to bring all stakeholders together. I aimed to create safe and supportive spaces where people felt able to speak openly (if they wished to) and had room to reflect. I therefore

decided early on that I would engage with each of the stakeholder groups separately through interviews and focus groups and invite all participants to a stakeholder event at the end of the research process. Acknowledging the importance of involving the research community from the beginning of the research process I sought to set up an advisory group with representatives from each stakeholder group. The specific methods I chose to employ are discussed in the following section.

In summary, the project was guided by PAR principles which align with some of the key principles of co-production in mental health research, namely respecting and valuing all forms knowledge equally, acknowledging unequal power dynamics, creating safe and supportive spaces and the commitment to continual reflection (Hickey et al., 2018). However, researchers have been criticised for misusing the term 'co-production' without adhering to each of the key principles included within official guidance (Jakobsson et al., 2023). The limitations of this project mean that, whilst my approach was informed by these approaches, this project should not be defined as a 'co-produced' mental health research project or a PAR project. I will now go on to consider these limitations in more detail.

Limitations of a PAR approach

The first and perhaps most important limitation of the PAR approach adopted related to my positionality. I was not a member of the research population and whilst I did have almost ten years of experience conducting qualitative research, limited scope and resources prohibited me from being able to train participants as co-researchers. My positionality contributed to my decision to use PAR and whilst I sought to involve participants and wider stakeholders in all parts of the research process, for example decision making, leading discussions, analysis, and review, I would be conducting the final analysis and writing up the thesis. Upon completion, I would receive a PhD which I hoped would advance my academic career. Whilst I was keen find other ways of disseminating findings that felt useful to the research community I was trying to create, ultimately, this meant we could not be described as 'equal partners'.

The challenges of conducting PAR as a PhD student, and within academic institutions more widely, have been discussed by many authors (Seymour 1998; Klocker, 2012; Southby, 2017). The requirement to seek ethical approval prior to accessing research communities and for any subsequent changes can limit flexibility and eat into already tight timeframes. In academic research projects, University ethics committees get the final say on what is appropriate, safe, and feasible for PAR participants; this has been referred to as 'bounded empowerment' (Felner, 2020). This meant that I went to participants and wider stakeholders with a set of pre-defined questions and a detailed proposal for fieldwork. This also means that

the project did not meet a vital requirement in official guidance on co-production in mental health research; shared ownership, decision making and responsibility from the *beginning* of the research process (Hickey et al., 2018).

The initial plan had been informed by the existing literature but also the project partner who was heavily involved in the development stages and was keen for the project to contribute to existing work at NHS Lothian. I realised later that I should have sought to engage informally with a range of community organisations, so that these conversations could have also fed into the design. Whilst I had intended to gain feedback on the plan from the advisory group and tried to make room for flexibility within the ethics application (e.g. changes to content and wording) the changes suggested were more substantive and required three subsequent submissions to the Ethics Committee at the School of Social Work and Social Policy. Reflectively, I regard this as my first failing in managing power dynamics in the early stages of the research process and a consequence of my lack of experience using PAR.

As identified within the literature review, another important limitation of PAR is the risk of tokenism and exploitation of participants. PAR is frequently described as 'meaningful' and 'empowering'. However, I identified a gap in the task sharing literature of exactly how participants were involved in PAR approaches and, more importantly, how they experienced this. I aimed to be transparent about the scope and nature of the project from the outset, explaining this in written consent forms and verbally, as to not overstate the potential or misrepresent the research in any way. I sought to understand the motivations of participants and wider stakeholders in early conversations and allow this to inform the research direction. I also recognised that the desire to involve participants would have to be balanced with the reality of time constraints faced by women who are single parents on low incomes and the need to avoid adding to existing workloads unnecessarily. I therefore decided to add this to the agenda of the first advisory group meeting. PAR generally requires more time and energy than conventional qualitative research methods as it usually involves repeated engagement for participants. As 'remuneration signalizes social recognition of the value of the individual's contribution to research' (Bergold and Thomas, 2012: para 37), I was keen to ensure that participants received financial compensation for their involvement. According to the literature on co-production in mental health research, non-tokenistic payment can also help to foster equal partnerships and motivate commitment to the research project (Bell et al., 2021). With support from both supervisors and the project partner, I was given permission to use the travel fund attached to the PhD studentship (which I hadn't been able to use because of the COVID-19 pandemic) to procure Love2Shop vouchers for participants. Participants received a £15 love 2 Shop voucher for the scoping interview and £20 voucher for each workshop.

Finally, I decided to include an evaluative component that allowed for ongoing reflection on the experiences of participants. In this way, I saw PAR more as a set of guiding principles and tools, something to aim for as opposed to a prescriptive definition of what I was doing. Thus, any sense of meaning and empowerment was not assumed by the decision to use a PAR approach but explored with participants throughout the research process. Having accounted for the limitations of PAR for this project, I felt this approach provided an opportunity to offer something more to the women I intended to research with, and wider stakeholders committed to mutual learning. At a personal level, this pushed me out of my comfort zone; I had to embrace the messiness, the likelihood that I would make mistakes and be open to reflecting on this with others.

Proposed research methods and ethical considerations

Reviewing research aims

As a starting point, I sought to understand how women who were single parents on low incomes made sense of their own issues with mental health and their experiences of mental health support. Edinburgh was chosen as the research site due to the situating of the project partner within NHS Lothian and the high proportion of women who are single parents on low incomes in the city when compared to other local authority areas in Scotland (Taulbut et al., 2016). I also wanted to contribute to a gap in literature in how people with lived experience could be better involved in designing/adapting and delivering evidence-based mental healthcare. Given the relative accessibility of Interpersonal Counselling (IPC) to those outside of mental health professional and its potential relevance to some of the issues known to be experienced by women who are single parents on low incomes, I chose to explore this approach.

As previously discussed, IPC derives from Interpersonal Psychotherapy (IPT) which uses the medical model as a conceptual framework (Law, 2011). Given my earlier critique of the medical model (chapter one), this may appear contradictory and thus demands further explanation. Whilst it is true that the decision to focus on IPC was motivated by the project partner's involvement in this area of work, the final decision was ultimately my own and was informed by several factors. Firstly, there were aspects of the medical model I found deeply problematic – namely the role of power and the absence of knowledge gained through the lived experience of social inequality creating a historic tendency towards individualised explanations of illness. However, I did not reject the medical model in its entirety and have instead argued that the binary thinking within mental health policy and practice which I identified within the existing literature (medical model vs. social model; mainstream vs. community; professional vs. peer), could be hindering progress. In my small way, I sought to contribute to work that challenged existing

hierarchies and negotiated boundaries; I was particularly inspired by 'task-sharing' approaches in the Global South that sought to democratise medical knowledge and merge 'professional' and 'lived' expertise.

Secondly, whilst I had drawn my own conclusions about the drawbacks and opportunities presented by the medical model, I did not want to assume these would be shared by the women involved in this project. As such, I sought to use the IPC model as a critical object for discussion around models for mental illness; this resulted in some surprising findings (described in the following chapters) that served to validate my concern towards developing shared understanding.

Thirdly, in the UK, 'evidence-based' talking therapies, alongside antidepressants, continue to be recognised by the NHS and are thus embedded within mental health services. As it is likely that someone approaching their GP for help with mental health problems will be offered talking therapy (with variable waiting lists), I was interested in work that explored how to make such approaches more meaningful, feasible and effective for marginalised groups.

Finally, I looked to deepen my understanding of the existing service landscape and any opportunities or barriers to this type of 'task sharing'. In response to these areas of interest, the initial plan taken to the advisory group was comprised of the following components:

Content and structure of workshops

The initial plan was to use a 'self-help' IPC manual created by the team at NHS Lothian as a tool to explore the approach with participants and a resource that could be adapted. Whilst I was not looking to focus on 'self-help', I felt that this document was preferable to a manual used by practitioners because it was written in lay language. This approach was also appealing as it would produce something 'concrete' and this was to be supplemented by a set of co-produced recommendations on how it should be used (i.e. the potential role of peer support workers), helping to garner a sense of shared ownership.

Given my aim of creating opportunities to discuss, debate and co-create, I sought to bring the women involved in this project together as a group As women who are single parents on low incomes experience high levels of isolation and loneliness, I hoped this might also be an opportunity for participants to meet and work with other mums living locally. Defining the exact method for doing this was complicated by the blurring of boundaries between focus group discussions (FGD) and workshops within PAR projects given the increase in creative or activity-based approaches used in the former (Caretta and Vacchelli, 2015). Whilst both methods involve processes of knowledge production between participants, the emphasis on 'reciprocal learning' in workshops (rather than simply data generation) is identified

as an 'underlying difference' (Caretta and Vacchelli, 2015: para 5.7). As reciprocal learning was key to my approach, and I sought to democratise the research process, positioning participants as 'topic experts', the format most closely aligned with the definition of a 'workshop'. However, the limitations described previously in relation to the 'PAR' approach adopted, and the extent of 'co-production', are also relevant here and it is important to reiterate that participants were not involved in (re)defining the research aims or any work independent of me as the facilitator (as is commonly the case in PAR workshops). Nonetheless, as 'workshops' best describe the approach adopted, this term is used henceforth to describe the group activities with women who were single parents on low incomes.

Given the extensive length of the IPC manual and the other research questions I wished to explore, the initial plan involved eight weekly workshops with a group of six-eight participants (please see Appendix 3a for a detailed outline). I sought to use a combination of discussion and activity-oriented questioning. I hoped that repeat engagements with the same group would create space for the 'reflexive cycles' so fundamental to interpretive inquiries (Blaikie & Priest, 2017: 111). Discussion points were to be written on the whiteboard and referred back to when considering possible changes to the manual including language, concepts and more relevant case studies. I was also keen to explore opportunities to draw on creative methods, for example illustrations and animated videos. Given the complex and sensitive nature of the topic, I sought to use a combination of discussion and activity-based questioning. For example, the use of projective techniques that allowed participants to share their perspective (for example on what a single parent might be feeling or needing) without having to share personal experiences unless they wished to. Such techniques have been found to make the research process 'more enjoyable, successful, and rich in in-depth data' (Colucci, 2007: 1431). In light of the potential for topics to be triggering, it was also agreed that participants should have experience of mental health issues but not currently be seeking treatment.

Access and power within workshops

As I was planning the research during the COVID-19 pandemic when rules regarding social distancing were changing frequently, I felt unsure on whether I would be able to conduct workshops in a face-to-face setting. Whilst recognising the challenge of conducting activity-oriented questioning in an online format, there did appear to be some advantages to considering this which aligned with the PAR principles underpinning the project. Previous research had found that internet mediated methods were more accessible to single parents as they negated the need to find childcare (Jenner and Myers, 2019). Furthermore, reflecting on research conducted during the COVID-19 pandemic, Howlett (2021) suggested that using Zoom created a more 'symmetrical relationship' with participants as they had greater control over the research environment than in conventional settings. Using

this platform meant that participants could choose how much of their homes they shared by changing the background, turn their camera or microphone off and more easily leave a discussion. They could also protect their own identity by changing the name that appeared on screen (confirming this first with the researcher). This of course relies on participants being able to access the relevant technology and their confidence using Zoom. I decided to precede workshops with a one-to-one call with each participant to introduce myself, answer any questions and (where required) run through the main functions on a practice Zoom call. With the support of PGR Director, I was also given access to iPads to loan to participants that required them for the duration of the fieldwork. Zoom also offers the advantage of providing both video and audio recordings, allowing for the analysis of visual as well as verbal data. Whilst this did appear to provide an opportunity to contribute to an emerging body of literature looking at how to do PAR online, I was also conscious of the potential for 'Zoom fatigue' (Santosh et al., 2020) and sought to discuss this with the advisory group before making any final decisions.

Evaluative component

I was keen to avoid adding to the time required of participants, so the evaluative component was kept to a minimum. This included a 5-minute Qualtrics survey for participants to complete at the end of each workshop where they were asked what they did and did not enjoy, could log any technological issues such as slow internet connection and report issues anonymously (see Appendix 3e). Survey responses were reviewed each week so that responses could inform preparation for the following workshop.

To support ongoing reflection, participants were encouraged to note any thoughts between sessions; I also kept a diary from the point of setting up the advisory group.

Programme of interviews with wider stakeholders

I conducted individual and focus group interviews with 21 stakeholders in a wide range of roles including staff working in local, third sector organisations involved in supporting the participant group, peer support workers and mental health professionals. The aim of this was to gather additional insights into the landscape for mental health support and service provision but also to gain 'buy-in' for any work that might follow this research project. It is worth noting that I use the term 'focus group' here, rather than 'workshop', as engagements with stakeholders followed a more conventional structure i.e. a discussion, facilitated by myself, following a topic guide of research questions (Carretta and Vacchelli, 2015). Further details related to the wider stakeholders interviewed are provided in the table below:

Wider stakeholders interviewed			
Role type	**Sector**	**Gender**	**Region**
3 peer support workers	Third sector	1 female; 2 male	Lothians
4 support workers	Third sector	3 female; 1 male	Lothians
3 service managers (of third sector organisations)	Third sector	3 female	Lothians
2 CEOs (of third sector organisations)	Third sector	1 female; 1 trans woman	Lothians
2 counsellors	Third sector	2 female	Lothians
7 clinical psychologists	NHS Scotland (5); third sector (2)	6 female; 1 male	Lothians (4); Greater Glasgow (2); Norfolk and Suffolk (1)

Table 4: Further information on the stakeholders interviewed throughout the research project

This programme of interviews spanned the duration of the fieldwork. Whilst I had hoped to be able to hold focus groups with each stakeholder group to encourage discussion and shared learning, the busy schedules and limited capacity of stakeholders meant that individual interviews were generally a more feasible option. Aside from one face-to-face focus group with peer support workers, interviews were conducted on Zoom and lasted 30-45 minutes. Topic guides for these interviews can be found in appendix 2b and 2c.

Other ethical considerations

Anonymity and confidentiality

All participants and wider stakeholders were sent an informed consent form to sign before participating outlining the purpose of the study and exactly how data would be used (see Appendix 1a); the content of this was reiterated verbally before commencing the interview. In line with the University code of practice, anonymity was granted to all participants, except where they are providing information as experts and have consented to being identified (University of Strathclyde, 2017: 21). As part of a broader effort to ensure that participants had as much control as possible in how they were represented, participants were given the option to choose their own pseudonyms. Within this thesis, wider stakeholders interviewed are referred to using a nonidentifiable description (e.g. 'Clinical Psychologist, NHS

Scotland'). All contact details I received for prospective participants were stored on password locked file on the University cloud system which will be deleted once the research project has been completed (i.e. once a lay summary of the final thesis has been sent to participants and participants have attended a follow-up stakeholder event).

Confidentiality is a cornerstone of ethical research practice and can be fundamental when it comes to creating an open and trusting research environment. Online mediated methods can present unique challenges to maintaining confidentiality that had to be considered carefully, particularly for workshops with participants, given the personal and sensitive nature of the topic. Zoom sessions were encrypted with a password which were sent to each participant individually to minimise the risk of the meeting being accessed by anyone outside of the participant group. In the unlikely event that someone outside of the group joined the call, I planned to terminate the session and send a new meeting invite to participants with a different encryption, however this did not happen. In a situation where the technology being used by myself or a participant had been breached, I planned to seek advice from the technical support team at the University. Again, this did not occur and therefor was not necessary.

Another possible risk with conducting group workshops from people's homes is that another person is already in the room or enters the room during the session. I set up a 'group agreement' with participants during the first workshop to discuss the protocol for these situations (. e.g., turning of camera or leaving the call entirely and coming back) and whether this differs depending on the situation (e.g. if it is a small child or an adult that has entered the room). I felt this could also be an opportunity to discuss what should and should not be shared by participants outside of the workshop discussions. All attendees (including myself as researcher) confirmed that they supported the group agreement, which was typed up on the whiteboard, signed by the group and saved securely to my desktop and then to the University cloud system. I began each session by asking each PAR participant to confirm verbally or in writing using the chat function that they were in a safe space and happy to continue. If a participant did not feel safe or comfortable to continue, I planned to encourage them to log out of the session or follow the protocol outlined in the group agreement (e.g. setting up audio headset or moving rooms) before the workshop could begin. However, again, this situation did not arise. Wider stakeholders involved in individual and focus group interviews were also asked to confirm that they are in a safe and private space (or were using headsets to protect the confidentiality of other participants) before workshops could commence.

The only time that confidentiality may not have been maintained is if a participant had revealed that they themselves were at risk of harm (physical, psychological or other) or that there had been illegal activity. For example, the participant group for this study experience disproportionately high rates of domestic abuse. An escalation process was set up and agreed with the advisory group and information about this was included on the informed consent form. I planned to discuss any course of action with the relevant participant first on a one-to-one basis after the workshop, however this was not necessary.

Research approach

Sampling and recruitment

An important starting point for fieldwork was the set-up of an advisory group (described in more detail below) which included community organisations (community partners) involved in supporting the participant group. Participants were initially recruited through community partners and other organisations they recommended. This meant that participants were already involved with local services. Whilst it is important to acknowledge that this does risk the sample being 'cherry picked' and prohibit input from wider range of women experiencing barriers to engagement, going through organisations that were able to identify people they felt confident were in a good place to participate felt imperative to protecting the safety and wellbeing of participants.

The advisory group also provided a useful starting point for recruiting wider stakeholders as group members recommended useful contacts. A 'snowball sampling' method of recruitment was then applied, as interviewees were asked if they knew other prospective stakeholders that might be interested in taking part. Prospective interviewees were first contacted (or introduced) via email and sent a participant information (PIS) sheet (see appendix 1b and 1c). All potential stakeholders were given at least seven days to consider whether they would like to participate. Wider stakeholders who were interviewed in relation to their professional roles, were not offered financial incentives. Having reflected on the incentives being provided to participants for each interview, peer support workers interviewed were also offered Love2Shop vouchers.

Setting up an advisory group

As the aim of the approach was to explore how communities could be better involved in the design and delivery of IPC, this required a range of expertise. A conscious decision was made to define this as an advisory 'group' rather than a 'board' as this was felt to better align with the PAR approach adopted and the rejection of hierarchical power structures. The project partner, a strategic lead within NHS Lothian, was able to draw on her contacts within relevant service networks to facilitate the recruitment of advisory group members. The advisory

group included the project partner, two 'community leads' who are both single parents working for local organisations relevant to mental health, a clinical psychologist and the Lead for Adult Mental Health services both working within NHS Lothian. The group first came together in June 2021, meeting four times between June and September.

During the first two meetings, the group reviewed the proposed approach to fieldwork and provided feedback. Whilst there was broad consensus that the project was important and had great potential, several concerns were raised about the initial plan. The community leads identified potential perceptual and practical barriers to engagement. These included the challenge of retaining the same small group over a prolonged period and the inaccessibility of IPC as a concept. Some concern was also raised about the potentially stigmatising and reductive nature of a manual targeting 'women who are single parents' and community leads emphasised the importance of including single parents with a broad range of perspectives and experiences. In discussions about how to ensure the process was enjoyable, concern was also raised about the amount that would be covered in each workshop if these were to be conducted in the evening once children had gone to bed and the prospect of 'Zoom fatigue' following 18-months of lockdown. The group agreed that it would be important to speak with a sample of prospective participants and ask them about these issues directly. It was agreed that between six-eight participants would be interviewed; this was also felt to be a good opportunity to begin building relationships and build a better understanding of motivations for taking part.

The group also agreed that it was important to create an information sheet or video about IPC that explains the concept without any medical jargon so that participants can make an informed decision about whether to get involved; one of the clinical leads agreed to support this process. Clinical leads raised concern around understanding what could be adapted within IPC under clinical governance guidelines and suggested that I complete the 2-day training in IPC to deepen my understanding of the method.

Scoping interviews

A total of six semi-structured, one to one interviews were conducted on Zoom with women who are single parents on low incomes living in Edinburgh generally lasting between 30 and 45 minutes. Each participant was given a £15 Love2Shop voucher a token of appreciation which was posted out the day after interviews were conducted. Ethical approval was received from School of Social Work and Social Policy (SWSP) for these to be offered on Zoom or face-to-face as socially distanced walks before or after existing support groups. The recruitment of participants was facilitated by the community leads who were sent a participant information sheet (appendix 1a) to share directly with people they felt may be interested and in a good

place to participate or to forward on to contacts in other relevant services. I was introduced to those that responded via email or sent email addresses to get in touch myself. It was agreed at the advisory group that a pragmatic approach to establishing whether a prospective participant was on a low income would be preferable to setting out a specific threshold; community leads, and contacts used their own knowledge of the women they were working with to ascertain if they met the relevant criteria for the project. Three participants were recruited through Dr. Bell's Community Centre in Leith and another five through One Parent Families Scotland (OPFS). Of these, one person did not show up for the interview and did not respond to follow-up emails. Another participant joined the call, asked if I was a single parent myself (which I explained I was not) and decided not to participate. Whilst disappointing, this latter example perhaps exemplifies the importance of shared experience and the value, where scope allows, of training peer researchers to conduct interviews (Hitchen et al, 2015).

The six women that participated in scoping interviews represented a broad range of experiences for a small sample. The age of participants ranged from late twenties to early fifties. The average age was therefore somewhere in the mid-thirties which is reflective of the broader population of single parents in Scotland (*See* Treanor, 2018). All but one participant had one child and children were aged between two and sixteen. Four women were White Scottish, one Polish and another South Asian. Whilst there was significant overlap in the experiences of all six women, there were important distinctions which included employment status, housing security, involvement of children's fathers and the nature of support provided by, or presence of, family members.

I began by asking participants about their involvement with the relevant service through which they had been recruited, going on to ask them about their experience of mental health support in Edinburgh more broadly, whether they felt there were any gaps in service provision and their view on peer support (see appendix 2a for the topic guide used). Crucially, I also asked them how they felt about the term 'single parent' and whether they would use this term to describe themselves; I wanted this to inform the approach and language I used in the workshops. For the second part of the interview, I shared my screen and showed them an infographic (included in Appendix 1a) of the proposed approach for phase 2, asking them to comment on what would motivate or deter them from taking part. Whilst scoping interview findings are reported in greater detail in the following chapter, there were several ways in which these influenced the revision of the plan for the 'group work' phase of fieldwork. A preliminary analysis of interview transcripts and fieldnotes was conducted between July-August 2021 and findings were taken to the fourth advisory group meeting on August 31st 2021 to discuss and agree implications for the next phase.

Firstly, all participants opted to have the interview on Zoom; when asked for feedback on the proposed approach, all felt that Zoom was convenient, negating the need for childcare and the stress of getting to a venue. As children went to bed at different times, interviews in the evening were scheduled to accommodate those whose children went to bed latest (8pm). My experience of doing these later interviews highlighted that the content of workshops needed to be stripped back; whilst we were still able to have rich conversations, I got the sense that participants were jaded after long days juggling childcare and other commitments. Half of the participants also opted for an interview through the day during nursery or school hours, explaining that this would be their preferred time for workshops. I had not anticipated this split in preference which presented a challenge to my initial proposal of one running one group. The initial plan had been to receive IPC training and create an accessible resource to use during interviews prior to them starting but the capacity of stakeholders and staff annual leave meant that it was not feasible. I did therefore find it challenging to explain the concept of interpersonal counselling (IPC) to participants in a concise way without using jargon. Where participants had mentioned that they had received some form of therapy, I would use this as a point of reference to aid explanation:

*'**Natalie**: So, you've been talking about CBT and all these different types that your GP has been mentioning. So, there's a type of counselling that's called interpersonal counselling and it's really focused on how you see yourself, your relationships with other people, support networks…'*

However, as I will go on to discuss in more detail, the accessibility of therapeutic methods such as cognitive behavioural therapy (CBT) was raised as an issue. Whilst IPC has been designed to be more accessible than CBT, the interviews reinforced the importance of accessible resources that could be used to support understanding, to enable all participants to engage meaningfully in group discussions. Almost all participants referred to the limited availability of counselling, long waiting times and expressed an interest in peer support.

I had very rich discussions with participants about the term 'single parent'. Even where participants did not have specific opinions and preferences, this led to reflections about what it means to be a single parent as compared to a couple parent (this is analysed further in the following chapter). What was striking however were the conflicting associations with the term which included distancing, identification and rejection. Two women, for example, explicitly preferred to use the term 'lone' or 'sole' parents as it distinguished them from others who they perceived to have more support. Whilst others used the term selectively depending on who they were with or embraced it as a core part of their identity:

*'**Gemma**: The single parent … lone parent … whatever you want to call it… I almost want to be a huge ambassador to push it'*

*'**Caitlyn**: … I've always said, single parents… I don't tend to like shout about it like if it's at school and stuff I'd never just come out with 'I'm a single parent' or a lone parent to other mums … like if I got to know them, it would probably come up but like I never sorta say the term to a lot of people … I just kinda keep it quiet, if I think they're maybe not a lone parent …I don't know why … I probably do still feel that there could be a stigma with the 'single mums' or 'single parent' thing… I don't know why I've just kinda always thought there might be a stigma'*

*'**Kim**: Erm… I always try to identify with a wider group but I think unless you are like a single… lone parent you can't understand it … y'know you can't understand what you go through'*

There was broad agreement that there was no ideal term and that the term 'single parent' would not put them of participating. Given the potential for stigma and the risk of reductivism, I did however decide to pick up on this in the first workshop to explore further.

When asked what might deter them from participating, there was some concern amongst participants about joining a large group of people that they did not know, being expected to share personal experiences (reinforcing the value of projective techniques) and present at the stakeholder event. All seven women however did express an interest in participating in the second phase of the fieldwork. In terms of motivations, almost all women interviewed referred to the opportunity to *do* something that could result in a positive change, share experiences and help other mums. Two participants also described feeling disempowered as they felt that single parents on low incomes were rarely given a voice:

*'**Jess**: You've mentioned a couple of times the payments and stuff… for me that's not really one of the reasons I would want to do this project… I mean obviously money's great but it's not one of the things that's motivating me to contribute towards this … it's more that [begins to cry] I think people like me need to be able to … I don't know it's just (…) I just feel like we're not given a voice … there's just nobody listening…*

*'**Monika**: ...each parent's experience can give other parents experience you know, like the sharing some ideas …sharing some tips, maybe some, you know, experience of the life, how the dealing can help other people, you know, so nothing could put you off when you when you can help someone else and have a chat and meet people…'*

Reflecting on these findings, the advisory group agreed that the following changes should be made to the initial plan for phase 2:

- Reducing the overall number of workshops from eight to four weekly workshops to address concerns related to retention
- Attempting to increase the overall number of workshop participants involved to capture a broader range of experiences

- Capping the number of workshop participants in each group at three-four (as opposed to six-eight as initially proposed) to make this less intimidating and create more space for all participants to contribute
- As the availability of participants varied according to age of children, it was agreed that there should be daytime and night-time slots to better accommodate preferences and provide greater flexibility
- To be both feasible and enjoyable over a shorter time period, the content of workshops needed to be stripped back. The intensity of the planned sessions was the result of trying to work through and review an existing manual. It was agreed that moving away from the manual and have a more open discussion about the concepts and principles of IPC would be preferable. It was particularly important to get the approval of the clinical leads for this change to manage any expectations around the provision of a completed manual at the end of the research process.
- Given the range of motivations for participation (including sharing experiences and awareness raising), moving away from the manual would also create more space for open discussion.
- There was a keen interest in peer work, so the final workshop was dedicated to a discussion of this and exploration of existing IPC projects involving peer support workers.
- Stripping back the content of sessions would also provide more space for women to share experiences (if they wished to) and discuss what they would like to happen with findings. In response to anxieties about joining big groups or presenting, I also added in separate findings workshop which only involved participants and other single mums. This was both to provide a safe and supportive space to critically explore the findings and form recommendations that could be taken to the stakeholder event (greater control and ownership).

A summary of these changes and an infographic describing the new approach was reviewed by the community leads sent to all participants with the dual purpose of demonstrating how their feedback had shaped the plan and reassure those that were concerned they would be expected to present or share personal experiences (see appendix 3b for a copy of this document).

The 'group-phase'

Six of the seven women that participated in the scoping interviews agreed to take part in the workshops. One interviewee stopped responding to emails, so it was not possible to establish the reason for withdrawal. There was a clear divide in the preferences for scheduling these; four women expressed a preference for an evening slot and two could only participate during the day. The main reason given for these preferences was childcare, for example, preferring to participate once young children had gone to bed or whilst older children were at school.

Unfortunately, despite the best efforts of all those involved in supporting the recruitment process, it was not possible to increase the overall number of participants in the time available as recommended by the advisory group. This meant that one workshop (group 1) had four participants and another had only two (group 2) – please see table 4 below. This was not ideal, but I was keen to ensure that it felt as easy and as comfortable as possible for the women who had agreed to participate to take part. This was not only central to the participatory principles underpinning the project but would also help to improve the chances of retainment. I therefore decided to run one group on a weekday evening and another on a (different) weekday afternoon.

Workshop group 1 (evening)	**Workshop group 2 (daytime)**
Gemma Caitlyn Yvonne Kim	Monika Mae

Table 5: A list of participants in each workshop for the second phase of fieldwork

The workshops broadly followed the structure outlined in the document in Appendix 3c. Importantly, as verifying meaning was part of the reflexive approach adopted for this project, we began by going over the findings of the scoping interviews to verify understanding; I was mindful to ensure this was anonymous. Doing this helped to build on the work we had done already, avoiding repetition that could lead to disengagement and demonstrate my commitment to validity, helping to develop rapport. We then moved on to discuss their experiences and perspectives of mental health support. Over the following three sessions, we focused on the concepts and principles of interpersonal counselling (IPC), reviewed existing projects and considered the potential of peer support to improve the mental health services available to women who are single parents on low incomes in Edinburgh. Workshops involved a combination of discussion, mind mapping and projective techniques. To support a reflexive, iterative approach, I began each workshop with a summary of the discussion from the previous week, inviting the group to verify these findings or add anything they had thought about since the last session. This had the added benefit of providing a 'recap' for anyone who had not been able to attend. At the end of each workshop, I posted a link in the chat box to a 5-minute survey on Qualtrics asking each person to reflect on how they found the session (*See* Appendix 3e). Once I had been able to analyse the findings of all four workshops, I brought the groups back together for a separate 'findings workshop'. Again, this provided an opportunity for participants to review the early findings, highlight any gaps or misunderstandings and add any final reflections.

Data Management and Analysis

The fieldwork involved multiple components, producing several different data sources. These are summarised in the table below:

Women who are single parents on low incomes	**Wider stakeholders**	**Other**
7 scoping interview transcripts	18 interview transcripts	Fieldnotes from IPC training
10 workshop transcripts	2 focus group transcripts	Research diary
Qualtrics evaluation survey responses		

Table 6: Summary of data sources gathered through fieldwork activities

All interviews, focus groups and workshops were recorded on Zoom and an audio recording was taken as a backup on a local device. Zoom recordings were saved locally to my PC in a password locked file and deleted after transcription along with the additional audio recording. A systematic approach was taken to transcribing interviews to maintain consistency (see appendix 3d for a copy of the transcription protocol). Raw data was anonymised through pseudonyms and care was taken to ensure that information included in all research outputs is not identifiable. Given the extent of data being collected, particularly during focus groups and workshops involving multiple participants, recordings were reviewed a minimum of two times to reduce opportunities for data to be missed. Participants contact details, codes and pseudonyms were stored in a separate, password encrypted file on the University cloud system. The same process for data storage was applied to survey data and fieldnotes.

When it came to analysing the fieldwork data, I opted to conduct thematic analysis, 'a method for identifying, analysing and reporting patterns (themes) within data' and across datasets (Braun and Clarke, 2006: 78). More specifically, I chose to conduct 'reflexive thematic analysis' which begins with the premise that knowledge does not exist independently of the researcher but is produced by them through the analytical process, informed by their own subjectivity, theoretical assumptions, analytical resources and data (Braun and Clarke, 2022). This approach thus aligns with the social constructionist paradigm, seeking to situate accounts within

'sociocultural contexts' and 'structural conditions' (Braun and Clarke, 2006: 85). This acknowledgment of wider context and the emphasis on reflexivity also complimented the feminist and PAR principles guiding the project which 'encourages the incorporation of the intersectional self in the production of knowledge' and pays attention to the influence of power 'constituted through relational social positions' (Rodriguez and Ridgway, 2023: 1275). I made sure to reflect on the potential impact of my position as a researcher, i.e. the 'social locations' within which I am embedded (Anthias, 2013), within research diary entries after each workshop; this document was then treated as a data source. It is worth noting that I sought to 'co-create' knowledge with the research community which included women who were single parents on low incomes (whose perspectives and experiences were prioritised) and wider stakeholders – I have reflected on this further below. As I had specific topics and theoretical ideas that I sought to explore with participants but also wished to remain open to other perspectives and experiences expressed within the dataset, my approach involved both deductive and inductive components. I will now go on to explain the specific process I adopted for conducting the thematic analysis.

In order to structure my approach to data analysis, I followed the six-step process outlined by Braun and Clarke (2006: 87):

Phase	**Description of Process**
1. Familiarising yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code (e.g. financial stress; childcare; trust; time)
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme (e.g. structural marginalisation; stigma)
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to

	the research question and literature, producing a scholarly report of the analysis

Table 7: Summary of process adopted for thematic analysis

Acknowledging that transcription is an 'interpretive' rather than a 'mechanical' act, this represented the first stage of analysis (Braun and Clarke, 2006). As mentioned above, I made sure to listen to recordings a minimum of two times; I then took time to read and re-read the transcriptions of workshops and interviews to familiarise myself with the data, noting initial thoughts and ideas. To support the second stage (coding), I moved all transcripts and other research documents into qualitative data analysis software NVivo; this helped to manage and organise the data, allowing me systematically code across different data sources and draw comparisons. This was particularly helpful as I sought to compare the perspectives of women who were single parents on low incomes with wider stakeholders. It also allowed me to connect responses from the same women, at different points in the research process, offering deeper insights into their perspectives and experiences. I was also able to include short biographies of each of the women involved in the project to help situate their responses in the wider context of their lives and the relevance of intersecting social locations (Anthias, 2013). It is worth noting that, whilst analysing data, I made sure to pay attention to social locations of 'dominance' and 'difference' i.e. aspects of privilege such as 'Whiteness' or, as I go on to explore in more detail, 'fertility' as well factors such as gender and socio-economic status (Anthias, 2013; Winker and Degele, 2011). I adopted both an inductive and deductive approach, beginning by pre-defining codes that related to the research questions, adding new codes as I reviewed and annotated each transcript. I then sought to consolidate the coding framework, by collating codes with related content and removing codes that were not as significant as first appeared. From here, I was able to begin identifying patterns of shared meaning across codes that could be generated into themes (phase 3). To support this process, I considered both 'prevalence' (the number of data extracts associated with a given code) and 'keyness' (how far the issue related to the research questions) (Braun and Clarke, 2006). I sketched out thematic maps to draw connections between themes, subthemes, and examples from the various data sources (phase 4), returning to the data repeatedly to test and develop my thinking, remaining open to challenge (phase 5). Crucially, analysis continued through to the final write up of the thesis as I linked themes back to research questions and the wider literature on task sharing (phase 6).

As the project was underpinned by PAR principles, I sought to ensure as far as possible that knowledge was 'co-created' alongside participants. I thus incorporated opportunities for 'member checking' into the research design. For wider stakeholders, this involved allocating five-ten minutes at the end of an interview, focus group or workshop to summarise my interpretation of the discussion, checking for any misunderstandings and if they had anything they would like to add. For women who were single parents on low incomes, I began each workshop by presenting my interpretation of what had been discussed in the previous session, so that participants could highlight any misunderstandings or add any further reflections. In doing so, I embarked on a series of 'reflexive cycles', a feature of interpretive studies involving:

'*sensitizing, questioning, exploring, analysing, theorizing and checking. These activities commonly produce issues for the researcher to further explore, cross-check, qualify, elaborate and/or better illustrate or define when next engaging with participants. In this way, participants and researcher act as coproducers of data and meaning.'*

(Blaikie and Priest 2017: 111)

From the perspective of both intersectional feminist research and PAR, this commitment to verification is crucial when working with participants whose views and knowledge are often marginalised and neglected (Baldwin, 2012). I also hoped that this would help to create a research space that encourages critical exploration, within which we could discuss, contest and negotiate 'taken for granted' assumptions or mainstream conceptualisations (Winker and Degele, 2011).

However, as workshops were conducted on a weekly basis, I only had the opportunity to conduct phase 1 of the analysis ('familiarisation' – see table 6 above) before sharing this with the groups. It is for this reason that I left several weeks before scheduling a 'findings workshop' with each group, by which point I had been able to move on to phase two and three and thus discuss and review the developing themes. Despite this, as the analysis continued through to the point of writing up, when I had the opportunity to situate findings in the theoretical literature, there were certain themes and subthemes that had not been fully formulated and I was thus not able to verify with participants. This is perhaps why authors emphasise the importance of balancing 'distance' and familiarity' with the data in the process of abstraction (having the space to fully develop/connect ideas once familiar with all data) (Blaikie and Priest, 2017). It might therefore be said that I was unable to achieve the final phase of 'theorising and checking' in the quote above (Blaikie and Priest, 2017). This feels most pertinent in relation to the subthemes of 'social class' and 'neoliberalism' (see chapter 4) as participants had never used these terms explicitly, rather I took this to be inferred from their reflections and ideas. With more time and resources, I would seek to incorporate a findings workshop with participants following the initial write up to verify the final

themes and my framing of these. This also highlights the value of involving peer researchers in each phase of the analysis.

Presentation and dissemination of data

A final aspect of the research process that feels pertinent to reflect on is the presentation and dissemination of data. As the researcher in this study, I held the power to decide what data was included within the thesis and how this was presented to the reader. As mentioned above, I was not able to involve peer researchers in the write-up stage - doing so, could have helped to democratise the decision-making process. I did however seek to mitigate the impact of these unequal roles. For example, I tried to include quotations verbatim, which are at times lengthy, including utterances, pauses and my own responses in an attempt to maintain, as far as possible, the authenticity of exchanges. Following the transcription protocol (Appendix 3d) helped to ensure that I adopted a consistent approach to this.

A core aspect of participatory research is recognising that the research findings themselves present opportunities for collaboration, capacity building and knowledge sharing. I intend to continue working alongside research participants, advisory group members and wider stakeholders to plan activities for the dissemination and further development of the data gathered through this study.

Overall reflections on the research process and methodological limitations

As mentioned above, acknowledging the marginalisation of women who are single parents on low incomes, I sought to prioritise their lived experiences within the research setting whilst also leveraging professional expertise through the formation of an advisory group and interviews with wider stakeholders. There were many benefits to this approach; I was able to build my own knowledge of IPC, so that I could take this to participants and ensure the validity of the resources I developed to share during workshops. I also formed a network through which I could disseminate the research findings and explore future opportunities beyond the project. However, it also allowed me to gain insights into the system surrounding IPC, the role of regulatory guidance, the issue of ownership and the complex processes required to make adaptations to the existing model. Despite being referred to as an accessible approach, information materials appeared to be aimed at professionals and required considerable reworking with support from advisory group members, namely a clinical psychologist (to help explain the content and confirm accuracy of 'lay' descriptions) and representatives from community organisations who also had lived experience (to assess the accessibility and sensitivity of lay descriptions).

Thus, there seemed to be somewhat of a conflict between the participatory principles applied in the research project and the privileging of professional knowledge within the broader field of IPC. I was very grateful for the support provided by the mental health professionals who helped to shape the project, however capacity limited the ability for them to attend workshops with participants. I feel strongly that the active involvement of a professional stakeholder with in-depth knowledge of the 'IPC system' and access to change mechanisms throughout the research process would help to increase impact.

As I was working alone, within the confines of a PhD project, there were limits to the number of workshops I was able to run and thus the amount of content we were able to cover. The concepts, tools and strategies for example only covered those used in the early sessions of IPC, focusing on formulating the case. Given the valuable insights gleaned from this project (see chapter 4), I contend that this type of approach warrants further investment of time and resources, from a range of stakeholders including those with creative skills who could support the co-development tools and resources. This could include the additional tools used by IPC practitioners when it comes to exploring the relevant focus area(s). Careful consideration would have to be given to monitoring relational power dynamics to encourage a sense of shared ownership.

The perceived novelty of this project, described by participants as "something different" and "not like anything [they'd] done before" points to the broader lack of participatory approaches to reviewing evidence-based methods in higher income settings. This appeared to be reflected in the lack of confidence demonstrated by the women involved, for example, in the prefacing of insights ("This probably has nothing to do with it but...") and the initial reluctance to critique the model. It struck me that this initial trepidation could relate to the positioning of 'lived expertise' in conventional mental health research and practice as having a specific purpose and space. As such, it was crucial that the research environment felt supportive, accounted for unequal power dynamics and positioned participants as experts. I contend that the following actions helped to achieve this:

- Speaking to each individual at the beginning of the process to establish their motivations for participating and preferences for scheduling workshops. This also provided an opportunity to have sensitive discussions about terminology. Sharing a report explaining how these conversations shaped the project helped to establish their role in decision making, build trust and rapport.

- Scheduling workshops online in the evening helped to acknowledge the social context (e.g. lack of childcare) but also offered women a greater sense of control over how much they shared. The development of a shared agreement (e.g. allowing young children to be present if they woke up during sessions) challenged conventional ethical research practice but provided another opportunity to pass decision making over to participants to try and ensure their safety and comfort.

- The foregrounding of participants' prior experiences and perspectives using different activities was a helpful way to get people talking (and thus develop confidence) given the accessible nature of this content before moving on to less familiar topics. This also provided resources (e.g. whiteboards) that could be used to facilitate the application of lived experience to the review of IPC and potential of peer support.

- Projective techniques were incorporated into workshop exercises as a means of giving participants control over how much they shared of their own lives.

- I found it imperative to re-instate my position as a researcher, rather than a mental health professional actively involved in work on IPC; this helped to overcome initial reluctance to critiquing the model and establish a sense of shared ownership over the task. This speaks to the wider issue of 'ownership' and could be more challenging for a mental health professional to navigate, requiring greater reassurance and encouragement.

- The experiences of participants were monitored weekly through an anonymous survey; here, they could report on factors such as the pace, accessibility, comfort and content of sessions. I also asked them how far they felt able to contribute their thoughts and ideas. This information allowed me to adopt a reflexive approach responding to feedback by amending plans for the following week.

- Repeat engagements with participants allowed me to verify understanding; I started each week with my understanding of the findings from the previous week, opening this up for discussion.

- As reported in other research projects, the women found it easier to comment on existing provision and more challenging to consider possibilities (there is another question here around how often they had been asked to do this previously). Presenting the group with example

projects from different contexts helped to stimulate discussion and generate new ideas.

It is important to be clear about the limitations of the methodological approach adopted for this project. Whilst inspired by participatory action research (PAR), the project is better described as being guided by participatory principles. As previously discussed, there are challenges to conducting participatory research within the confines of a PhD project; the requirement to gain ethical approval prior to meeting with the advisory group or engaging prospective participants meant that aspects of the project were pre-defined. For example, the decision to focus on 'IPC' was informed by the perspectives and priorities of project partners at NHS Lothian, rather than being proposed to and agreed with participants. Such issues can be overcome if PhD students are already embedded within the communities of interest. However, there was evidence to support the potential relevance of IPC for women who are single parents on low incomes and agreeing to focus on this provided unique opportunities to merge professional and lived expertise. Finally, to allow for repeat engagements and in-depth discussion, I was only able to work with a very small number of participants. Finally, as previously mentioned, I myself am not a single parent; reflecting on my research diaries from this time, I believe this did have an impact, particularly in the early days of the project at the point of recruitment and in developing rapport. Given the ongoing interest amongst participants and stakeholders involved in this project, there are exciting opportunities to extend this work. This could involve recruiting former participants as peer researchers, increasing the number of women involved to gain a wider range of perspectives and more active involvement of mental health professionals to help influence change.

Conclusion

Within this chapter I sought to demonstrate the compatibility of the multi-level intersectional feminist framework which guided this study and the principles of participatory action research (PAR). The theoretical framework allowed me to account for the multiple social locations held by research participants (e.g. gender, ethnicity, 'Whiteness') identifying points of connection and divergence from one another; this helped to avoid the 'essentialism' and 'culturalism' I found to be inherent in the task-sharing literature (see chapter 2) and develop a more nuanced understanding of the meaning of lived experience to the women involved (see chapter 4). Incorporating PAR principles into the design of fieldwork created the space required for these conversations (i.e. repeat engagements) and ensure that they informed the more practical elements of fieldwork, rather than simply providing theoretical insights.

Power structures and knowledge hierarchies emerged as key themes within this study; applying PAR principles to the research design allowed me to account for the potential influence of this at each stage of the research process. The theoretical framework helped me to distinguish different levels of experience (structural; representational; individual). Accounting for this in the design of research materials and the approach to data analysis created opportunities for participants to define their own experiences within the research space. This drew attention to the inadequacy of ascribed identity categories (i.e. created by those in power) and stigmatising discourses in reflecting the realities of the women involved, whilst acknowledging the influence of these on their mental health.

This study responds to a gap in participatory research within the task sharing literature which details the research process making it difficult to ascertain the extent of participation and risks masking tokenistic involvement. As such, this chapter has sought to provide a transparent account which details how the advisory group and participants shaped the direction of fieldwork. Importantly, this involved reflecting on the limitations of the approach. Given the challenges associated with conducting participatory research within the confines of a PhD project and the influence of the project partner in early decision making, I have argued that the study is best described as being underpinned by PAR principles, rather than a 'PAR project'. Nonetheless, this study provided many theoretical, methodological and practical insights. A unique aspect of this methodology was the incorporation of a survey to establish how far participants felt able to contribute, and the utilisation of this data to shape fieldwork activities. Whilst ambitious, the research design also created an opportunity for people with lived experience to engage critically with an evidence-based method (IPC) and reflect on emergent work from the global literature on 'task-sharing'. This led to rich discussions about the framing of mental health, the feasibility of conventional tools and approaches for marginalised groups and potential opportunities to maximise peer roles. These findings are explored in the following chapter.

Introduction

Before exploring the potential of 'task sharing' to improve the mental health support available to single parents on low incomes, I wanted to ensure that the research process was grounded by the experiential perspectives of participants. Authors have pointed to the potential of intersectional frameworks that acknowledge factors at the structural (e.g. policies/institutional practices) and representational levels (e.g. norms and ideologies) in countering individualised explanations for health inequalities within research and practice (Kapilashrami, 2020). However, overfocusing on these levels of experience risks undermining the role of individuals in wider systems of oppression. Authors adopting a 'multi-level' intersectional framework recognise individuals as active agents, who interact with representations and can (re)produce social structures in the performance of social identities and through social interactions (Winker and Degele, 2011). Acknowledging the reciprocal relationship between these three levels of experience (structural/representational/individual), 'allows for the study of health at different intersections of identity, social position processes of oppression or privilege, and policies or institutional practices' (Bauer, 2014: 10). Accounting for these different levels of experience helps to demonstrate the potential discordance between ascribed 'categorical identities' (e.g. 'single parent) and the subjective positions adopted by individuals (Choo and Feree, 2010), whilst retaining the existence of structural categories as subjects of analysis (Anthias, 2012). This aligns with a wider movement within gender and women's studies, critical race studies and cultural studies 'to treat the formation of political subjects as a contested process of self-creation in a field of power relations' (Choo and Feree, 2010: 134). In line with the PAR principles of this research project, this underscores the importance of prioritising the perspectives of participants. As posited by Winker and Degele:

'Starting out from the social practices of a person, we are able to reconstruct identities they construct, as well as the structures and norms they draw on: in the process of subjectivization, which categories do social actors relate to? Which norms, principles and interpretive patterns affect them? What are the structural contexts their agency is embedded in? Those are the questions that can be posed in order to correlate the three levels of research with each other, without losing sight of the interrelation between the various categories of difference. '

(2011: p.57)

Following this process, I therefore began by asking participants how they felt about the term 'single parent' and whether it was a term they would use to describe themselves. This section starts by reflecting on the responses to these questions which resulted in rich discussions about the reductionist nature of the 'single

parent' identity category, pointing to the lack of state funded childcare and the significance of informal support networks in relation to women's mental health.

Discussions revealed the pervasiveness of normative discourses around 'good motherhood'. Applying the concept of family practices, I consider the ways in which single parents navigate the 'nuclear family ideal' in their everyday practices and how this may shape interactions within wider family networks. I move on to consider the structural contexts within which women's experiences are embedded and how stigma, as a by-product of normative discourse, operates as a mechanism to maintain structural marginalisation (Walker, 2014). I end this section by returning to the limitations of 'single parent' as an identity category. I utilise the theory of 'benevolent othering' as a heuristic tool to avoid essentialising participants, and single parents on low incomes more broadly, as 'passive victims' in the process of marginalisation. This leads to a final discussion about the multiplicity and fluidity of participants' social identities in different socio-political contexts, providing insights into the meaning of 'lived experience' as a resource to improve mental health support and an important foundation to build upon in later sections of this chapter.

Conceptualising 'single parenthood'

The single parent identity category

The term 'single parent' is a socially constructed category which is said to represent a 'highly stigmatised' status in Scotland (Treanor, 2018: 98). Before exploring the experiences of women described as 'single parents', I sought to understand what this term meant to people belonging to this population, if and how this formed part of their identities and whether there were preferred ways of describing their parenting situation. Methodologically, prioritising this discussion as part of one-to-one scoping interviews aligned with the PAR principles. I am not a so defined 'single parent' and wished to avoid utilising my power as researcher by endorsing this term; doing this would also be based on assumed meaning and could result in surface level discussions about broader experiences of 'single parenthood'.
One-to-one semi-structured interviews with seven participants revealed multiple and complex associations with the term 'single parent'. Notably, two participants expressed frustration at the unitary nature of the term 'single parent':

"I don't think it goes far enough to be honest because I've got a lot of friends who call themselves single parents because they're no longer with the father or the mother of the child and they're not because there's another parent there… which is completely different. So, my friends who are in a situation where they can you know give their child over for half a day … two days… overnights [exasperated laugh] … I don't have that and it's a completely different kettle of fish. There's no … there's no safety net … well I do have safety nets built up now, but I think it's just a different dynamic. I look at myself more as an erm as a sole parent, sole because I'm the only parent……

a parent with a partner is completely different… a parent with [becomes emotional], you know, family nearby who can help is different."

(Jess, early thirties)

Jess felt strongly that the term 'single parent' failed to distinguish her own experiences with those she regards as having more support either from the child's other parent or family members. She chose to use the term 'sole parent' as a means of differentiating herself. Similarly, Gemma also expressed frustration at the broad use of the term, emphasising the importance of co-parenting. Gemma preferred to use 'lone parent':

"I tend to use the term 'lone parent' … but it really frustrates me on the other flip side of it is when people say they're a single parent but I have [shakes head] no involvement with my child's Dad pretty much… OK he lives in Edinburgh … we might talk to him but in terms of my child, he has pretty much no involvement. So, I think it really bugs me when people use the word 'single parent' when they're actually not … they're co-parenting and things you know so…I'm a lone parent … I'm a one parent family. My contact with [child's father] is very minimal…. he's not involved with parenting my child and will probably never … but yeah I think [lone parent] maybe just sounds nicer to me I don't know."

(Gemma, mid-thirties)

Caitlyn, who was in her late twenties, further supported this distinction explaining that 'some people say solo parent [but] it depends if the other parent is involved'. Treanor criticises the use of 'single parent' as a 'unidimensional comparison category' within research and policy for failing to distinguish between different typologies (2018: 81). Others have referred to the lack of consensus amongst scholars globally in defining 'single parents' which, amongst others, might include people who are never married, divorced, dating, cohabiting, co-parenting and/or living in extended households (Yorks, 2021). Historically understood in relation to the idealised norm of heterosexual, couple households, the pathologisation of 'single parent families' appears to have collapsed a complex and diverse array of experiences into a generalised 'other' (Yorks, 2021).

Whilst authors have critiqued the implication that 'single parents' have never been married (*See* Treanor, 2018), the women in this study appeared to be less interested in the representation of their relationship status and more on their parenting role. In the accounts above, Jess and Gemma emphasised their day-to-day responsibilities, drawing comparisons with those who may have more emotional, practical and financial support. This emphasis on 'doing' rather than 'being' speaks to Morgan's (1996) concept of 'family practices'. Reflecting on existing research, Morgan posited that use of the term 'the family', as a static structure to which people 'belong', was oversimplified and carried 'normative baggage', failing to

account for the fluidity and complexity of family lives and relationships (2011:4). Not only does 'family practices' draw attention to the symbolic importance of social activities in the constitution of family relationships, it also provides a conceptual tool for understanding family life across different household types and time periods (Morgan, 1996). According to Morgan:

'Practices are often little fragments of daily life which are part of the normal taken for-granted existence of practitioners. Their significance derives from their location in wider systems of meaning.'

(1996: 189/90)

Authors have gone on to consider the implications of this for 'non-normative' families. Finch argues that the bounds of the nuclear household are more easily defined, meaning people in 'normative' family formations can rely more on these 'wider systems of meaning' to convey their family life (Finch, 2007). Empirical research suggests that people in 'non-normative' families rely more on display to demonstrate that 'these are my family relationships, and they work' (Finch, 2007: 73). In particular, this display of everyday activities (to family members, social workers, researchers etc.) can be driven by an 'over-riding need' to demonstrate 'good parenting'(Smart and Neale, 1999). The 'single parent' category has been described as a 'political construct', understood in relation to the normative ideal of a couple household. Various research studies have explored how single parents are seen to threaten conservative ideals by 'destabilis[ing] the notion of the nuclear family based on marriage' (Dermott and Pomati, 2016: 63). This ideological framing of 'single parents' has been focused around 'deficiency', calling into question the quality of parenting received by children in single parent households (Dermott and Pomati, 2016). Participants involved in the project expressed an awareness of this perception; in an early mapping exercise participants in both groups suggested that a woman who was a single parent on a low income is likely to feel 'judged by other people' and that they 'aren't good enough'.

In a qualitative study of 26 'lone mothers', Carroll and Yeadon-Lee (2021) explored the way in which participants used 'display' as a response to what they regarded as a stigmatised identity. The authors identified the assertion of a 'distinct maternal identity', the 'good lone mother', during interviews which included independence, resilience, self-sacrifice and 'being both mum and dad' (Carroll and Yeadon-Lee, 2021). Interestingly, as will be discussed later in this chapter, the same traits were referred to by participants in this study. At the centre of this appears to be positive acknowledgment of what it is they *do*; participants appear to be responding directly to the nuclear household 'norm' as a reference point. However, the varying situations of participants in the sample, which includes those who are co-parenting, supported by extended family and those with 'no practical and emotional support'

are not distinguished; perceived positive attributes are instead coalesced (Carroll and Yeadon-Lee, 2021: 509). Whilst perhaps distinct from the normative ideal of 'coupled parent', this conception of the 'good lone mother' risks reducing multiple maternal identities into what becomes another unilateral category. It could be argued therefore that Jess and Gemma, who do not co-parent, are asserting a 'distinct maternal identity' which is eclipsed under the term 'single parent'. Failure to acknowledge their specific parenting role could in part explain the frustration expressed by both women. The desire for recognition could also be placed in a broader context where neoliberal concerns related to welfare dependency and child development (both of which are discussed in more detail below) have arguably overshadowed the maternal care work performed by single parents (Calder, 2018).

Interestingly, the two participants who did not speak English as their first language both used the term 'single parent' to define their (different) situations:

"To be honest, I am a single parent, because even [though] she has a dad, he don't invite into her life. Everything what I do, I do by myself, so I can see clearly that I am single parent. Because I am waking her up, I deal with her trauma or whatever is coming, I raising her, I feed her… I am with her 24 hours, so I am a single parent, because the other parent is not in her life. He was and now he has disappeared."

(Monika, early forties)

"…for me being single mum I know it's not easy, because, like for example, when I have ex-partner, even one hour, two hour, we can get the break right - like for me I always get the free two nights every week you know? But the day by day without partner - everything I do by myself…I do myself, because we are yeah we're single mum right?"

(Mae, mid-thirties)

The comparative lack of critical engagement with the term 'single parent' could perhaps be explained by a lack of fluency and the absence of cultural reference points shared by other participants, however, this would require further exploration and a greater number of participants. The reflections above did provide rich insight into what the term meant to Mae and Monika; as was the case with others parenting role, day to day responsibilities and support (or lack of) were emphasised.

The topic of 'freedom' emerged as something that could be simultaneously gained and lost in the process of becoming a single parent. When asked as part of projective exercises during workshops to describe how a single parent on a low income might be feeling, participants were quick to suggest 'stuck' 'overwhelmed' and '[unable] to see a way out' (See fig. 4), linking this, in part, to the inability to leave the house alone and get 'headspace'. It is important to place this in the wider

context; supporting wider research findings (Duncan et al., 2001; Burstrom et al., 2010; Moilanen et al., 2016), the lack of state funded childcare was presented as a primary issue by participants. Childcare costs in the UK are the third highest of the OECD countries, rendering it unaffordable for those on low incomes (OECD, 2022). Conversely, participants in group 2 highlighted the freedom gained by living as a single woman, not having to worry about another person (partner) and live life independently; the freedom to make decisions about the children appeared to depend on whether participants were co-parenting. This further highlights the importance of acknowledging situational differences between people placed within the 'single parent' identity category but also the privileges that can be gained through being 'single'. These positive aspects of experiences will be explored in greater detail in a later section.

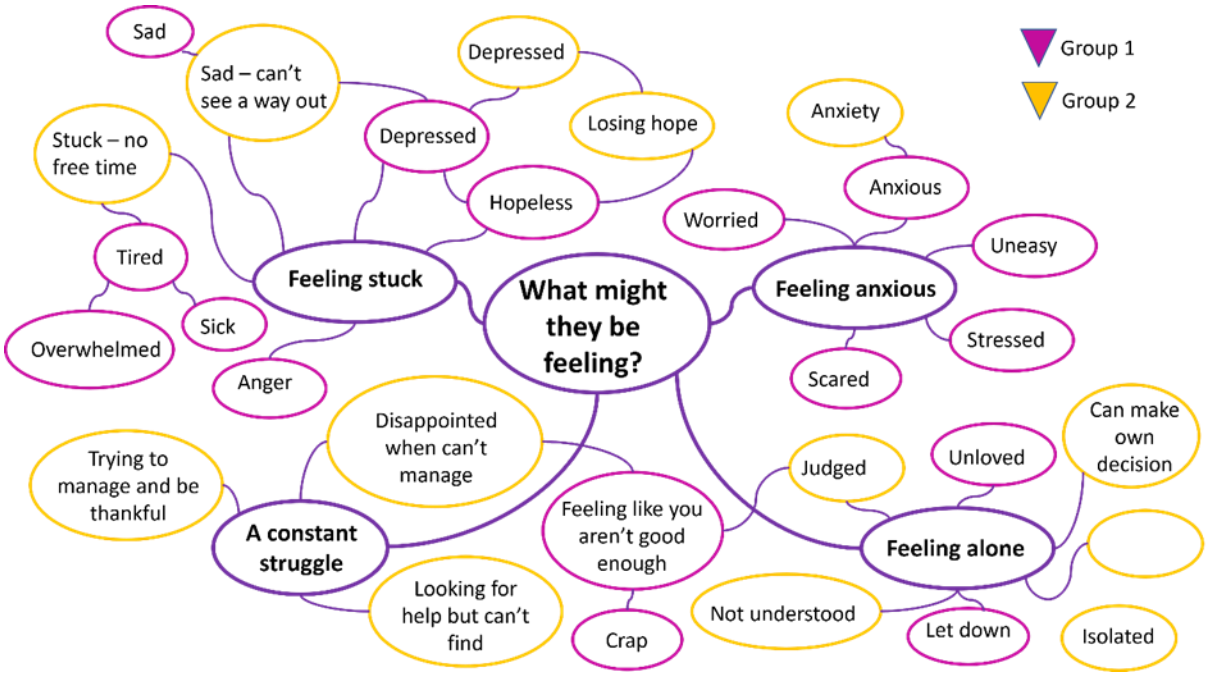

Figure 4: Conceptual map of participant's responses to projective exercise: 'How might women who are single parents on low incomes be feeling?'

Kim, who was in her fifties and the oldest of the participants, appeared to be more ambivalent about the term 'single parent' adopting a broad definition that included people living in couple households, however this is also primarily connected to how much support she received on a day-to-day basis:

*"***Natalie:** *I am interested to know how you feel about the term 'single parent' and if that's a term you'd use to describe yourself?*
Kim : *Yeah, [shrugs] I'm a single parent … there's no other parent involved … he doesn't have his Dad involved… he hasn't seen his Dad in years, erm*
so yeah I mean even when I was married I was a single parent cause his Dad worked away from home. His Dad was only around at weekends, so I've basically been a single parent since my son was born, cause his Dad… worked away for a week or whatever at a time…"

Here we perhaps a disconnect between the 'official' identity category recognised at the structural (i.e. in government policy) and experiential levels. Whilst 'officially' defined as a couple household, the absence of her husband during this time due to work commitments, meant that she regarded herself as a 'single parent'. Again we see the value of 'family practices', focusing on what families *do* rather than what they *are* (Morgan, 1996). Similarly, when asked which services 'single parents on low incomes' were likely to engage with, a stakeholder from a third sector involved in frontline work reflected that:

"I often can't tell if my parents are single parents (…) quite often they are with the husband or a partner but that husband or partner has very little to do with the upbringing and parenting and that's often a cultural thing. So, we will have families from other cultures where (…) it can be quite odd…I can end up supporting a Mum and her husband's a doctor, you know, but culturally where they are from, the women does all the childcare and that's her job – to manage the house. If they don't have family here which often they don't, then that's really difficult. That works in a culture where you've got your sisters and your mums and your aunties and you are sharing that burden but they are not, so they are isolated, sort of, <u>culturally</u>…"

This quote further highlights the oversimplification of the term 'single parent' to categorise experience. There are several factors here that require unpacking. As with Kim 's reflection above, this account challenges the assumption that partners in nuclear households play active, supportive parenting roles. Kim 's husband is not present as they work away, whilst the woman in the second account 'does all of the childcare' due to cultural expectations of gendered roles. It appears such expectations stem from a cultural norm of the 'extended family' wherein mothers would be supported by female family members; a support network removed for people migrating to a new country without their relatives. It is important therefore to recognise that the nuclear model may not in fact be the 'norm' for cultural minorities living in the UK, and that migrant mothers may have to 'engage in negotiations over the meanings of specific cultural forms, and… create new cultural forms for doing intergenerational and care work' (Erel et al., 2018: 58). Authors have referred to the sense of loss experienced by migrant women from countries where high levels of family support is a cultural norm in the early stages of motherhood (Tobin et al., 2018).

In this case, the saliency of cultural norms means that even where a family may be able to afford formal childcare, this does not mean it is 'accessible'. A stakeholder interviewed who supports first generation migrant women in Edinburgh from various cultural backgrounds highlighted that, even if support networks are initially in place, women can be ostracised from entire communities for leaving their partner. 'Feeling alone' emerged as another experiential component in the early mapping exercise with participants involved in this study, drawing attention to the importance of social support.

Informal support networks

The centrality of social support in defining the experiences of the women described above brings us back to the frustration expressed by Jess who emphasised that she did not have family around to help. This point was also raised by Gemma and Yasmin who did not have regular contact with family and by Monika and Mae who had left family behind in other countries when they moved to the UK. In contrast, Kim and Caitlyn described how their mothers had been much more involved. The increased reliance on extended family members and kinship networks by single parents has been widely documented.

The authors of a recent global, systematic review referred to this as 'wider communities of care', highlighting grandparents in particular are 'side-lined in research and policy initiatives, despite the diverse range of primary and secondary caregiving roles they often assume' (Sadruddin et al., 2019:1). Drawing on qualitative research with single and two parent families in England, Walker et al. concluded that there was a disconnect between the perceptions of family life held by children in single parent families (as involving extended family and friends) and those of policy makers centring on married parents as a 'parental and economic institution' (2008: 435). Grandparents can be an important source of practical, financial and emotional support to single parents, helping to reduce parental stress (Harper and Ruicheva, 2010). Given the potential significance of this support to impact maternal health outcomes, there is a surprising lack of research on this topic (Parkes et al., 2015). Grandparents have also been found to alleviate the impact of poverty on children in single parent families (Walker et al., 2008). Perhaps due to a tendency in health research to focus on children's development over maternal wellbeing, authors have long documented the role of grandparents in fulfilling the perceived parental responsibilities of absent fathers. For example, helping with homework, providing career advice and attending school meetings (Buchanan and Rotkirch, 2018). However, empirical research also reveals the way in which grandparents consciously adopt the role of 'replacement partner', providing emotional support and discussing practical worries with their adult children (Buchanan and Rotkirch, 2018). In both cases, normative ideas about family life appear to encourage compensatory behaviours. Research suggests that this can

result in more intensive and involved relationships between grandparents, parents and grandchildren (Harper and Ruicheva, 2010; Dyches et al., 2016). This can be seen in Kim 's reflection of her Mum who had recently passed away:

"We were close… the three of us were really close because there was only the three of us, d'you know what I mean? And it's hard … she was protective of me but even more so of him… he's blonde hair and blue eyes, so he was her blue-eyed boy [laughs] (…)"

Importantly, research suggests that the single mothers can take pride in facilitating stronger relationships between grandparents and children, providing them with what can be perceived as a missing structure in their lives (Buchanan and Rotkirch, 2018; Carroll and Yeadon-Lee, 2021). Supporting wider research findings, the concern of participants as to children's wellbeing as a causal factor determining their own mental health is a central theme to emerge from this research project. This emphasis on 'replacement' could be said to reconstitute the nuclear model, again evidencing the pervasiveness of cultural norms. The effort of grandparents and others to 'fill in', arguably implies, at the representational level, that something is 'missing', thus promulgating the normative ideal. It could also alleviate pressure on institutional structures to adapt policy and practice to better meet the needs of single parents. This risks further marginalising single parents without support networks in place. Acknowledging the significance of grandparents as a resource for single parents, it is perhaps not surprising that this was a significant topic for those with (Caitlyn and Kim) and without (Jess; Gemma; Monika; Mae) this form of support; this arguably implies a form of in-group marginalisation and speaks to the frustrations of participants seeking to highlight the diverse everyday realities of single mothers.

The support provided by grandparents however should not be idealised. The reliance upon grandparents by working parents in the UK is said to be surprising given that it is described as a 'liberal market economy' and authors have argued that the unpaid labour of grandparents has not been recognised (Sadruddin et al., 2019: 539). Care provided by grandparents has been described by working mothers as 'the next best thing' to maternal care because it can be trusted and 'comes from love'; payment for this has been found to be more of an exception than a rule (Wheelock and Jones, 2002: 454). It feels pertinent at this point to acknowledge that this is a gendered trend. Whilst the important role of grandfathers has received recent attention (S*ee* Mann et al., 2016), evidence continues to suggest that grandmothers are the main providers of care (Kanji, 2018). Whilst beyond the scope of this study to explore in depth, the potential implications of this unpaid labour for grandmothers warrants further consideration, especially considering the increase in state pension age. This is particularly concerning for low-income families given ongoing welfare reform measures and increases in the cost of living (Kanji, 2018). The experience of utilising informal care networks comes with its

own challenges for mothers, particularly those unable to afford alternative options and thus left with no choice but to rely on family members. Such arrangements can place strain on family relationships (Jun, 2022). Caitlyn described feeling guilty about having to move in with her mother as her son had special needs and her mother struggled to manage with his behaviour. In a very recent research project exploring the experiences of single mothers in the UK receiving benefits, participants described feeling like they were 'needy and a burden to their relatives' (Jun, 2022: 206). Having to rely on financial support from relatives was described as particularly difficult, inducing feelings of shame, helplessness and depression (Jun, 2022).

Adopting a multi-level intersectional framework that prioritises the micro-level experiences and perspectives of participants has highlighted that whilst identity category of 'single parent' exists at the structural level, as an organisational tool for government policy and research purposes, it eclipses a wide range of family formations into an essentialised 'other'. This is what Walker refers to as the 'relational imperative of stigma' wherein those stigmatising primarily differentiate 'on the basis of group or category membership, paying relatively little attention to the individual attributes of the persons being stigmatized' (2014:50). This appears to be set against the normative ideal of the nuclear family, upheld by political discourses, which positions the single parent family as a 'deficit model'.

Authors in the field of intersectionality have advocated for the inclusion of dominant categories as subjects of analysis as a means of challenging their normativity (*See* Anthias, 2012); here it is worth noting that 'couple families' are rarely referred to as such, they just 'are', existing without qualification. Utilising the concept of 'family practices', focusing on what families *do,* rather than what they *are* helps us to recognise the heterogeneity of single parent families, moving beyond the mother/child dyad to focus on the role of co-parents, family and female kinship networks (Mitchell and Green, 2002). Demonstrating the pervasiveness of normative discourses in shaping social interactions, evidence has identified the assertion of a 'good lone mother' identity as a response to deficit models, encouraging women to self-sacrifice; this concept and the implication for mental health will be returned to throughout this analysis. We have also seen how families work to 'fill-in' for perceived missing structures in mothers' and children's lives (arguably perpetuating the nuclear ideal) helping to share the burden of everyday responsibilities. This is particularly important given that, in line with wider research findings, participants in this study emphasised the importance of freedom and headspace for mental health. Failing to recognise the value of support networks therefore denies the experiences of those, like Jess and Gemma, who do not have access to this resource. It also demonstrates the assumptions inherent in the single parent identity category and the possibility for connection between women in different social locations, for example those in couple households or on higher

incomes that share the experience of isolation due to cultural expectations around gendered roles. Income was however a significant issue for participants; placing this in the wider economic and political context, issues related to welfare reform and the affordability of formal childcare, can limit the agency of 'single mothers', leaving them with no choice but to rely on informal networks, resulting in feelings of shame and depression. Given the saliency of stigma related to welfare reform and the labour market for single parents, I will move on to explore this in greater depth in the following section.

Returning to the conceptualisation of single parenthood, discussions revealed a need for what Vachelli and Mesaric have described as 'intersectional sensitivity', demonstrating that people cannot be 'put in a box' (2021: 423). This presents a challenge for research and practice seeking to be sensitive and responsive to multi-layered identities. As described above, in discussing the term 'single parent' with participants, I sought to develop a shared language, which aligned with the way in which women self-defined. There was consensus amongst the group however that there was no 'ideal term'. In a recent study, Treanor (2018) chose to use the term 'lone parent' because of the stigma associated with 'single parent' in Scotland. Gemma suggested 'lone parent' sounded nicer but a stakeholder with lived experience felt it sounded 'sad' and emphasised being 'alone'. Both 'lone' and 'solo' parent were also used to differentiate experiences - applying these terms to the wider group would have been to dismiss these associated meanings. In the end, the consensus amongst participants was that 'single parent' would be used but with an awareness of its limitations. Adopting a multi-level intersectional framework allows for critical analysis, exposing how the identity categories function at the structural and representational levels, whilst comparing this to the everyday experiences and perspectives of participants. As will be explored in later sections, the positions of women shifted as we moved through the research process, demonstrating the fluidity of social identity depending on the specific social context. These early discussions of identity issues also provided important foundational insights for exploring the meaning of 'lived experience' in relation to task-sharing in later workshops.

Understanding the structural context of women's experiences

The anti-welfare stereotype

In the previous section, I considered the wide-ranging circumstances and backgrounds of women in Scotland described as 'single parents on low incomes'. It was therefore interesting to discover during interviews and workshops, the apparent existence of a specific stereotype. A development worker explained that, in addition to a wide range of women they supported, they did also have the 'classic Scottish single mum', described as being young, White Scottish, on a low income, without a partner from the point of pregnancy. In two interviews with mental

health professionals, after mentioning that my participants were women who were single parents on low incomes, interviewees would respond referring to 'young mums' despite the average age of participants being mid-thirties. Wider research studies have challenged this conception of the 'young, lone, unmarried mother', highlighting that the average age of single parents in Scotland is 36 years old, most are divorced and only 3% are teenagers (Treanor, 2018: 82). As identified within the literature review this forms part of a broader stereotype of 'single mothers' as 'scroungers' who are manipulatively dependent on state support, limiting the life chances of their children (Dermott and Pomati, 2016: 64). Anderson (2015) notes a similar depiction of migrant mothers depicted as having 'anchor babies' to gain settlement rights. In an early scoping interview, a third sector stakeholder reflected on how difficult it could be for single parents left with no choice but to rely on the welfare system for support:

"…that is actually very difficult for a woman who… had money and wasn't on benefits. So the benefit system is very difficult and it is a real shock at what they are expected to live on. For example, a woman that has a mortgage won't get help with her mortgage…whereas if you rent you will. So …a lot of our work can be that sort of bridge over that initial shock and getting themselves out of it… giving them the breathing space to be able to find out where they stand… what sort of job could they do that is going to fit in with childcare that they can afford."

The struggle of managing on benefit payments alone was referred to frequently by participants who used economising practices such as fixing and selling old clothes and careful budgeting to get by. Two participants (Monika and Kim) spoke of having to rely on food banks due to delayed or missed benefit payments. A representative of Shakti Women's Aid explained that single parents they support often do not have visas or have been trafficked and therefore have no recourse to public funds. These accounts support wider research findings which challenge the conception of welfare dependency as an easy or lucrative option (Gillies, 2007; Jensen and Tyler, 2015).

Participants also emphasised how the welfare system, labour market and lack of affordable childcare limited opportunities to move into secure employment. Monika, for example, was placed in temporary accommodation after spending time in a women's refuge. To improve her employment options, Monika was attending college to develop her English language and IT skills. Her goal was to one day work for Women's Aid, who had supported her during a difficult time, so she was volunteering where she could for a similar organisation. She had been taking casual paid work but, as she was unable to afford childcare, this was limited to school hours making it difficult to reach the minimum hours required by the DWP:

"…the job centre just don't really understand the situation, they just say 'oh you need to looking for job - you need to work a minimum of 16 hours because if you're doing the courses'... And I

ask her, 'where? [Mimicking pointing to document] Can you show me the day which one? Because I have just only one for this moment - I see you have all the details, what I'm doing with who and how many hours' I say, so [shrugs and shakes head]… you know to say 'Oh, we will cut the benefits for you if you don't find the job and now it's new law coming in about that' and I'm like mmm [rests head on hands, looks up and shakes head] But … I manage… I'm not giving up you know. I'm doing stuff for my future, for my daughter's future so I want to keep going with that."

(Monika, Participant)

Monika knew that the employment options available to her without the skills she was building would be minimal and that she may be moved into permanent accommodation in another area. However, she felt under pressure from the job centre to reduce the time she spent in college and find whatever paid work she could. This interaction is described by Walker (2014) as the 'manifestation' of institutional shaming wherein welfare officers can act as conduits in processes of inequality. The importance of learning skills was emphasised by one stakeholder because 'single parents can feel like this is it for the rest of my life'. In the workshops, the group agreed that 'feeling stuck' characterised the experience of being a single parent on a low income (fig. 4); this can be understood in a day-to-day sense (as explored in the previous section) but also in terms of controlling their life trajectory. Moreover, Monika felt frustrated that the limitations on her time were not understood, and she referred to the constant monitoring by the job centre multiple times throughout the project as causing stress and anxiety. Describing her own lived experience as a 'single parent', one stakeholder holding a senior position in a third sector organisation reflected:

"I was 16 when I was pregnant… I left school without any education, and you know and yeah that's how I would have been labelled. And if I had relied on the support that was meant to be there and available, I would never be in the position that I'm in now…I'd still be living [there] probably never having had employment because there was also a barrier to working…I had to make a conscious decision to get a job and have reduced income than I had when I was on benefits…and many people aren't in a position to make that choice.... I had to do something, apart from being a parent yeah otherwise I think I could have easily slid down the taking medication and just being in a hole that I was never able to get out of, but in terms of finances, that was a real difficulty."

(CEO, Third sector organisation)

This depiction speaks to wider evidence revealing limited employment opportunities and poor working conditions associated with low skilled jobs offering the flexibility required by single parents unable to afford childcare (Samzelius and Cohen, 2020). When compared to European Union countries, the UK labour market has been described as 'highly flexible' (Goodall and Cook, 2022). Standing (2021) has argued that the rapid increase in insecure jobs has functioned

to conceal under/unemployment and led to an emergent class of people he defined as 'the precariat'; I go on to consider this, and participant's experiences of the UK labour market more broadly, in the following section.

"It's all systemic": the labour market

Employment law assumes that people will conduct paid work 'in the absence of having to care for someone else' (Grabham, 2021: 7/8). Whilst precarious work may offer greater flexibility, it also grants employers greater discretionary control (i.e. allocating shifts and renewing contracts); this has been found to make it more challenging for women to discuss their childcare responsibilities (Grabham, 2021). Standing (2021) acknowledges the disproportionate representation of women withing 'the precariat'; a group of workers defined by short-termism, minimal employment benefits and a lack of trusting relationships in the workplace. This is argued to result in a 'mass incapacity to think long-term', induce stress, frustration and anxiety (Standing, 2021: 21). Authors have since argued that such responses (defined as the 'precariatised mind') are also gendered and can be heightened by additional caregiving responsibilities (Goodall and Cook, 2022). Whilst a study of single mothers in the Growing up in Scotland (GUS) found that being in employment could positively influence mother's mental health and children's social-emotional wellbeing, this applied to full-time, higher-status occupations. Mothers in lower paid, insecure work reported worsened mental health and more financial issues with negative repercussions for children's wellbeing (Fiori, n.d.). Another study found that children of single mothers in low-paid, insecure employment had become worried about how tired and stressed they had become (Treanor, 2018). The financial and health implications for single parents of low paid work can render paid employment an unviable option, leaving no choice but to manage on benefits (Gillies, 2007).

Supporting recent research findings (Herten-Crabb and Wenham, 2022), the challenge of maintaining employment without adequate state funded childcare was identified as a pivotal issue by participants, brought to the fore during the COVID-19 pandemic. Participants described having to use annual leave or call in sick to care for sick children and moving in and out of employment due to mental health problems or the insecure nature of their contracts. Caitlyn, for example, found a part-time position in retail, a job she enjoyed and was able to work around her son's nursery and school hours, however she was made redundant during the pandemic. Another participant who had a highly skilled job faced a different set of challenges:

"I couldn't be furloughed whatsoever so HR told me that my options were to take unpaid leave, use my annual leave or just work my hours flexibly so I basically tried to work one or two days a week … just at night [voice starts breaking] … when I put my son to bed and lockdown's so stressful anyway and then at eight'o'clock at night having to log on and having to work until eleven, twelve at night it was [shakes head] absolutely awful [begins crying]. I just get so stressed thinking

about the fact that I was put through that for so long and not knowing when it was going to end. I was in tears to the HR department about it saying I can't cope. And they would say "Oh I've got a young son… I don't know what I would do without my parents to help"… [Puts hand up – visibly upsetl] I don't have that you know. I don't have any family nearby who can … could take him so it was just an awful situation and I'm still quite bitter about it to be honest… they don't have a fucking clue."

(Jess, early thirties)

Reflecting on qualitative interviews with working mothers in the UK, Grabham (2021) also found that where women lacked 'bargaining power', they took on the stress of juggling childcare and work responsibilities themselves, for example taking sick leave and risking disciplinary action. This led to interviewees feeling 'cognitively and emotionally overwhelmed'; something Grabham describes as the 'care-fog' (2021:96/97). For some, the impact of 'care-fog' further limited their ability to negotiate better working conditions (Grabham, 2021). In a projective exercise where participants mapped how a woman who was a single parent on a low income might be feeling, one of the first suggestions was 'hopeless'. This sense of hopelessness seemed to combine the feeling of being 'trapped' in the home and in their circumstances with the feeling of powerlessness against the structures, systems and processes underpinning welfare and employment. Participants described being pushed into a state of dependency and financial vulnerability with implications for their mental health and wellbeing:

"It's a little bit like … for me, I always work in my life, I never been on benefits in my life, I always have everything done by myself, without any help. For this moment… the situation I am [in] it's [shameful] for myself as a parent I feel like I fail to be a parent in a good way, you know [shrugs]. It's feeling like you … [shakes head] … feeling like you're hopeless…you don't know what happened, you don't know what to do. The health - it's upside down…"

(Monika, early forties)

"I've always been someone who has been quite passionate about fighting causes on behalf of others [emotionally] and I think this is the first time I've really felt a victim … I feel like my status as a lone parent… I am being victimised by so many people and I just find it incredibly frustrating and this is where a lot of my emotion comes because I just (…) don't feel able to really address any of it because it's all systemic and yeah… I guess I just need to be a bit more accepting of things I suppose…"

(Jess, early thirties)

The accounts above describe the process of structural marginalisation limiting the ability of participants to maintain meaningful employment and determine their own trajectories. Walker refers to this process, positing that 'structures systematically exclude opportunities for equal engagement that might challenge stereotypes or

enable positive interaction while reinforcing, through circumscribed access, inequality, status loss, and negative mythologizing' (2014: 51). As a result, participants feel they are ascribed identities such as 'benefit recipient', 'victim' and 'other' which conflict with their own sense of self. Neoliberal models of 'good citizenship' are said to have shaped conceptions of 'good mothering' as to now include paid employment (Maher et al., 2021). As has been found in previous studies, Monika felt her status as a benefit recipient means she has 'failed' as a parent (*See* Carrol and Yeadon-Lee, 2021). This is perhaps why Anderson described poverty, deservingness and (failed) citizenship as 'highly gendered', positing that the relation of women to membership of the community of value is not only about race and class, but also about the right kind of motherhood (2015: 74).

Low-income mothering has been portrayed as 'irresponsible' and even 'immoral' (Cooper, 2021). Participants demonstrated an awareness to these conceptions. For example, Mae, originally from Indonesia, whose children's father was from Scotland, reflects:

"I know I'm not from the rich family or whatever and easy for [ex-partner's family] to put me down, right? But I want to show is not because they're rich, is not because I from the not really great country, but I just want to see this [puts hand on heart] about the person, you know? I just want to show I'm good for everything. See I drop kids… pick up, drop, I still can get work and then I know my home is not really clean, but at least they warm, they have food. So it's making me prove…make me feel 'yeah sure everybody I'm good mum you know even though I'm single. You know this motivation for me…"

(Mae, mid-thirties)

Here again, we see an antiquation of 'good mothering', income and responsibility but the fear of ethnocentric judgments made on her ability to mother based on where she is from indicate an racialised as well as a gendered dimension to what is perceived as a 'stigmatised identity' (Carroll and Yeadon-Lee, 2021). Authors speak of the marginalisation of racialised migrant mothers in the UK who are 'expected to prove their ability to belong by conforming to neoliberal ideals of the good citizen, involving especially their ability to contribute through paid work and to integrate themselves and their children into "British values"' (Erel et al., 2018: 69). Mae appears to respond to this, displaying practices aiming to 'prove' that she is a good mother even if this meant sacrificing her own health. In later discussions, Mae talked about struggling to juggle paid work, childcare and housework, relying on anti-depressants and 'pushing herself so hard' she ended up in hospital after collapsing whilst out shopping.

Kim, whose own mother was a single parent on a low income, spoke about times when she was experiencing mental health problems, and her mother would be 'one of the ones that used to say "Ah just get on with it"'. The minimisation of mental

health problems, understood as part of the struggle of low-income parenting has been identified in the wider qualitative research (Anderson et al., 2007; Abrams et al., 2009; Stack and Meredith, 2018). Participants thus appeared to find themselves at the intersection of neoliberal discourses related to poverty, ethnicity, motherhood and mental health. It seems that neoliberal discourses, emphasising paid work as a tenet of citizenship (without due consideration of structural barriers) can be internalised by women and incite feelings of worthlessness. These appeared to intersect with normative discourses related poverty, race, ethnicity and 'good mothering' encouraging women to withstand poor working conditions and deprioritise their own needs, with negative implications for their mental and physical health.

"You have to fight": other statutory structures influencing mental health

Thus far, we have considered the structural and representational marginalisation apparent within the welfare system and employment policy. However, deficit-oriented discourses also appeared to be prevalent in other statutory systems related to health and social care. A stakeholder reflected that the majority of women they support in abusive situations 'have such a high level of shame, they blame themselves for being in the situation', focusing more on their own behaviour than the 'perpetrator' (Support Worker, Third sector organisation). She went on to argue that when it comes to child custody arrangements, the legal system can reinforce this way of thinking:

"…the family courts are very black and white… they go from the base point that contact [with the child's other parent] is good regardless, so the survivor victim's solicitor has to prove way above and beyond the dangers that that child and woman are being put at. Because a lot of the work is through Legal Aid - it's kind of looked upon as a side piece of work, you don't get fully paid for it so I've been in situations where I've attended court …and the solicitor turns up five minutes before and says, "Right, what's this case about?"- so when you talk about women feeling traumatized and feeling stigmatized and then…re-traumatizing them by going through the court…."

This account provides another example of the systematic nature of discrimination (Walker, 2014). Mackay (2016) refers to the default assumption in Scots-case law that contact with both parents will be in the best interests of the child and that the extent to which evidence overthrows this assumption is left to the discretion of individual sheriffs. In response to funding cuts to the Scottish legal aid budget, the Scottish Legal Aid Board (SLAB) now requires solicitors to demonstrate the need for family court proceedings above alternative methods such as mediation (Mackay, 2016). Having analysed papers from 208 child court disputes in Scotland where there were allegations of domestic abuse and conducted interviews with sheriffs, the same author concluded that the extent to which women and children

were protected varied, emphasising the need for mandatory training for family law practitioners on the impact of domestic abuse on women and children (Mackay, 2016). Thus, having internalised the stigmatising views of the majority, women can enter legal processes where they are further discriminated against due to their lack of financial resources, devaluing their case in the hands of solicitors.

Women can be placed in positions where they are forced to rely on professionals with expert knowledge to navigate complex systems built upon normative ideals, creating a sense of dependency and powerlessness. Awareness of this can further traumatise, with consequences for mental health, meaning that the process itself could perpetuate health inequalities. The requirement to 'prove' the validity of their experience forms part of a wider picture set out by participants during mapping exercises as Yasmin posited:

"Sometimes I feel like you have to fight your case like to say how bad you really are and I just don't think sometimes they believe me."

A central theme to emerge throughout the research process was that of not being listened to, understood or believed. The requirement to 'evidence' how difficult a situation is could also point to the normalisation of suffering as part of motherhood described above. Authors have uncovered a long history of 'mother blaming' discourses wherein mothers are held responsible for children's wellbeing without due regard for social and economic constraints (Maher et al., 2021). In fact, Carroll and Yeadon-Lee (2021) posit that the construction of the 'bad mother' versus the 'good mother' stems from the scrutinising practices of professionals in health and social care throughout the 20th Century. It is perhaps unsurprising therefore to discover low levels of trust amongst participants in professionals involved in child custody processes. Monika, for example, did not trust the communication she received from her social worker who was liaising with her child's father; she felt they focused more on the 'law side' rather than responding to the wishes of her daughter not to visit him. The role of social workers in monitoring their abilities as a parent also emerged as a concern. Caitlyn, for example, worried that if she mentioned she was struggling to a doctor, it would be escalated to social services. The feeling of being judged was also referred to by a counsellor supporting women who are single parents on low incomes:

"I think that this will come up with a few people is particularly when working with social workers - who I just think of the most incredibly difficult job - I'm not knocking social workers but as a perception from the clients that what's offered as support isn't always perceived as support…the perception of it not being supportive but being critical in some way. I think low self-esteem among single parents is a huge thing."

This indicates an awareness of the role of staff as representatives of institutional structures who enact policy at the interactional level as we have seen with the experiences of welfare officers and employers. Sinai-Glazer points to the political nature of 'seemingly private encounters' between mothers and social workers which are 'situated within powerful macro systems of cultural, social and national ideologies of motherhood' (2016: 359). In the examples above, it appears that the internalisation of historical discourses associated with institutional structures can manifest in feelings of low self-esteem, leading to assumptions which may not align with the intentions of social workers (Walker, 2014). This illustrates the value of social constructionism for understanding social work practices, capturing the way in which social reality can be constructed through interaction and impact self-perception (Urek, 2005); the implications of this for service engagement will be explored further in the following chapter.

In sum, neoliberal ideology has emphasised financial independency as a tenet of responsible citizenship which is said to have shaped ideas around 'good mothering' (Maher et al., 2021). Political discourse which has stereotyped the 'single mother' as scrounging and negligent has been used as part of a broader anti-welfare rhetoric to garner public support for welfare reform measures (Dermott and Pomati, 2016; Herbst-Debby, 2022). This has translated into specific welfare policies which have impacted the material reality of single parents, reducing the (already limited) amount they are eligible to receive. The inflexible prioritisation of paid work, enforced through surveillance and the threat of sanctions, appear to restrict opportunities for education and training, pushing single mothers into precarious, low skilled jobs (Jun, 2015). The failure of welfare and employment policy to acknowledge the everyday realities, childcare responsibilities and aspirations of single mothers is a form of structural marginalisation that can be manifested at the interactional level through encounters with professionals creating unequal power dynamics, influencing self-perception and limiting agency (Herten-Crabb and Wenham, 2022). This lack of representation and limited agency can be felt in the frustrations of participants who describe not being understood, heard or having a voice.

The erosive impact of juggling childcare responsibilities, work and the prospect of employment insecurity has mental health consequences; the experience of 'care fog' can further limit the capacity of individuals to challenge working conditions (Grabham, 2021). Returning to the concept of family practices, we must account for the possibility that single mothers will still want to demonstrate that their family 'works'. Discourses such as the 'good lone mother' (Caroll and Yeadon-Lee, 2021) could act as mechanisms encouraging single parents to withstand poor conditions to avoid stigma associated with a range of intersecting factors including poverty,

mental health, gender and ethnicity, potentially perpetuating health inequalities. For some, the expense of childcare and the negative impact of precarious work on their health render paid employment unfeasible which leaves them with no choice but to manage on welfare payments (Gillies, 2007); we have seen how this can lead women to internalise the concept of 'failed motherhood' (Anderson, 2015). The political conceptualisation of single parents as 'limiting the life chances of their children' thus appears somewhat ironic when we consider structural and representational mechanisms functioning to reproduce inequality by limiting the agency and opportunities available to women in this study and wider research (Carroll and Yeadon-Lee, 2021). This process appears to play out across a range of statutory services with which single mothers come into contact. The conceptualisation of professionals by participants as 'conduits' of structures built on stigmatising discourses appears to invoke feelings of distrust, leading women to experience support as surveillance. This has the potential to reproduce feelings of low self-esteem and has consequences for mental health service engagement, an issue I go on to explore in greater depth within this chapter.

This section has focused on the structural context within which women's experiences are embedded, as foundational insights for understanding the potential of 'task-sharing', paying attention to the institutional and representational processes shaping the experiences of research participants. However, whilst it is important to highlight structural marginalisation, over focusing on the structural and representational levels of experience risks further victimising single mothers on low incomes by denying their subjective agency (Winker and Degele, 2011). I respond to this issue in the following section, utilising the concept of 'benevolent othering'.

Avoiding 'benevolent othering'

"There is some power": challenging deficit-oriented discourses

In the previous section, I considered the role of normative discourses as a mechanism functioning within statutory structures. However, 'deficit-oriented' discourses can also be utilised by third sector organisations representing the interests of marginalised populations. A comprehensive review of the literature found that the concept of 'benevolent othering' was usefully applied to understand how mental health organisations used 'sanitised' images which edited out potentially confronting responses such as anger, hostility and non-compliance (Grey, 2016). These well-intentioned efforts to garner public support are described by Grey as 'simplistic and self-serving representations that gloss over the complexity and diversity of people's lives' (2016: 243). Consequently, people with mental health problems were presented as 'entirely passive and de-contextualised, alone, awaiting help from someone else' (Grey, 2016: 246). One Parent Families

Scotland (OPFS) recently advocated against the use of 'vulnerable groups' in favour of 'situations of vulnerability', arguing that the former is 'disempowering' (2021: 6). This speaks to wider critique of the term 'vulnerability' in the depiction of marginalised groups, as a nebulous term that is 'deficit-oriented', implying weakness and dependency (Brown, 2011: 319). It has been argued that the label of 'vulnerability' can be discordant with self-definition, essentialise social groupings and further exclusion (Brown, 2011). The term is often used within social work practice, and within various professions, without being clearly defined (Sherwood-Johnson, 2013). It is argued to uphold the liberal ideal of the independent subject and deny the universality of 'vulnerability' as something that unites rather than divides us over the life course (Sherwood-Johnson, 2013).

As I sought to achieve a nuanced understanding of the potential of task sharing in a way that felt meaningful to the women involved in the project, I was acutely aware of the risk of benevolent othering. Thus, it feels important to verify that whilst the women involved had experienced structural and cultural marginalisation, this was not accepted passively. Whether it was the right to be housed in a certain area, continue their education or access help (explored further in the following section), mirroring the findings of wider research, the need to 'fight' was a recurring theme throughout the research process as well as feelings of anger and frustration (Stack and Meredith, 2018). The women involved in this project withstood oppressive structural practices, reflecting that single parents 'battle through', were strong, independent and 'resilient' (See fig. 5 below). A stakeholder from Women's Aid explained that they no longer used the phrase 'fleeing' domestic abuse as it evoked an image of a 'scared little woman running away', counter posing the brave decisions made by women who leave their homes. During workshop discussions, participants were quickly able to identify skills that they had developed as a single parent, including 'multi-tasking', 'budgeting' and being a 'jack of all trades' (fig. 5).

Figure 5: Conceptual map of participants' responses to 'what strengths do women who are single parents on low incomes have?'

Whilst displaying qualities of the 'good lone mother' (Caroll and Yeadon-Lee, 2021), participants did not necessarily endorse the normative nuclear ideal. Participants reflected that single parents often had closer bonds with their children. Monika for example compared her own situation (struggling to manage on welfare benefits) to that of her 'couple' friends who returned to work when their baby was 6 months old. She described the time she had with her daughter in her early years as the most precious time in her life and felt this led to a closer bond. Another example which arguably resists the neoliberal emphasis on economic productivity, was the consensus within group 2 that 'people are more important than money'; this was grounded in a discussion about the value of time with children and the pure love that they provided:

"Yeah, I think, so the kids you know, the only thing to really keep us going as a single parents is our kids. There is some power, which you know when you with family like together…maybe you don't feel that much strongness because… you got someone else with you, but when you're totally alone it's just the kids give you amazing power, you know? Never mind how you feel…how you fed up sometimes – when you look at your child, then you know you… you can do it. You need to show them how to deal with the life never mind how hard it is…"

(Mae, mid-thirties)

A recent qualitative study of 15 single mothers in the UK also found that the presence of children was 'protective' for their mental health, preventing suicidal

behaviour (Stack and Meredith, 2018). Reflecting on normative expectations about 'happy families' as focusing on marriage, Gemma described her son as "[her] happily ever after". Finally, some described the decision to leave ex-partners as improving their safety, health and happiness, even if the experience of structural marginalisation and stigma made circumstances challenging. Importantly, this helps to avoid narrow (normative) explanations of mental health issues that are deficit-oriented for example focusing on the parenting abilities of single mothers on low incomes, the absence of fathers and the behaviour of children, instead turning the spotlight back onto structural stressors. Balancing these aspects of experience with the feelings of failure, shame and loneliness previously discussed demonstrates the complexity of subjective agency as a 'dialectical process' within which 'women resist stigma and take pride in their parenting while also internalising gendered and classed 'good mother' constructs" (Carroll and Yeadon Lee, 2021: 518; *See also* Choo and Feree, 2010).

Social identities and 'lived experience'

Recognising the complexity of identity (re)construction as a dialectical process can help to avoid another pitfall of 'vulnerability discourses'; the grouping of single parents into an 'essentialised other' (Peroni and Timmer, 2013). Adopting an intersectional lens, Anthias proposes that 'social locations' are a more useful conceptual tool than groups in understanding experiences of inequality. According to Anthias, our social location is:

'…embedded in relations of hierarchy within a multiplicity of specific situational and conjunctural spheres. Therefore, the lens is turned towards the broader landscape of power which is productive of social divisions and does not remain fixed on the manifestations of the latter. In other words, locations relate to stratification (at local, national and transnational fields), within a contextual and chronographic context, i.e. they inhabit a 'real time and place' context.'

(2013:130)

Here, inequality and difference are defined as processes rather than characteristics possessed by individuals; social categories (e.g. gender, class…) are described as 'boundary making forces' which assume different formations at different times and social contexts (Anthias, 2013). Acknowledging this element of fluidity, allows for the possibility that individuals may be 'in a position of dominance and subordination simultaneously on the one hand or at different times or spaces on the other' (Anthias, 2013: 131). This accounts for the heterogenous experiences of single parents whose individual everyday realities are shaped by differential access to resources, race, class, disability, sexuality etc... Participants expressed an awareness of this, for example, Monika who experienced racism and isolation as a result of her migrant status referred to challenges faced by mothers who were refugees without recourse to public funds. Women in one workshop expressed

gratitude at being able to have children, referring to 'couple friends' on high incomes unable to conceive; the topic of 'fertility privilege' is an interesting area receiving recent attention (*See* Johnson, 2016). This draws attention to the possibility for points of connection in dominant social locations, acknowledging other factors such as Whiteness, heteronormativity and ableism that can be overlooked in groupings that 'other' (Hankivsky et al., 2010; Walker, 2014).

This also supports a more nuanced understanding of 'lived experience'; whilst the structural category of 'single parent' may be an oppressive force, participants agreed that the experience of parenting on their own put them in a unique position to be able to 'offer peer support and advice' (Fig. 5). Participants repeatedly emphasised that you can 'only truly get it' if you've been there, however, at this point the women demonstrated fluidity in boundary making. Gemma, for example, who had previously distinguished her own experience from single parents with more support, here positions herself against a woman from a couple household:

"I'm open for someone that is complaining that they're tired or their husbands been at work you know I won't dismiss that. I'm not like 'well I'm on my own all the time' type of thing so yeah I'm always open for seeing the wider part of it but no one can truly understand what you go through unless you've experienced it I feel."

(Gemma, mid-thirties)

It feels pertinent to reflect on a Zoom call with a prospective participant who quickly asked whether I was a single parent; when I told her I was not, she said that she no longer wanted to participate because "you don't have a clue". This further demonstrates the value of 'lived experience' as a resource in a research context, supporting participant engagement through the identification of commonality (Vaughn et al., 2018). Another way in which the 'single parent' identity appeared to be adopted was in relation to social justice.

"…you've mentioned a couple of times the payments and stuff… for me that's not really one of the reasons I would want to do this project… I mean obviously money's great but it's not one of the things that's motivating me to contribute towards this … it's more that [begins to cry] I think people like me need to be able to … I don't know it's just (…) I just feel like we're not given a voice … there's just nobody listening… Policy makers at every level… decision making don't consider us and it's just so frustrating because we've just got so much we can give and we're just constantly up against it … constantly firefighting and trying to keep our head above the water at every single level and it just shouldn't be this hard for people."

(Jess, early thirties)

Here it might be argued that the lens is shifted to the 'broader landscape of power' (Anthias, 2013) and the saliency of the 'single parent' identity at the structural level. Even where participants may be keen to highlight the reductionist nature of this

identity category in understanding their everyday practices, they shift their position in response to structural marginalisation. McIntosh and Wright (2018) reflect on the increased popularity of 'lived experience' as a concept in social policy, yet the meaning of this, they contend, is rarely clarified. They expressed concern that 'lived experience' can be interpreted to mean highly unique and individual, pushing societal structures outside of the 'analytical gaze'. They point to the value of feminist theorising of lived experience which highlights the risk of essentialism in claims around identity, whilst acknowledging the gendered embodiment of experience in particular historical and social locations (McIntosh and Wright, 2018). Beginning with narratives (rather than social structures), enables the identification of:

'a strategy of recognition that is attentive to feelings, bodily states, interactions and identities that tend to be devalued or ignored. In this sense, lived experience can be invoked as a shorthand for empathy, conferring respect and esteem'

(McIntosh and Wright, 2018: 456)

In the account above, Jess speaks about the opportunity to 'do' something where single parents have a collective voice – for Jess, this was a bigger priority than the financial incentives offered. This position also reflects emerging work on the concept of 'collective citizenship' wherein people experiencing marginalisation unify, drawing on the value of lived experience to achieve the social change required to improve mental health (Quinn et al., 2019). Importantly, a 'collective citizenship' approach does not ignore the unique needs of individuals (thus addressing the risk of reductionism already outlined) but acknowledges the value of social support to promote empowerment (Quinn et al., 2019). Far from 'awaiting help' (Grey, 2016), the opportunity to help others by drawing on their own experience was referred to as another motivating factor for participation:

"The more people that can help the better… that's my nature I like to help. I don't like accepting help, but I like to give it [laughs]"

(Kim, early fifties)

"…it's something that I feel quite passionate about so yeah things like this are not always formed by the people who are needing to be involved and I think that's what's important here is that you need people to shape manuals and shape processes that matter I think … if you don't understand the situation, you can't always write that … you can't be the one that decides or almost dictates it… yeah, something like this is going to help people hopefully d'you know whether it be me right now or people in the future"

(Gemma, mid-thirties)

Research suggests that the opportunity to develop valued roles within communities and/or social networks (i.e. through helping others) can help to acknowledge the

worth of members; this recognition is seen as a crucial component of citizenship and has positive implications for mental health and wellbeing (Reis et al., 2022; MacIntyre et al., 2019). This further demonstrates the potential value of participatory research projects as sites for collective citizenship; such approaches 'embody the key principles of citizenship' adopting inclusive practices that encouraging active participation in the research process (e.g. decision making) (MacIntyre et al., 2019). This is particularly relevant in the context of single mothers who are often denied the opportunity for reciprocity due to structural constraints. Within 'collective citizenship 'power rests within the group', thus redefining the single parent identity category in the research context as a potential force for social change (Quinn et al., 2019: 364).

Conclusion

In line with PAR principles, this research project began with the perspectives of participants, working to understand what the term 'single parent' meant to them. Their critical reflections highlighted the importance of avoiding assumptions about self-identification; utilising a multi-level intersectional framework to analyse these early discussions, it was possible to distinguish between structural, representational and individual realities of 'single parenthood'. At the structural level, the 'single parent' identity category emerged as an oversimplified construction utilised by the government as an organisational tool which groups women in varying situations and family formations into an essentialised 'other'. Seemingly, this facelessness makes it possible for political discourses, operating to protect the ideals of the nuclear family and financial independency, to create a fictional reality, which has stereotyped and demonised single mothers on low incomes. These depictions serve to justify the nuclear family model as the dominant form of social organisation; as a result the women involved in this study did not feel represented in employment and welfare policies and felt penalised by statutory systems and processes. Professionals working within these systems, with limited agency, can be regarded as conduits of oppressive practices; participants described feeling discriminated against in their interpersonal interactions with staff members leading to wider distrust of professionals.

Discriminatory (mis)representations also appear to seep into the public consciousness and play out through everyday interactions, in some cases, even between family and friends. Supporting wider research findings, the women involved in this study, showed an awareness of stereotypes, perceiving, fearing and sometimes internalising stigma. In an effort to resist this stigmatised identity, participants fought to prove their worth as mothers in unforgiving structural conditions, often sacrificing their own wellbeing. Thus, far from existing as separate 'versions' of reality, categorisations and discourses intersect and are reproduced through social interaction, operating as a system which maintains inequality. It therefore stands to reason that more nuanced depictions of women's

lives, highlighting the many strengths of single parents and the positive aspects of lone parenting threaten to dismantle the myth of the nuclear ideal.

Third sector organisations seeking to demonstrate the impact of structural marginalisation can also resort to oversimplified depictions which represents women as 'passive victims'; in this case victimisation operates as a mechanism to garner public support and funding. 'Lived experience' has been described as a 'funder's buzzword' due to its frequent but generic usage in recent years (Goldstraw, 2021). Without a critical understanding of what this means to the people it is said to represent, we risk recreating an 'essentialised other', limiting the potential of 'lived experience' as a resource within mental health services. The participatory approach adopted in this project meant that participants could deconstruct the concept of 'single parent', demonstrating that far from a fixed identity, it exists in various forms across different levels of experiences and in specific socio-political contexts. The women involved in this project were situated across multiple social locations which shaped their material and social realities, finding points of connection and divergence. Participants' reflections illustrate why it should not be assumed that because a person joins a group or a research project for 'single parents' that they self-identify as such. Failing to recognise this could further alienate people with lived experience and fuel distrust in mental health services. As the findings of this chapter have demonstrated, identification with the 'single parent' identity category can be an act of political agency against social injustice. These early discussions were crucial in developing a shared language with participants, allowing us to reconstruct the context for their mental health struggles and opportunities for 'task-sharing' to improve mental health support.

Chapter 5: Experiences of mental health services and perspectives on mental health support

Introduction

Having explored what it can feel like to be a single parent on a low income experiencing mental health problems and the multi-level causal factors contributing to distress, participants guided me through their experience of accessing mental health support. The following section explores participants' perspectives on mental health support and their experiences of mental health services. In early workshops, I asked participants how a single parent struggling with their mental health would be feeling and what they would need, mapping responses onto whiteboards on Zoom. Using the same method, we also considered what is important when it comes to mental health care and what could be improved. This section combines the findings from these workshops and one-to-one scoping interviews where participants spoke more directly about their own experiences.

The accounts of participants described in the previous section, depicting what it means to be a single parent on a low income in the current socio-economic and political context, were crucial in laying the foundations for understanding their experience of the mental health system. Continuing to apply the multi-level intersectional framework previously outlined, I explore how stigma operated to delay help seeking, meaning that participants were left to navigate complex and fragmented service landscapes whilst experiencing mental distress. I consider the apparent role of political rhetoric in creating discursive strategies designed to obscure the impact of austerity, shifting responsibility for systemic issues onto overstretched staff and the women themselves. The quality of relationships with mental health professionals were identified as being critical by participants. However, connecting the specific experiences of the women involved in this project with wider research, I discuss various factors that not only appear to limit the potential of therapeutic relationships but may perpetuate existing inequalities. Central to this is the apparent neglect of lived experience in the design and delivery of mental health services, in professional training and within therapeutic encounters.

Accessing mental health services

Barriers to help-seeking

When asked how single parents on low incomes might be feeling, 'struggling to manage' was a primary theme throughout discussions and participants made frequent references to the need to 'cope'.

"*We just battle through because we've got our kids to put first. Basically… it doesn't matter what we're going through - they come first"*

(Kim, early fifties)

"*When you're really fed up of everything, and you just you have some moments you totally break down with everything and you'll just think is maybe just better to go from this world… This is my example … this is what I thought one time you know? Just call my ex, give her at the weekend and just go because I was thinking she'd be better. He has family… new wife… child, maybe she have better life with him because it's a full family… that was the moment when I asked doctor for help because I knew it getting wrong.*"

(Monika, late thirties)

In chapter 4, I considered the dichotomous nature of the 'good lone mother' ideal which could motivate single parents on low incomes to keep going whilst at the same time discourage the prioritisation of personal needs. I explored the negative impact that this had on the mental and physical health of the women involved in this study who had been worn down by the mission to manage against persistent societal stressors. This could be compounded by intergenerational stigma as exemplified by Kim 's mother, herself a single parent, who advised Kim to 'just get her head down and get on with it'. The normalisation of mental health problems as a natural response to environmental circumstances has been found to prevent engagement with mental health services for single parents elsewhere (Stack and Meredith, 2018). Here, help seeking appears to be conceptualised as 'giving up' and, for Monika, this led to suicidal thinking fuelled by thoughts that she was not 'enough' for her daughter. This mirrors the findings of a recent qualitative study with single parents on low incomes in England; participants delayed help seeking until the point of crisis with some describing suicidal thoughts (Stack and Meredith, 2018). It is worth pausing here to consider the role of stigma. Acknowledging the frequent use of the concept without clear definition, authors have sought to demonstrate how stigma operates at different societal levels, congruent with the structural, representational and individual levels of the multi-level intersectional framework guiding this thesis (Livingston and Boyd, 2010).

Structural (or 'institutional') stigma is said to refer to the embodiment of cultural ideology into institutional practices (e.g. policies, systems and processes), legitimating power differentials and the exclusion of marginalised groups through the restriction of rights and opportunities. Social stigma (representational level) pertains to the endorsement of a stereotype by large social groups who act against the group, enacting stigma through their interactions/behaviour towards those being stigmatised. Finally, 'internalised stigma' is said to operate at the individual

level and described as the "psychological point of impact of societal stigma on people with mental illness" (Boyd et al., 2014, p17 *as cited in* Bradstreet et al., 2018). Under 'internalised stigma', a further distinction is made between 'felt stigma', (an awareness of societal perceptions) and 'self-stigma', referring to the acceptance of negative stereotyping, impacting an individual's sense of self (Livingston and Boyd, 2010). This distinction helps to avoid the assumption that societal stigma will translate into self-stigma; it has been suggested that having a valued social role and access to social support can 'buffer' the impacts of societal stigma (Bradstreet et al., 2018).

Returning to Monika's depiction, the conceptualisation of 'help-seeking' as a sign of weakness and poor parenting appears to reflect the internalisation of neo-liberal discourses around 'good mothering' resulting in self-stigma. Elsewhere however, participants expressed concern about structural (or 'institutional') and group stigma without endorsing the stereotypes they believed were in operation. Another reason given for 'trying to cope', for example, pertained to a lack of trust in professionals; for three participants accessing statutory services (e.g. GP) also involved overcoming fears about social service involvement. This fear of stigma, that health and social care professionals would question their ability to parent if they sought help, appeared to act as a barrier to service engagement at an earlier point. It therefore follows that a structural (socio-economic pressures; institutional stigma), representational (group stigma) and individual factors (felt and self-stigma) coalesce to influence help-seeking behaviour. Importantly, whilst the form of stigma and the way in which this intersected across different levels of experience varied, the outcome (delaying help-seeking until crisis point) appeared to be the same. Authors have argued that more research is needed to better understand the impact of stigma on mental health service engagement amongst single parents (Stack and Meredith, 2018).

Whilst influenced by structural factors, this discussion of stigma, focused on individual perception, risks obscuring the role of services in responding to perceptual barriers and encouraging engagement at earlier points. A 'decisive shift to prevention' has been a long-standing national priority and part of a commitment by the Scottish Government (2011) to reduce inequalities and subsequent demand for reactive public services. However, efforts are said to have been hampered by funding cuts, adding additional pressure to overstretched services, resulting in 'crisis management' (Audit Scotland, 2016). In a recent survey which garnered responses from more than a quarter of the Scottish social care workforce, 65% reported that workload pressures meant they had limited time for preventative work (Miller and Barrier, 2022). As previously mentioned, with the exception of the latest mental health and wellbeing strategy (Scottish Government, 2023*a*), there

has tended to be a greater focus on treatment and the social determinants of mental health (e.g. poverty and stigma) appear to have been somewhat neglected . This is argued to have upheld a somewhat individualised and medicalised conception of mental health (Smith, 2013). As a result of the barriers discussed here, participants approached services at the point of experiencing mental distress. Once support was sought however, participants described being faced with additional challenges; these are explored in more detail in the following section as important context in exploring the role of 'task-sharing' in improving mental health support available to women who are single parents on low incomes.

Navigating the service landscape

All participants involved in this project eventually sought help yet depicted several other challenges to accessing mental health support. The landscape for mental healthcare in Scotland is complex involving a combination of generalist and specialist services delivered by statutory services, third sector organisations or private companies. Participants felt that this could be confusing and overwhelming. The accessibility of the healthcare system was raised as an issue by the two participants, not originally from the UK, who agreed that single parents may 'look for help but can't find it'. Limited knowledge of the mental healthcare system amongst women who are racially minoritised was also raised as an issue by a stakeholder from a third sector organisation supporting this population in Edinburgh. However, this appears to be a broader issue.

A recent participatory research project exploring the perspectives of people with mental health problems, families and carers in Scotland found that 'not knowing what to look for, where to look or who to ask' was a central barrier to finding support (French et al., n.d.: 3). They felt that having a clear overview of all services, including what they do, waiting times and how to access them, would help to 'empower themselves to choose' (French et al, n.d.). Authors have however questioned the notion of 'choice' within current mental healthcare systems, identifying the emphasis on information to support individual decision making as a discursive strategy that shifts responsibility from the state to individuals and communities (Teghtsoonian, 2009). The concept of choice is argued to 'camouflage austerity' as people are presented with a list of pre-determined options, selected on the basis of cost-effectiveness (most often time limited and fragmented across underfunded third sector services) and the perception that they are 'evidence-based' (outcomes can be quantified – this is explored further in the following sections) (Teghtsoonian, 2009; Kiely, 2021). The inclusion of waiting times as part of the information requested by participants also feels pertinent; this

could be interpreted as an attempt by those without the resources to pay for private healthcare to regain some control whilst highlighting that power over access ultimately lies elsewhere (Kiely, 2021). Given the restriction of rights and opportunities here (access to timely support) and the legitimation of power differentials, this can be identified as a form of structural/institutional stigma (Bradstreet et al., 2018). The perception of 'choice' has been said to serve another function related to 'responsibilisation'; 'sustain[ing] a belief that adequate care is, spatially and temporally, almost within reach: the only barrier is a person's inappropriate decisions or "headspace" (Kiely, 2021: 726). As described by Gemma:

"…you know it can be hard that my health visitor is giving me one recommendation but my GP overloads me sometimes, sometimes giving me lots of information… he gave me three different options for CBT [exasperated facial expression] but that was in amongst other options. So there was then like talking therapy, counselling, three different options of CBT … erm… medication and it was just like a whole list and I'm like [looks up and shakes head] yeah so … d'you know what I do? Nothing! [Laughter]"

Here, Gemma emphasises her personal inaction when presented with vast swathes of information from different health professionals. This points to a bigger question around how far the mental health system has been designed to support people approaching the system in distress, who can be left citing personal inadequacy as a reason why they haven't been able to access appropriate support (Kiely, 2021). This arguably provides another example of the internalisation of institutional into 'self-stigma' (Livingston and Boyd, 2010).

Participants accessed different services in a plethora of ways. Referral pathways for third sector services such as support groups included self-referrals made having seen adverts on Facebook, posters in the local area or by word of mouth, otherwise it was through other services they were involved with or the GP. Whilst participants spoke positively about the range of services available (discussed further below), again this was described as overwhelming; it was argued that being linked into multiple services could also be confusing. Several comments made by stakeholders and participants related to the 'fragmented' nature of the system and services not always being joined up. This is something I considered in the introductory chapter of this thesis as I worked to understand the research setting for this study. The shift towards 'specialisations' within mental healthcare is said to have been part of a neoliberal agenda to make more efficient use of expertise; the outsourcing of resources to third sector services reliant on short-term funding has also been associated with meeting the demands of austerity, contributing to a sense of temporality (Kiely, 2021). Yasmin described feeling frustrated at being 'lost in the system', having to chase referrals and repeat her story.

Situating this in the broader policy context, the 'unduly cluttered and fragmented' nature of Scotland's public service landscape was acknowledged with the 2011 report for the Christie Commission (Scottish Government, 2011). As previously described (see chapter 1), the Scottish Government introduced the Public Bodies (Joint Working) (Scotland) Act 2014 which sought to bring health and social care services together as one, integrated system (Scottish Government, 2019). Through the development of health and social care partnerships which encourage joint funding and provision across the public, third and private sectors, the hope was that care would feel 'seamless' to people accessing services (Scottish Government, 2019). Whilst arguably still in the early stages of implementation, evaluations and qualitative research has concluded that a lack of joint infrastructure, such as integrated IT systems, has impacted the ability for joint working and information sharing (Pearson and Watson, 2018).

Eccles (2018) points to 'fiscal retrenchment' as a barrier to collaborative working as professions turn inwards to defend both capacity and professional identity; following the theme of 'responsibility', he posits that a focus on inter-professional working can conceal deeper seated issues related to resourcing and the (in)ability to tackle inequalities. The women involved in this project arrived at mental health services bearing the weight of structural and cultural marginalisation; this experience had left them feeling unseen and unheard. Workshop findings suggest that being 'lost in the system' has the potential reinstate this sense of invisibility. Furthermore, qualitative research with service users and carers has found that having to re-tell your story can lead people to feel their experience is devalued and cause additional distress (Jones et al., 2009).

Initial engagement

In Scotland, the system is designed such that GP practices act as 'patient gateways' for healthcare services (Scottish Government, 2018). For participants in this project, referrals for counselling tended to begin with an assessment by a GP. When asked about how mental health services could be improved, participants in both groups referred to the 'GP being the first port of call'. Difficulty booking GP appointments was raised as a challenge as well as building a relationship with the same person, however experiences were mixed:

"Access to GP is still nightmare - phone every morning 'Oh sorry we don't have a space!' You phone on the time when they start open surgery, and there is no space already."

(Monika, late thirties)

"…my GP knows <u>everything</u> and she's got me help that I've needed…put me forward to things…she looks into it for me and she'll phone up and check on me. So, I'm quite lucky that way with my GP but it can be hard to get appointments and when you've got to go and speak to

someone else as Gemma says…you've got to go through all your history again, it's a bit annoying and you get frustrated…"

(Kim, early fifties)

Caitlyn, who feared going to the GP about her struggles with mental health in case they contacted social services, eventually built up the courage to make an appointment. She was given what she felt was a 'short appointment' (10 minutes) with a GP she had not previously met and did not feel confident that they fully understood her situation. Whilst these accounts may differ, they all point to issues with time (access and length of appointments) and the 'relational continuity of care' (seeing the same GP and building a good relationship). The same issues were found to be significant in a wider study of 72 patients living in a deprived area of Glasgow:

'Patients from deprived areas want holistic GPs who understand the realities of life in such areas and whom they can trust as both competent and genuinely caring. 'Without this, they may judge doctors as socially distant and emotionally detached. Relational continuity, empathy and sufficient time in consultations are key factors in achieving this.'

(Mercer et al., 2007)

This standpoint appears to be reflected in Kim 's quote above, where she described feeling lucky that her GP 'knows everything' about her and made the effort to check in with her during difficult times, perhaps perceived to demonstrate 'genuine caring'. Pausing to reflect on the author's reference to 'social distance', it seems pertinent here to acknowledge that whilst the UK has been recognised for improving the gender and ethnic diversity of the medical profession, less progress appears to have been made in regard to socioeconomic disparity (Alexander and Cleland, 2018). This pertains to a long-standing trend wherein the highest social class is said to be represented 30 times more than the lowest amongst applicants to medicine (Dowell et al., 2015). In areas of economic deprivation, it therefore seems highly likely that patients will not share the same socio-economic background with their GP, pointing to a gap in lived expertise.

The quote above is supported by wider research findings emphasising the importance of time and relational continuity in building understanding and rapport between professionals and service users who do not share the same background (Ajayi, 2021; Stafford et al., 2023). Time is of course constrained by heavy workloads. The limited capacity of GPs has been recognised by the Scottish Government. As part of the shift towards health and social care integration described above, in addition to increasing the overall number of GPs in Scotland, reforms to primary care have included the implementation of multidisciplinary teams in GP practices (Scottish Government, 2017*b*; 2018). For people with mental health problems, this could mean that they are signposted directly to a community clinical mental health professional such as mental health nurse, whilst those with

more complex problems (such as co-morbidity) would have longer appointments with the GP (Scottish Government, 2017*b*). The hope was that this would reduce the workload of GPs and improve the quality of care for patients, who could access care when and where they needed it (Scottish Government, 2017*b*). However, evaluative research suggests that reforms have 'not developed at the pace and scale required' and limited capacity, particularly in areas of economic deprivation, continue to limit opportunities for change (Donaghy et al., 2022: 4). There was broader concern that the public had not been appropriately consulted on changes and that being triaged by reception staff to an alternative health professional could be damaging for relationships between GPs and patients (Donaghy et al., 2022). Having already explored the complexity of emotions experienced by participants at the point of help seeking, and the importance of developing trusting relationships, this feels significant. Given the apparent dearth of lived experience (of marginalisation) amongst the GP workforce, the lack of consultation with patients here is also concerning, representing the first of several examples in this chapter where the value of lived experience in (re)shaping services appears to have been overlooked.

"I wanted to avoid the tablets": anti-depressant medication

Participants in both groups had felt pressure from GPs to consider anti-depressant medication and some felt that this was a means of managing waiting lists for counselling:

"***Gemma***: *I think sometimes the push for medication…. just from speaking to people - that can be quite a push for that, rather than other things being offered or being explored first…*
Kim: *Yeah*
Gemma: *But people can feel pressured into that or being told that that's almost like the only option.*
Kim: *Mmhhmm*
Natalie: *Yeah, and do others agree with that?*
Caitlyn: *Yeah, like if you go to the doctors, they tend to suggest medication first rather than like putting you forward for counselling or like CBT"*

Placing this in a broader context, of 218 people with depression recently surveyed in Scotland, 48% were not referred for psychological therapy and 49% were prescribed medication without psychological therapy (SAMH, 2020). This is particularly striking when we consider that a meta-analysis of studies involving 13,722 patients found that psychotherapies outperform other methods in the treatment of depression (Furukawa et al., 2021). The term 'pressure' was used repeatedly by participants in relation to anti-depressants. In a systematic review of studies involving 342 GPs and 720 patients in the UK, patients felt unable to make suggestions about their treatment as they perceived their GP to be the expert (Parker et al., 2020). GPs have reported that the lack of time available to listen to

patients and limited psychological services encouraged the prescription of anti-depressants which are more readily available (Parker et al., 2020). Arguing that diagnosis should be a 'two way negotiated process, rather than an activity strictly in the doctor's expertise', the authors demonstrate the potential influence of structural factors in shaping the relational dynamics between GPs and patients (Parker et al., 2020: 443). Such constraints appear to limit opportunities for patients to explain the wider context for their symptoms and consider the type of treatment options that might work for them. This provides another example where lived experience may be dismissed and is particularly concerning for those who are marginalised, like the women involved in this study, who already feel unheard and misunderstood.

Participants in group 1 shared the view of single parents on low incomes recently interviewed in England that medication would not address social stressors and reduce them to a 'fluffy state' that could worsen their situation (Stack and Meredith, 2018: 238). Feminist scholars have critiqued the privileging of antidepressants for failing to acknowledge 'the emotional and gendered context of depression that shapes women's self-knowledge' (Fullagar and O'Brien, 2012:69). Thus, anti-depressants become part of an effort to manage women with mental health problems as 'risky subjects' due to their caring responsibilities and restore them to productive citizenship (Fullagar and O'Brien, 2012). Participants in the second group who took antidepressant medication suggested that this could be the 'right decision at the time' whilst describing situations where they had felt pressure to consider this option to help them manage worsening circumstances:

"I just cry every day of November, December, so my doctors try give me anti-depressants twice and I don't want to take it before but my one support worker say to try it and maybe make me feel calm little bit…my feeling is a little bit calmer, so I continue…"

(Mae, mid-thirties)

"I wanted' to avoid the tablets because I got already a lot of tablets for my health… for other things like my back and hip problem and asthma. So I did not want to take other tablets, but unfortunately the situation pushed me for help more…"

(Monika, early forties)

Medication was often spoken about in the context of 'struggling to manage' and both women expressed their desire to stop taking anti-depressants as they moved on with their lives. There was a sense that ceasing medication represented 'full functioning'. This speaks to wider research citing concern about the long-term use of anti-depressants and the risk of dependency; a study exploring women's use of antidepressants found that failure to discontinue because of withdrawal symptoms and the fear of relapse, created a sense of dependence on medication and limited personal agency (Cartwright et al., 2018). Crucially, in a recent survey of 66 GPs in

the UK, only one-third (29%) felt they had 'adequate' knowledge of the antidepressant withdrawal process and over two-thirds (68%) stated that they would like more training (Read et al., 2020). Returning to prior discussions of 'responsibilisation' (Teghtsoonian, 2009), this offers another troubling example of the internalisation of systemic issues as 'personal failing'. The structural factors at play here - funding cuts, GP capacity, gatekeeping of limited resources and a lack of investment in training – are eclipsed beneath individual concerns of participants about their own inability to manage and sense of dependency. Yet again, we hear echoes of anti-welfare rhetoric heralding independence and self-sufficiency.

In these depictions, women appear to surrender their sense of personal agency and self-confidence; anti-depressants allow them to function in their caring roles, without addressing the societal stressors causing their distress. The pressure placed on prescription arguably reinstates an individualised and medicalised conception of mental health issues, drawing attention away from the economic-political context (*See* Llewellyn-Beardsley et al., 2022). It thus seems logical that this could limit opportunities for political agency and the potential of collective citizenship. Before concluding this discussion, I wish to clarify that I do not deny the general effectiveness or appropriateness of anti-depressants as a treatment option, particularly when combined with other forms of support, nor common misconceptions around potential side effects (Jaffray et al., 2022). The concerns raised here relate to the socio-economic and political context within which anti-depressants were prescribed to the women involved in this project and the implications for personal agency.

"You're in crisis but can't do anything": waiting lists for counselling services

One of the main issues identified by participants was that they felt anti-depressant medication was used by GPs as a way to manage waiting lists for counselling and other specialist services. Wider stakeholders frequently referred to waiting lists as an operational challenge. Scottish Government guidance indicates that '90% of people referred for psychological therapies should begin treatment within 18 weeks'; average waiting times peaked during the pandemic and have since fallen again, yet still fall short of this target (83.1% as of June 2022) (Public Health Scotland, 2022). All participants had some experience of counselling; whilst some received counselling within two weeks, others had to wait for up to a year. Participants in both groups mentioned that the expense of private counselling meant that they were unable to consider this as an alternative option; thus financial constraints appeared to limit their ability to access timely support. Those working in third sector organisations, who provided 'in-house' counselling services, frequently bought up issues related to funding. For example, funded places being allocated geographically rather than based on need:

"…it's very limited spaces, so we have extensive waiting lists and we tend to get a lot of referrals from the North and South East, so if you're a woman living in in the North or South West you're more likely to get the service a lot quicker than you would, if you live in that other area, so there is it's not really fair, in my opinion."

(CEO, Third sector organisation)

This depiction appears to evidence the 'inverse care law' discussed in the literature review supporting this thesis, wherein the allocation of funding is based on population size rather than need (Hart, 1971). This leads to inadequacy of funding for practices in low-income areas, where health issues tend to be higher, thus perpetuating rather than mitigating health inequalities (Maclean et al., 2015).

Reflecting on the impact of the inverse care law in Scotland (see chapter 1 for a more detailed description of this), Knifton and Inglis (2020) have advocated for poverty to be recognised as part of the assessment of care and called for greater investment for mental health services in low-income areas. Another third sector stakeholder had been involved in setting up a counselling service which offered a 'lifeline' to women experiencing grief who were facing long waits for NHS referrals. However, limited funding severely restricted the number of women they could refer, resulting in their own extensive waiting list. Those working in non-health services in the third sector spoke of making referrals but waiting a long time for mental health assessments, leading to frustration that they were not able to get support for women when and where they needed it. A stakeholder holding a senior position within NHS Scotland placed this in the broader context of human resources:

"Mental health is such an issue that you know the Scottish Government have been made to put quite a lot of money into mental health ... the problem is there's not the staff… it's OK giving us the money, if there's not the pool of staff to recruit from what's the point. But I guess that's where we are at the moment… workforce supply is not keeping pace with demand and it will take years before that balances out."

(Clinical Psychologist, NHS Scotland)

Specialised counselling services, for example those offering 'culturally sensitive' counselling sessions available in other languages, were said to be particularly oversubscribed. Monika had been on a waiting list for sessions with a Polish counsellor for 12 months; whilst she had received counselling in English, she found it difficult to understand 'professional language' and unable to fully express herself. A stakeholder supporting women who are racially minoritised also referred to the challenge of finding counselling to support women speaking various languages. This issue has been picked up in wider research (*See* Loewenthal et al., 2012). Thus,

we see how the intersection of factors such as income, ethnicity and gender shape the resources available to racially minoritised women who are single parents on low incomes, and how this structural discrimination could leave them at greater risk of poor health outcomes (Shundi, 2021).

I began this section by referring to the reasons why participants delayed help-seeking until the point of mental health crisis. Findings suggested that for some of the women involved in the project (Yasmin; Caitlyn; Monika), once they engaged with services, resourcing issues meant that they were left experiencing distress without meaningful support:

"I think there is a real gap …when you've had a referral for somewhere… there's a real gap in the middle, where you have to wait like six months or 12 months or whatever it is… erm…like you're in crisis, but can't do anything…"

(Yasmin, mid-twenties)

The variation in the experiences of the women involved in this study, who lived in different parts of Edinburgh, speaks to the concerns of stakeholders as to the existence of a 'postcode lottery' when it comes to the availability of counselling services. Whilst the women involved in this study maintained engagement with services, stakeholders interviewed raised that long waiting lists result in high levels of attrition as people 'give up and lose hope'. This observation is supported by wider evidence indicating that the longer a client waits for a service, the more likely they are to withdraw from treatment completely (Goodman et al., 2012).

Experiences of counselling

Availability of counselling and practical barriers to engagement

As mentioned previously, all of the women involved in this project had received counselling at some point, in some cases multiple times and there was broad consensus that access to counselling was a fundamental component in supporting single parents on low incomes experiencing mental health problems. This was most often Cognitive Behavioural Therapy (CBT)[11] but also included person-centred, grief counselling and, in one case, art therapy. None of the participants had received Interpersonal Psychotherapy (IPT) or Interpersonal Counselling (IPC) which is the brief version and the focus of this study. The prevalence of CBT here is perhaps not surprising; CBT has enjoyed 'political and cultural dominance' in mental healthcare (Williams, 2015). Focused on numerical outcome data, CBT has a robust empirical base and therefore appears to have been favoured by NHS funders

[11] See glossary for a brief description of CBT, IPT and IPC

operating within a positivistic rather than interpretivist research paradigm and an environment prioritising cost-effectiveness (Williams, 2015; McMain et al., 2015). It is a highly structured approach, characterised by an active, directive therapeutic stance; it can be completed in a short period of time and (as I go on to illustrate) provided in various formats such as self-help manuals (Keijsers et al., 2000; NHS, 2019). However, it is not 'insight oriented', focusing instead on altering individual thought patterns; it has therefore been critiqued for failing to acknowledge social stressors and perpetuating neoliberal ideologies (Dudley, 2017). The single parents on low incomes involved in Stack and Meredith's (2018) study rejected therapies focused on cognition and emotions, however, as will be explored in this section, the picture was more complex for the women involved in this research.

Whilst one person had received counselling from a service within the NHS, in most cases this was delivered by a mental health professional employed through a community-based organisation. When asked about their individual experiences of counselling during scoping interviews, the accessibility of counselling, both practically and conceptually, emerged as priority issues. Participants spoke of the need for childcare to attend appointments and the value of services that offered creche facilities. This was felt to be especially effective when the organisation was familiar to children:

"Childcare is a massive factor cause obviously you can't go to counselling like if you've got little ones, but you've got nowhere to put them. So I've had to take my youngest with me before when they were much younger… there wasn't much I could do and obviously I was just at that point where I needed to go to counselling, end of story so it's not great…"

(Yasmin, mid-twenties)

"We don't always have people that we can take them to. [Son] is in nursery but he's in nursery on the days that I work. I can't send him to nursery other days and that's what was really good with the Dr. Bell's [family centre] sessions is we walked into the centre, we dropped the kids off at creche, we grabbed a cup of coffee and then we walked along to the room. And then after the session we took five minutes or so to unwind and then went back, picked our kids up. We were all in the same building and we knew our kids were safe… it was a familiar building to them too, so that helped and it made you feel that you could relax…"

(Gemma, late thirties)

These detailed reflections not only speak to the wealth of literature citing the importance of addressing practical barriers (e.g. childcare), but also psychological stressors related to single motherhood. As highlighted by Gemma above, participants agreed that it was crucial to know that their children were safe and comfortable to be able to focus. In addressing these contextual stressors, providers can 'enable their clients to focus more fully on their psychological functioning, thereby increasing their ability to benefit from psychotherapy' (Goodman et al.,

2012: 187). This demonstrates the value of integrating counselling services into third sector organisations that were already familiar to families. It was thus concerning to hear wider stakeholders involved in running these services discuss how challenging it could be to gain funded childcare places, meaning that they were only able to offer this to a very limited number of people. The issue of childcare also meant that a 'flexible' approach was appreciated by participants who recalled having to rearrange appointments because of children becoming sick but also other emergencies and appointments. Most participants involved in this project described attending regular sessions, which is perhaps not surprising given their commitment to the research project. A third sector stakeholder who provides counselling to women who are single parents on low incomes however said that most of the women they support will only manage to attend one appointment per month despite wanting and planning for more regular sessions. On the issue of attendance another third sector stakeholder in a counselling role asserted, "I'm just calling things as they are, you know? If they attend the session that's pretty much a victory."

Supporting the concerns of stakeholders regarding the existence of a 'postcode lottery', there appeared to be discrepancies in the availability of counselling services to women living in different areas. Caitlyn, for example, was referred for CBT with a psychiatric nurse at her GP practice who wanted to offer her weekly or fortnightly sessions but only had capacity to see her once a month:

*"**Caitlyn**: Sometimes I feel like your GP… they tell you just to look up websites and stuff like they don't have a lot of time in appointments really to talk… so they'll sort of say like 'oh here's some information to take home' and like 'look up the website yourself' and 'download this app' and stuff. Like with the CBT… it was sorta like 'Oh, I've only got a 20-minute slot because I've got someone else coming in', so they didn't really have long appointments and it was a lot of paperwork, I was taking home and like stuff and I had to look up the stuff myself…like websites and things…*
***Kim**: I think to do that makes your anxiety… makes your mental health even worse because you've got pressure on you to 'Ah I need to get this done, I need to get this done!'*
***Caitlyn**: Yeah and sometimes you can't even think like to look at websites and stuff you want more just to talk to them and them give you different ways rather than doing it all at home and thinking 'ah I've got all these bits of paper and I've got to sit and read through it all yourself and sometimes your just not really in the mindset to do it…"*

The approach described here may be defined as 'guided self-help' wherein a health professional 'guides' the patient in the use of a self-help intervention or 'health technology' (e.g. a written manual or website)' (Coull and Morris, 2011). At the structural level, this account appears to demonstrate how restricted funding can limit the resources and time available to professionals in low-income areas (Mercer, 2007), prohibiting the agency of individuals to consider therapeutic options that

best suit their circumstances. At the individual level this has the potential to amplify unequal power dynamics between mental health professionals and clients. The phrase 'I've *got* to sit and read through it all' (emphasis added) implies a sense of powerlessness in this scenario and the obligation placed upon Caitlyn to make up for gaps in provision in and around her childcare responsibilities. The use of personal, reflexive pronouns in Caitlyn's account ('I had to'; 'I've got to'; 'myself') appears to signify her sense of being alone in this process. As with GPs, it is unlikely that therapists/counsellors will share the same socio-economic background with their low-income clients (Proctor, 2018); research has found that women on low incomes can be sensitive as to whether therapists are able to understand their situations (Goodman et al., 2012).

Caitlyn refers to 'just wanting to talk'; dialogue has been found to be central to the formation of trusting therapeutic relationships (Wilson, 2021). Reflecting on their work with marginalised populations, an experienced clinical psychologist within the NHS postulated that 'it can take a long time to break down those initial barriers'. Kim provided a lived experience perspective:

"Oh, they'd have to work hard to get my barriers down that's for sure. As I say, it's basically just being there all…not all the time, but knowing that they are there to support me and not just goin' 'Aye, ok, mmhhmm' like some people do you know? You know what I mean they just go 'yeah just do that just do that' but they don't think of the situation that you're in and then you're kinda like 'Well I don't want to continue with this anymore because I don't feel it."

Where therapists work to understand the context of client's lives, this positions the client as 'expert' leading to feelings of empowerment and self-worth (Wilson, 2021). Thus, the importance of listening, particularly for women who are marginalised, should not be understated. The need for protected time also feels relevant here reassuring Kim that 'they are there', that she is not alone in working to address the issues she is experiencing. In Caitlyn's case however, the limits on the time available to her were made starkly apparent. The allocation of 'homework tasks' denied her reality as a single parent on a low income, adding to Caitlyn's excessive workload and increasing distress. There was general agreement amongst stakeholders that effective counselling requires some work on the part of the client, for example, applying strategies. However, counsellors interviewed felt that the feasibility of homework tasks should be discussed with individuals and had to 'feel possible' to be empowering.

It feels pertinent to note that Caitlyn did find some of the strategies and techniques offered by CBT helpful in addressing negative thinking, supporting the view that it is the therapeutic relationship rather than the specific approach that matters in understanding the quality of counselling (Bondi and Fewell, 2003). Kim, for example, had a much more positive experience of CBT:

" I've got to tell you that my CBT therapist … she was really good. I had an hour with her for nine weeks I had it and then she extended it for another three weeks and then I was struggling again so I got in touch with them and they gave me her back for another two weeks. So I was quite lucky. Erm she set up like a personal goal ladder of what I wanted to achieve every day and not to pressurise myself. So she was pretty good and I had a big thing come up in October and she's actually made me a voice clip to have on my phone, so I could listen to this before I had to do what I had to do so that was really, really helpful …"

(Kim, early fifties)

In contrast to Caitlyn's experience, Kim 's therapist appears to have adopted a person-centred approach to CBT. Kim appears to have guided the process (indicated by setting her own goals) supporting the development of a trusting relationship. She was able to access longer sessions over an extended period, during which time her therapist worked to understand Kim 's needs, tailoring her approach to ensure strategies felt manageable and meaningful. A third sector stakeholder in a counselling role also emphasised the importance of time when supporting single mothers on low incomes:

"…patience and very, very much slowing down. Really, really slowing down and going at their own pace, because CBT is quite directive so hence I've been really kind of talking…having a more integrative approach where you actually establish a therapeutic relationship [first]… you have to be patient and just wait for it… apply a person centred approach and just be there always and one day they'll be ready…."

Participants in both groups made frequent references to the fact that 'everyone is different', that counselling works best when therapists work to 'understand you' and tailor their approach to suit the person they are supporting. This speaks to discussions in the first findings chapter about the need to acknowledge structural contexts whilst also recognising single parents on low incomes as unique individuals. The importance of time here appears to have a deeper meaning beyond access. As previously discussed, and reaffirmed through the experiences of participants, single mothers on low incomes frequently deprioritise their own needs and get little time to themselves. Third sector stakeholders in counselling roles suggested that part of the therapeutic process was about carving out 'me time':

"…like therapeutic work is really allowing them to have that 'their time' you know, like needing 'my space', 'my time' and, like really reflecting and actually just really relaxing you know, just letting go because it's just it's so important for them…they have so many things going on, lots of stressors, you know their exes and, like the context and maybe financial issues and mental health issues and the list goes on and on, so the therapy 50 minutes you know, this is just it's like a dream for them so like that's why I said, if they do manage to get to the session on their own, without distractions you know, then that's already a win…"

The psycho-social feasibility of counselling

In the previous section, we focused on the importance of acknowledging the structural context of women's lives in the establishment of trusting and effective therapeutic relationships. However, there can be a tendency for research to overfocus on the practical and logistical barriers to engagement for people on low incomes, neglecting to consider the psycho-social accessibility, usefulness, and relevance of therapeutic approaches (Goodman et al., 2012). Another theme to emerge was the accessibility of content covered during counselling. Participants struggled to recall the type of counselling they had received and some found the use of acronyms confusing. Participants in the first group agreed that it was important that professionals explained things properly or were available to support understanding. Reflecting on her experience of one-to-one CBT, Gemma recounted that:

"I just didn't get on with the lady who was doing it. Em I didn't know the difference between a 'thought' or a 'feeling' and she was not explaining it in the best way to me…she just got a bit irate with me almost that I just couldn't understand… whether it was just my understanding or the way that she was explaining it to me I don't know so yeah, I had two sessions and was just like 'I can't continue' so she asked me how I thought about something and apparently, I answered how I felt about it… you know I came out and cried and yeah, it didn't help."

The didactic, authoritarian approach described here was so upsetting for Gemma that she felt she had to discontinue her sessions. To better understand this account, it feels important to first acknowledge the issue of social class. As previously discussed, therapists in the UK tend to be middle class (Trott and Reeves, 2018); the prevalence of class as a cultural phenomenon in the UK is widely documented, easily identifiable by indicators such as accent, dress and ethnicity (Proctor, 2018, Wilson, 2021). Research has indicated that working class women can be subject to a 'middle-class gaze' which can position them as 'lacking value'; acute awareness can result in efforts to 'prove their worth' (Skeggs, 2011). The 'good lone parent' ideal discussed extensively in the previous section provides an example of this. Class dynamics, left unmanaged, thus have propensity to induce feelings of shame (Gallo, 2020). It could be argued that Gemma's therapist demonstrates a lack of awareness of the impact of their communication style and an unwillingness to adapt their approach to reach a mutual understanding.

Despite the significance of class, authors have called attention to the lack of research exploring class in relation to counselling and psychotherapy in the UK (Ballinger and Wright, 2007; Balmforth, 2009). Class has also been neglected within guidance and training; it has been argued that therapists can feel uncomfortable

addressing the issue in their practice (Gallo, 2020). Failing to acknowledge this 'can have the effect of reproducing classism and reinforces the discourses that support structural inequality' (Gallo, 2020: 72). Where managed appropriately however, the therapeutic space can be utilised to reframe negative discourses. Gemma went on to engage in group therapy at a third sector organisation where a development worker with lived experience supported the therapist to facilitate sessions, drawing on their lived experience:

"…it was really relaxed and down to earth. I took something away from it because they used one of my examples…and broke it down and that made me realise that it wasn't as bad… I used to look back on that day and think it was the worst day of my life but now I actually look back on it after being in that group session and being like actually it wasn't. I did all these good things… I was a good person. I was a good Mum. So yeah, I took quite a lot away from that session."

Acknowledging the way in which neoliberal ideals appeared to shape participants' conceptions of 'good mothering', Gemma's reframing of her experience of parenting in the account above arguably exemplifies how neoliberalism can be reproduced or challenged through therapeutic discourse (LaMarre et al., 2019). These 'microshifts' may not result in structural level changes to the neoliberal capitalist system, but they can 'invite alternate ways of storying experience [whilst] amplifying subjectivities transgressive or disruptive of neoliberal governmentality' (2019:249). We could conceptualise this reframing as a form of 'micro-resistance', helping to undo the internalisation of structural/institutional stigma (into self-stigma) described earlier in this chapter. This however is said to rely on the attunement of therapists as to the role of neoliberalism within and beyond the therapeutic space (LaMarre et al., 2019).

There was a preference amongst participants for relaxed and informal approaches, counterposing the formal speech, rigid body language and structured style found to be associated with the 'middle class' (Gallo, 2020). Third sector stakeholders demonstrated awareness of this, for example, finding ways to 'offset the tension' that can be inherent in counselling rooms by having objects on the table that clients could play with whilst talking. The desire for a less structured, non-directive form of therapy led Jess, who had tried CBT, to opt for art therapy where she felt she could work through things [herself]' as opposed to receiving prompts and suggestions. It is worth noting that the level of direction and structure introduced to the art therapy setting depends on the specific approach adopted by the art therapist (Lith, 2016). Where the art therapist takes a facilitative approach, the client can embark on 'self-initiated' activity and adopt a position of some control (Heenan, 2006; Öster et al., 2009). Where this works well, clients can gain a sense of 'self-efficacy' through creative and critical thinking (Kapitan, 2014). The lack of reliance on verbal communication can make art therapy a more accessible option for people expressing difficult emotions, people with learning disabilities or language barriers (Zubala et al., 2023). Acknowledging that it was not necessarily

right for everyone, Jess explained that art therapy had helped her to make connections to her childhood, make sense of her relationships and was now able to focus her energy in different places which she felt had been positive for both her and her young son. Mirroring the discussion above, the potential for empowerment and capacity building is said to be contingent on the ability of the art therapist to acknowledge their power, take account of the social context of client's lives and recognise clients as experts in their own lives (Heenan, 2006; Carr and Ashby, 2020). Two stakeholders interviewed highlighted the potential value of art therapy for women who had experienced trauma such as domestic abuse and non-native speakers yet found it challenging to access funding. The findings of systematic reviews have evidenced the multiple benefits of art therapy for people with common mental health problems such as depression and anxiety, however the availability of art therapy is still said to be limited, particularly in rural parts of Scotland, and the instability of funding for these approaches has been cited as a broader issue (Watts et al., 2018).

Other issues related to inclusivity were brought up frequently by stakeholders who felt that advances were needed to make therapeutic services more meaningful, useful and safer for minoritised groups. A clinical psychologist in the NHS referred to the "historic lack of trust in the medical model for mental illness" and the heteronormativity inherent in therapy delivered within the NHS. They had recently attended a training programme which helped them to realise that they aren't passive and have 'blind spots'. There was a sense that whilst awareness was growing within the NHS, there was still much work to be done. A third sector stakeholder reflected:

"[training] excludes people of colour and sexual minorities …I have seen people who have those protected characteristics who find it hard to trust….and worry about having to just say more than they want to or find themselves educating their therapist, when the therapist should be educated, you know [shakes head] I feel like around racism, in particular, like there is a real difficulty for white therapists um because they're so often so worried about coming across as racist so then they are racist, because they don't ask the important questions … this is like essentially part of your training… I would say even trans issues can be quite difficult, so if you are from a minority group it becomes harder and harder to seek that kind of support…that's where you rely on peer support like I think there are more informal peer support networks in the trans community or possibly within some migrant groups that we know of…"

Reflecting on their experience of delivering cultural competence training to CBT therapists in the UK, Naz et al. (2019) identified a lack of confidence in asking clients about their culture, ethnicity and experiences of racism as they feared causing offence; there were said to be few opportunities to reflect on these issues during supervision, develop skills and confidence. Without adequate support, White therapists can be subject to feelings of shame and guilt when a client

discusses racism; this can lead to self-focus, emotional withdrawal and a loss of empathy, effectively perpetuating racism within the therapeutic encounter (Naz et al., 2019). Others have pointed to the need for therapists to recognise the ethnocentric assumptions built into dominant therapeutic models (including art therapy); therapists have been urged to adopt self-reflexivity and maintain awareness of 'western lenses' in practice and training (Eastwood, 2021; Kapitan, 2015). Similar themes, emphasising the importance of the therapeutic relationship, and the desire to be understood, have emerged in research with transgender people; even where therapists had 'gender specific' knowledge, there could be issues with the application of this, leading to assumptions about some problems being related to gender identity (Applegarth and Nuttal, 2016; Hunt, 2014).

Strikingly, whilst all the women involved in this study had received counselling at some point, the gap cited most frequently during workshops in both groups was 'having someone to talk to', that was non-judgmental, available and could understand their situation. Upon first hearing this I had focused on the availability of ongoing support and the potential value of peer support (discussed in more detail later). However, it seems this could also relate to inconsistencies in the abilities of therapists to adequately acknowledge and respond to differences in social background and the social context of women's lives. This connects to the wider findings outlined in this chapter highlighting the apparent absence of lived expertise guiding practice (here a 'task' that could be better shared).

When I asked stakeholders from third sector organisation and NHS Scotland involved in running counselling services about the involvement of people with lived experience in shaping service design, they generally referred to the way that 'person-centred' or 'integrative' approaches allow them to respond flexibly to the needs and preferences of the person they are supporting. In this way counselling is said to be 'led by the client'. A stakeholder holding a senior position within NHS Scotland reflected on what they believed was a shift in approach in recent years:

"it's always about focusing on the therapist being approachable and open… actually meeting people where they are rather than expecting people to come up to a certain standard. You can describe it as… um… that approach based around being with somebody rather than going to somebody. Because traditionally, clinical psychology has got a really nasty reputation of doing things to people. In other words telling people what they've got to do to get better and measuring that and evaluating it whereas that denies the whole process of people recovering psychologically … it's a journey and it's about accompanying people on that journey and it's so important, especially when you are working with vulnerable service users in this population that you are describing who… not having enough money, having to look after kids, maybe not having a support network round about."

Counsellors interviewed appeared to endorse this approach, each emphasising the importance of being flexible and 'non-judgmental'. However, Chantler (2005) has

argued that person-centred approaches do not sufficiently address the structural dimensions of inequality and that more attention to be paid to gendered and racialised conditions of worth, intersectionality and minoritisation.

Crucially, none of the stakeholders interviewed were aware of cases where people with lived experience had been involved in directly shaping psychotherapeutic services. It is also worth noting that having identified two projects which had adapted IPC so it could be delivered by youth workers and peer support workers (discussed in greater detail in the following chapters), people with lived experience do not appear to have been involved meaningfully in the design of these projects either. In fact, wider research points to the general inadequacy of feedback mechanisms in psychotherapeutic services; approximately 3-15% of people are known to have negative experiences, yet little is actually known about these (Hardy et al., 2019). Baines et al. (2019) posit that most feedback tools are designed by professionals and assume compatibility between the agendas of patients and professionals. Another clinical psychologist within the NHS felt that participatory approaches can seem "other wordly spaceship" to people in public health. When asked how they would like to see mental health services develop over the next five years, they reflected:

"I would like to see public health professionals supporting the work of others … I think we should always have our own small case load but move towards helping others … I like the idea of a cascading model to (I hate the word empowering but..) empower people to take some of this stuff on."

The women involved in this study demonstrated an awareness of this lack of engagement which had, in part, motivated their interest in this project.

Meetups and support groups

Family activities and outings

In addition to medication and counselling, other forms of mental health support provided by third sector organisations were mentioned frequently. These included meetups/outings, support groups and access to a 'respite creche'. Firstly, the ability to attend meet ups and participate in outings with other families provided an opportunity to meet other women in similar situations. Some valued meeting other single mothers specifically whilst others appeared to identify with mothers in different (albeit challenging) situations. Participants and wider stakeholders referenced a plethora of different activities; this included walking groups, exercise classes and even 'wild swimming' where mums were able to use creche facilities, socialise and gain 'headspace':

"…they're not structured mental health activities but I take six mums for a walk on a Monday morning while their kids are in the creche and they just love it because … a single mum… any mum… but a single mum in particular is really worried about their child because they think … especially if they are suffering from mental health issues … they're really worried that it is going to affect their child. So, to know that there is a creche for two hours with structured play for their children and they can just get out and chat to each other is massive – do you know what I mean? To a mum with a small child who is on her own with that child all the time. It reduces isolation and it gives the child and the mum that two hours apart, so it's really good for attachment and for resilience …"

(Support Worker, Third sector organisation)

Participants spoke very positively about these opportunities and there was agreement amongst stakeholders that participating in such activities could help to (re)build confidence.

Other activities had been designed to include children negating the need for childcare; these included buggy walks, fancy-dress parties and day trips to museums and castles. Participants saw these as valuable opportunities for children to socialise whilst they got to know like-minded people. The usual cost of activities for children, particularly at weekends, was referred to in both workshop groups as having the potential to reinforce poverty. The potential of these services to address social isolation should not be understated. Other qualitative studies with single parents on low income has found that financial hardship creates physical, social and psychological barriers to participation in social activities; this can lead to isolation with corrosive implications for mental health and wellbeing (Stack and Meredith, 2018). Stakeholders in two key organisations explained that organised day trips sought to overcome barriers to educational family activities as these were not always affordable and many women they supported did not have a car. Extracting data from the Millenium Cohort Study, using a sample of 14,595 children from across the UK, Cooper et al. (2020) found a significant income gradient related to 'trips outside of the home' indicating that financial resources restricted the types of activities mothers on low incomes could do with their children. 'Cultural cultivation', which include activities like trips to museums, is regarded as a 'parenting ideal' more accessible to middle class parents (Cooper et al., 2020). Given the potential link identified thus far between feeling like a 'good mother', mental health and self-esteem as well as the health implications of compensatory behaviours (e.g. self-sacrifice), it appears that such outings could have indirect, complex benefits as a form of mental health support. However, such outcomes can be hard to evidence; research has drawn attention to the instability of funding for third sector services, particularly smaller community-based services who can struggle to compete with more powerful organisations (Christofferson, 2019).

As activities were centred around the broad interests of children, three participants raised that they may not be appropriate for very young children or adolescents; Kim for example could no longer attend certain groups once her son became a teenager. Caitlyn, whose son has additional support needs, often attended groups led by organisation specifically for disabled children and young people as her son was better able to engage with the activities. This points to the salience of the argument made by participants that single parents have unique needs when it comes to service provision. Participants also mentioned more structured support groups, centred around a topic or skill, for example, a wellbeing group and meditation class with other single parents. Mae repeatedly emphasised the importance of positive thinking, a skill she had developed through attending counselling, the wellbeing group and meditation class:

*"**Mae**: Just be thankful… But again I really try to push the positive thing because when too much depressed already, too much thinking about the negative… I think we will be down. Yeah everything happen is just be stronger.*
***Monika**: Pain make us strong! [laughs]"*

Peer support within community groups and services

As wider stakeholders reflected, one of the main aims of these activities was to address the isolation commonly experienced by single parents, develop friendships and wider support networks. When participants joined the first workshop for this project, there was only one participant that did not already know the other group members; the rest had met at various support groups and meet-ups, in some case swapping numbers and meeting up separately. Kim, for example, described meeting '[her] single mums' on Zoom for Friday night drinks during the pandemic. When I asked stakeholders involved in running these services about the role of peer support, they suggested that despite there not being any formal roles, peer support occurred organically and was an important part of the experience for attendees. Importantly, the main reason given for the absence of formal roles was the limited availability of funding. This motivated one support worker, whose hours had been reduced due to funding cuts, to facilitate the setup of a WhatsApp group so that members could support each other outside of office hours:

"the other thing we did is we started a WhatsApp group or the parents did, so that they can communicate and talk when the services aren't runnin' because what we try and do is we facilitate the groups…we don't, you know, supervise but we're trying to empower the families and we've seen that take off big time because I hear on the Saturdays, you know that the mums are all meeting up and they're going out playing bowls, the children are going round each other's houses…"

Participants who had been involved in this WhatsApp group brought it up during workshop discussions. Acknowledging that it had initially helped to 'keep in touch and be friends' (Gemma), it eventually become 'too much':

*"**Caitlyn**: … see if you're going through your own stuff and other people are like constantly putting problems and stuff, sometimes you're like taking on their problems and stuff…*
***Kim** : Yeah…*
***Caitlyn**: It just really became like too much … the messages were coming all the time and if you're like dealing with your own child or doing other things you just can't keep up with the messages…*
***Kim** : Nah, nah. It just got too much.*
***Caitlyn**: I read them all but sometimes there was just too much.*
***Gemma**: I felt that there was an individual using that basically instead of contacting professionals… Some of the things they were saying to us… we shouldn't a been … it's okay to listen to your friend's problems but I think they were basically bypassing professionals and I think they did need professional help.*
***Kim** : Ah definitely… I agree. But that was said in the group chat constantly.*
***Gemma**: So that made it incredibly difficult, and almost frustrating and hard. You know it can make it hard when you want to help someone but you can't… well we can't…"*

Thus, whilst the well-intentioned efforts of this support worker and colleagues to reduce dependency on the service and strengthen (more readily available) peer support amongst the women involved, participants appear to have felt overloaded with the problems of others and ill equipped to offer support. This led to feelings of stress and frustration before people began leaving the group. We know from the previous accounts of participants and wider research that single parents on low incomes can already feel they 'aren't good enough'. Thus, it seems that such experiences could worsen feelings of low self-esteem. As explored within the literature review attached to this thesis, research has evidenced the importance of developing clear roles for peer support workers, supervisory support and adequate training to ensure a positive experience and safeguard their wellbeing (Ibraham et al, 2020).

There also appeared to be several barriers to participating meaningfully in group activities. Participants agreed that attending groups with new people could be anxiety-inducing and could put some people off. Challenging idealistic conceptions of 'interest groups', the existence of cliques presented a challenge to support workers introducing new members. In her scoping interview, Yasmin asked to know who would be participating in the project positing that 'all the single mums in my area have turned against [her]'. A third sector stakeholder in a support role reflected on the challenge of creating the right 'dynamic' when setting up a group or introducing new members. They recounted a time when they invited someone

who was not strictly eligible to join because they were friendly and outgoing and would encourage others to relax and open up. Another third sector stakeholder in a similar role spoke of times where they had to mediate between groups who had fallen out during day trips. Thus, support workers appear to play a crucial role in managing group dynamics and facilitating the formation of relationships. Here the concept of 'benevolent othering' (Grey, 2018 - see chapter 2), which encourages the recognition of people with mental health problems as diverse, complex human beings, rather than 'passive victims', is helpful for acknowledging the challenging work undertaken by those running community services who exert emotional labour in the manufacturing of informal support networks.

Language barriers and cultural differences were also said to present challenges to social integration amongst groups. Monika avoided joining larger groups until she felt more confident speaking English. A third sector stakeholder found that racially minoritised families could get left out. They had looked for ways to encourage openness amongst groups, for example, cooking dishes to learn more about the different cultures amongst group members. Another third sector stakeholder supporting racially minoritised women also mentioned 'cooking' as an effective way to encourage sharing and learning about different cultures and drawing to aid communication. They had also sourced funding to take those attending a women's support group to the cinema, bowling and to learn how to ride a bike, positing that this not only encouraged bonding but could also be empowering for women previously denied autonomy and independence. There was however said to be a gap in supporting women to move on from these services and develop relationships in the broader community.

When asked whether people engaging with third sector organisations were involved in the shaping services, there were few examples of formal activity. Support staff did however go to great lengths to do this informally, maintaining an ongoing dialogue with clients, gathering feedback and suggestions and seeking relevant opportunities. The ability to respond to requests however was said to be hampered by lengthy funding application processes, meaning that by the time a new service was implemented, those originally involved may no longer be eligible or involved with the organisation. It is worth noting at this point that qualitative research suggests that the relaxation of 'administrative and budget oversight' by the state and other funders in England and Scotland during the COVID-19 pandemic allowed third sector organisations to respond quickly and flexibly to the needs of those they were supporting (Cullingworth et al., 2022). Whilst it appeared that third sector organisations were well placed to provide support in a way that felt accessible and familiar to participants, all third sector stakeholders referred to limitations on funding and waiting lists. Accessing childcare places was flagged as a particular challenge, especially where this was conditional on someone's attendance to a group with limited places:

"We used to get given some money for that so a health visitor or social worker could phone us and say 'this mum is not coping – she needs breathing space' you know and we could offer that mum or family one or two spaces a week so they could put [their child] in the creche for two hours and it was usually pre-nursery and that was really valuable and in fact it's really missing and we still get health visitors and social workers referring families but we have to charge for that childcare space unless they are taking part in my group you see so that gets really complicated so actually yesterday the creche manager and myself were sitting saying 'right this parent, if she's really skint, see if she'll do the walking group or the active mums group or whatever and then at least the kid gets two hour creche and she gets an activity' but actually sometimes what that mum could do with is two hours to herself…"

(Support Worker, Third sector organisation)

This stakeholder went on to explain that people had previously used the time to go to the hairdressers, sit in a café and apply to jobs or just enjoy two hours alone. Given the emphasis placed by participants on 'feeling stuck', (See Fig.4) it is perhaps not surprising that the concept of a 'respite creche' (access to childcare that is not conditional) was discussed as an inherently valuable form of mental health support during workshops. A stakeholder from the Edinburgh Rape Crisis Centre (ERCC) also underscored the importance of flexible funding to find appropriate childcare for women living in different geographical areas, working in partnership with other organisations.

Conclusion

The findings of this chapter illustrate the way in which structural, representational and individual factors intersected to shape the experiences of the women involved in this project as they moved through mental health services. At the structural level, the apparent preference of NHS funders towards approaches that are deemed to offer value for money, and the disproportionate allocation of resources, appear to restrict the options available to professionals to offer to those seeking mental health support in low-income areas. I have conceptualised this as a form of institutional stigma which creates unequal power dynamics between mental health professionals and participants who were denied the opportunity to draw on their subjective knowledge and make genuine choices about the treatment options that felt right for them.

Acknowledging neoliberal influences which have shaped the current mental health service landscape, it has been possible to uncover what appear to be discursive strategies (e.g. the illusion of choice) which function to obscure the impacts of austerity, shifting attention away from resourcing and onto the inability of (distressed) individuals to make a decision or (overstretched) professionals to work in more preventative and collaborative ways. We saw a similar pattern in the women's experience of being prescribed anti-depressant medication; a cost-

effective solution for GPs with limited capacity which fuelled unequal power dynamics, drawing attention away from societal stressors and encouraging individualised narratives related to dependence and coping. There appeared to be a gendered dimension to this, restoring the women's abilities to function in their caregiving roles whilst numbing their political consciousness. Each of these examples point to the internalisation of structural problems into 'self-stigma'.

Pointing to broader systems of inequality, single parents on low incomes are unlikely to share the same socio-economic background as the professionals they encounter. The accounts of participants suggest that the impact of social distance could be minimised where professionals acknowledge their social position and commit to understanding the social context of their lives. However, funding constraints meant that the time required to achieve this was not always available. There also appeared to be important gaps in training and guidance meaning that mental health professionals lack the confidence and skills to address sensitive issues such as class and racism within therapeutic encounters. Findings also indicated gaps in professional knowledge related to the psycho-social feasibility of dominant therapeutic models for minoritised populations. Where classed, gendered and racialised positions are acknowledged, individuals receiving therapy (of various forms) can be supported to challenge hegemonic narratives; whilst this may not lead directly to structural change, it seems this process could help to expose institutional stigma and buffer against the internalisation of systemic issues. Where social context is not acknowledged however, due to the discomfort, capacity or limited awareness of the therapist/counsellor, it seems that this can amplify social distance, legitimate discourse and reinforce stigma at the individual level. Findings point to important, missed opportunities to leverage lived expertise within training and guidance for mental health professionals exploring the feasibility of content and the appropriate navigation of sensitive issues related to inequalities. More broadly speaking, the absence of participatory approaches was troubling, implying a failure to recognise the potential of lived expertise in shaping mental health services that feel meaningful, useful and relevant.

Third Sector providers demonstrated an awareness of material and psychological stressors for women in the design of their services and sought to respond flexibly to their evolving needs. Unfortunately, stringent funding criteria and lengthy application processes appears to have hampered these efforts. This is said to be the result of unequal power relations between the state and third sector; authors advocating for the loosening of funding conditions have argued that 'the sector needs to be trusted and empowered to respond to the needs of its communities' (Cullingworth et al., 2022: 17). Community-based third sector organisations provided much valued opportunities for participants to connect with others in similar situations. A lack of funding however meant that well intentioned efforts to

maximise the value of peer support occurring organically within these services, meant that participants were inadvertently expected to compensate for gaps in provision without adequate support. Participant's reflections on the WhatsApp group provides yet another example of 'responsibilisation'; not only did this experience add to the issues they were dealing with on a daily basis, it also seemed to invoke a sense of individual failing at not being able to help someone in need (we return to this example in later sections). Furthermore, such situations have the potential to damage personal relationships and cause divisions, arguably represented by people leaving the group. Again, this serves to redirect attention to the individual level, limiting opportunities for collective action against structural issues. Third sector organisations are well placed to mobilise social capital; yet without appropriate investment and autonomy, opportunities to leverage lived experience in meaningful and empowering ways appear to be restricted (Cullingworth et al., 2022). Having explored the individual, representational and structural contexts for the mental health experiences of women involved in this project, we moved on to consider the feasibility of interpersonal counselling (IPC), which is the focus of the following chapter.

Chapter 6: Exploring Interpersonal Counselling (IPC)

Introduction

Thus far, I have reflected upon the data gathered during individual scoping interviews and the first group workshops. In this early stage in the research process, I sought to develop a nuanced picture of women's lives, the existing service landscape and their perspectives on what was important in mental health care. Responses to various exercises and discussion points were mapped onto white boards on Zoom and/or Google jam boards, so that these could be used as reference points in later workshops. The aim of this was to ensure that all future discussions and recommendations related to the potential of 'task-sharing' to improve mental health support were grounded in the individual, representational and structural contexts of participant's lives. As previously mentioned, distinguishing between these different levels of experience can help to avoid overly individualised explanations of health inequalities (Kapilashrami, 2020). The comprehensiveness of this framework also attends to multiple social locations (Anthias, 2012), helping to avoid the issue of 'culturalism' (the overemphasis on cultural difference) identified within the existing literature relevant to 'task-sharing' which can contribute to othering and mask broader systemic issues (Johnson et al., 2004).

In the second and third workshops, we moved on to discuss interpersonal counselling (IPC) as an approach to 'task-sharing', exploring how participants felt about various aspects of this model. A detailed explanation of IPC can be found in chapter 2. This was inspired by examples of task-sharing in LMIC and sought to respond to the gap in research within higher income settings looking at how to involve people with lived experience in the task of reviewing the format, structure, focus, language and tools used within 'evidence-based' talk therapies. IPC was chosen based on the perceived relevancy of content to mothers on low incomes according to members of the advisory group and within the wider literature (Toth et al., 2013). As it has been designed to be delivered by non-health professionals (see following section), the content of IPC has been argued to be more accessible than other similar methods (Weissman et al., 2014) and thus lends itself well to adaptation utilising participatory methods. However, examples of this remain minimal and adaptations appear to be driven by professional teams. As members of the advisory group were leading on work in IPC, this presented somewhat of an opportunity. It is important to make clear that, as I am not a mental health professional and did not have access to such expertise during the workshops, 'adaptation' was beyond the scope of this project. I did however seek to review the various aspects of IPC with participants to gain insight into the potential feasibility

of the approach for single parents on low incomes in Edinburgh and identify opportunities for future research.

In order to build my knowledge of IPC prior to the workshops with participants, the advisory group arranged for me to attend a 2-day IPC training course led by an advisory group member who is a clinical psychologist and specialist in the area[12]. Two members of the advisory group, both single parents on low incomes involved in the delivery of community-based services, also expressed an interest and were invited to join. I gained permission to record the rich discussion that occurred during this training and draw on these insights over the following pages. Following the training, I looked for accessible resources that I could share with participants which clearly explained what IPC was. Despite my best efforts to utilise the contacts I had made in the field, I was unable to find information materials that were appropriately accessible. This was interesting given the emphasis on the relative accessibility of IPC; it seemed that this was a general observation on the nature of the content covered within sessions (as compared to cognitive models) rather than the information available to those looking to learn about the approach.

It was therefore agreed with the advisory group that I would create a short information video[13] which was free from jargon and could be shared with participants ahead of time. Ensuring that information was presented in an accessible and engaging way was not only integral to the PAR principles underpinning the project but also helped to facilitate meaningful discussion. The process for making the video was supported by a clinical psychologist who monitored the validity of content and members of the advisory group with lived experience who reviewed the video to ensure this felt accessible and sensitive to the issues being explored. I also sought to build my understanding of how IPC worked in practice and spent time speaking to stakeholders involved in two projects; one involving peer support workers who were delivering IPC to fellow veterans in Scotland (Fitzpatrick, 2018) and another involving youth workers who had been trained to deliver IPC to adolescents in England (Wilkinson et al., 2018).

I was specifically interested in 'task-sharing' and at the time of conducting my fieldwork, examples of IPC being delivered by people who were not mental health professionals were limited. The projects identified above provided opportunities to explore factors relevant to task sharing, such as supervisory structure, professional identities and acceptability to different client groups in different geographical contexts. However, they also each offered specific insights, for example the project with veterans was based in a local area, so there were many

[12] This was Interpersonal Counselling – Learning (IPC-L) with a focus on learning rather than delivery

[13] The link to this video will expire on 26th December 2025. If you would like to view the video after this point, please contact the author.

relevant insights related to the local mental health service landscape; it also involved peer support workers, providing an opportunity to explore the role of 'lived experience'. The second project with adolescents was based in England but was larger in scale, had recently been evaluated and a proposal was underway for this to be rolled out; this provided an opportunity to consider broader structural factors influencing the feasibility of the approach. I had to remain aware of the limitations in place here when gathering and analysing data; acknowledging this is only two studies and considering the potential relevance (or not) to women who are single parents on low incomes living in Edinburgh.

The findings discussed in this section are therefore drawn from multiple sources; discussions and reflections from the workshops with participants, insights and discussions from the IPC training and interviews with stakeholders involved in delivering IPC (e.g. managerial staff and peer support workers).

IPC structure and modality

"It just feels wrong to rush someone when they're opening up to you": The number and length of sessions

As none of the participants were previously familiar with IPC, I decided to start with the more practical aspects of IPC, namely the number and length of session and the format for delivery. IPC is a time limited approach, usually conducted over six sessions with the option of a further session if required. All but one participant (Gemma) raised concern that six sessions would not be enough to meaningfully address the interpersonal issues described. Yvonne (group 1) for example felt that it would be "tight if you want to make real progress". Similarly, Monika (group 2) suggested that it can take a long time to recover, and that people can need the space to take things 'step by step'. Yvonne and Monika had previously described being lost in the system and waiting a long time for therapy; the prospect of addressing issues in a relatively short time period was felt to add pressure. Acknowledging that the shift in emphasis within the NHS towards short-term therapies has been associated with the identification of 'cost-effective' solutions (Aguilera, 2018), this could be argued to represent the internalisation of 'financial pressure' in the wider system as time pressure at the individual level. It may also be indicative of a lack of trust in the system and the ability to access further support if needed after sessions had finished. Some research has explored the negative emotions (e.g. frustration) experienced by therapists using time limited models where they feel clients could have benefitted from longer-term support (Iannou, 2017; Hanif, 2018). However, very little appears to be available on the perspectives of clients as to the time-limited nature of therapies; this perhaps reflects the prioritisation of 'clinical outcomes' over personal experiences/perspectives in measures of effectiveness and the absence of lived expertise in the design of feedback tools (McPherson et al., 2020).

Conversely, highlighting the significance of individual preference, Gemma felt that six sessions would feel more manageable and less overwhelming, positing that if she was asked to commit to longer-term counselling, she would probably 'talk [her]self out of it'. Gemma previously reflected that she felt overwhelmed by the plethora of options provided by her GP and health visitor when she initially discussed her mental health issues. She explained that she did not have time to review the various options and felt unclear about the time commitment involved; the simplicity and transparency of the IPC model was therefore appealing, and the limited number of sessions felt doable. Caitlyn, who had previously expressed frustration at the inconsistency of the CBT sessions she had received, asked about the 'regularity' of sessions, suggesting that six sessions could be feasible if they were conducted on a weekly basis. These various stances can thus be understood in the context of participant's prior experiences, inconsistencies in service availability and the propensity for overwhelm.

Concern was also raised as to the time allocated to sessions (typically 30 minutes). There was consensus across both groups that sessions should be a minimum of 50 minutes. Caitlyn, for example, said that 30 minutes would feel 'rushed'. Speaking to evidence in the wider literature, the importance of time (i.e. lack of time in appointments with health professionals) emerged as a central theme in the first workshops (see chapter 5) and was seen to characterise the support provided by CHWs in the task-sharing literature (Taylor et al., 2018). Mercer et al. (2007), for example, identified time within appointments as a fundamental component in the establishment of trusting relationships with professionals as it was seen to denote genuine caring. This is known to be particularly important for people from marginalised groups like single mothers on low incomes who may have had negative interactions with professionals and experience high levels of mental health stigma (Goodman et al., 2012).

An experienced peer support worker interviewed who was working with another group for whom there are known to be high levels of mental health stigma (*See* Coleman et al, 2017), also reflected on this issue. They explained that they had been given flexibility in how they delivered IPC and therefore chose to split the first session into two separate hour-long sessions as "it just feels wrong to rush someone when they are opening up to you". They also extended the remaining sessions according to the needs of the person they were supporting. It is interesting to note that other peer support workers interviewed at the same organisation with less experience in the counselling role referred to the challenge of trying to fit everything into 30-minute sessions, indicating that they were adhering more closely to the original model. A similar concern was raised by junior mental health workers in the UK who struggled to keep to time on an IPC pilot supporting women with perinatal depression (Evans et al., 2021). As I will go on to explore in further detail,

it has been suggested that strict adherence to the IPC guidelines may have negative consequences for the therapeutic relationship (Kontunen, 2020).

The women involved in this study repeatedly emphasised that they often felt health professionals did not or could not understand their situations (see chapters 4 and 5); research suggests that creating space for dialogue can help to address these concerns (Goodman et al., 2012; Wilson, 2021). IPC is said to prioritise the subjective experiences of clients and 'create space for people to share their stories' (Kontunen et al., 2020). However, IPC was designed to address an operational issue (growing demand) and thus 'time limited' in nature. The findings explored above indicate that there could be a conflict between the ideology underpinning IPC and the emphasis on operational efficiency. This may in part explain why one stakeholder in the field suggested that IPC was "full of contradictions".

"Sort of like an action plan": The structure of IPC

Whilst there was some concern about the specific number and length of sessions, the 'time-limited' nature of the approach, and the focus on a particular problem area, was viewed more favourably. Three participants in group 1 agreed that this would avoid 'going around the houses', drawing on previous experiences of counselling where they felt it had taken a long time to identify and discuss the actual issues they were dealing with. By contrast, they felt that IPC was designed to quickly identify what people needed 'in that moment'. Reflecting on her previous experiences, Mae shared this sense of frustration with more in-depth, psychoanalytical approaches which pay attention to past experiences:

"it takes a long time so sometimes it's very difficult for me like talking about some things and we need to keep going over and over and over it again, the same thing, to find the solution. But it makes me feel very down with the past, because I know I can't change it, but I need to go over that you know what I mean? So it's like… it's traumatic again for me."

In this depiction, Mae describes being required to go over painful experiences in her past in order to move forward. This appeared to conflict with her preference for 'positive thinking' (a skill developed through mindfulness training) as a means of recovering from depression. The focus within IPC on 'here and now' issues, that may be addressed utilising the relevant tools and strategies, took on a deeper meaning for participants who had previously described feeling stuck, hopeless and frustrated.

"*Um, I think it's [IPC] is quite good, because, you get to do the homework and review the progress so it's not just like counselling where you're just sort of talkin' it's more sort of like an action plan where you're like reviewing stuff and trying out things to see if you feel better at the end of it. So, it's not really just a chat you're sort of… it feels like you're making more progress."*

(Caitlyn, late twenties)

This action-oriented nature of IPC appeared to appeal to participants who had previously described wanting to 'do' something to combat the feeling of helplessness. This supports the findings of a larger research project with single parents on low incomes in the UK wherein participants shared the frustration with 'just going over things' and expressed a desire for approaches with 'more solutions' (Stack and Meredith, 2018: 238). The reflection above from Caitlyn is particularly interesting as she had previously expressed frustration with her experience of CBT due to the over-reliance on 'self-help' materials, which she struggled to complete, and limited contact time with her counsellor. Rather than homework being a problem per say, this insight demonstrates that, for Caitlyn, a balanced combination of contact time, homework tasks and collaborative review would help her to feel she was making progress.

In a study comparing the experience of providing IPC with low intensity CBT to women with perinatal depression, practitioners felt that IPC paid greater attention to the emotional aspects of women's experiences and that this allowed them to be more responsive during sessions (*See* Ingram et al. 2021). Working together to identify issues and strategies was said to feel more 'collaborative', leading the authors to conclude that the nature of the therapeutic relationship was different between the two approaches (Ingram et al., 2021). Returning to this project, the women involved felt that it would be difficult to identify one problem area to focus on and the support of the counsellor would thus be crucial. Kontunen (2020) emphasised the importance of shared decision making within IPC which ensures individuals feel supported but maintain an active role, a process that contrasts more paternalistic models in medicine. However, recent qualitative research analysing the problem formulation process in IPC found that joint decision making was not an inevitable consequence of the IPC model relying instead on the abilities of counsellors to listen and create space (Kontunen et al., 2020). Those that attended to the manual in a strict manner tended to adopt unilateral decision-making, whilst those that adapted their approaches to the individual were better able to identify solutions and positive outcomes for clients (Kontunen, 2020). This appears to demonstrate the value in prioritising the subjective experiences of those receiving IPC to identify strategies that feel workable. It also supports a recurring theme highlighting the significance of therapist skill and confidence in determining the effectiveness of approaches and experience of clients (Hardy et al., 2019; Mcpherson et al., 2020).

The significance of identifying workable issues and solutions should not be understated. Throughout the fieldwork participants and wider stakeholders repeatedly emphasised the importance of strategies that had to feel both

manageable and meaningful in order to be empowering (See chapters 4 and 5). In a UK pilot, adolescents who received IPC from youth workers were said to appreciate that goals were broken up into manageable tasks which were reviewed each week, and that this boosted their self-esteem (Wilkinson et al., 2018). However, as demonstrated above, this process is complex and requires confidence and skill on the part of counsellors to be able to move beyond the manual; failure to do this has been argued to weaken the therapeutic alliance (Kontunen, 2020). Peer support workers interviewed for this project who were relatively new to delivering IPC described the problem formulation as the most challenging aspect of the model. 'Joint decision making' may hold particular significance for women, such as those in this study, who have experienced marginalisation, who felt that they were not listened to, understood or believed (Goodman et al., 2012). The women involved in this study proposed that the problem formulation process would allow counsellors to tailor their approaches to meet individual need. This was felt to acknowledge that 'everyone is different', something that participants believed was crucial to respect in mental health support provision. This appeared to speak to participants' experience of reductive discourses and stereotyping (see chapter 4).

As mentioned above, IPC is designed to be operationally efficient – the training for IPC counsellors is therefore brief, typically being conducted over the course of 2-3 days (Weissman et al. 2014; Evans et al., 2021). This was confirmed by stakeholders interviewed for this project; peer support workers and youth workers each received 2 days of training for the IPC practitioner role, followed by regular supervision (See Wilkinson et al., 2018). Authors have recommended more 'process-oriented' training, support and supervision as well as clearer, more detailed manuals to ensure greater consistency in the establishment of collaborative therapeutic relationships (Kontunen, 2016; Kontunen et al., 2020) . It is also important to note that this represents a gap within the academic literature on IPC, which has paid greater attention to efficacy than qualitative experience (Ingram et al., 2021); a further example perhaps of the privileging of quantitative data in the task shifting and task sharing literature.

Safe space and control: The format for IPC delivery

The next aspect of IPC discussed during workshops was the format for delivery, beginning with the different types of people that might deliver this type of counselling. Following the examples provided during IPC training, participants were asked to consider how they might feel about receiving IPC from a nurse, social worker or peer support worker who had received specific training. This question was particularly relevant to the topic of task sharing and sought to respond

to the gap in literature exploring how people might feel about receiving counselling from someone who is not a qualified therapist. Participants in group 1 felt it would be important to have a choice as to the type of person who conducted the sessions. Participants in both groups felt it would be 'fine' to receive counselling from a nurse but opinions differed in relation to social workers. Those who had previously described having negative interactions with, or experiencing distrust towards, social workers appeared to be apprehensive about the prospect of receiving counselling from someone in this role:

*"**Caitlyn:** I think like a peer support worker is less professional kinda thing… I would feel like if it was a social worker or something I don't know if I would open up as much but like a peer support worker seems more likely to be friendly… I don't know it just seems less professional.*
***Yvonne**: Yeah I agree – if it was like … well maybe like a nurse or a peer support worker but if it was a social worker… it's unlikely that I'm gonna do it to be honest…"*

Gemma, who described having friends who were social workers, and Mae, who had a positive relationship with her social worker, were impartial. However, participants in group 1 agreed that because of the negative associations commonly held towards social workers by single mothers on low incomes (see chapter 4), this may not be an ideal fit for a counselling role. To situate these reflections in the broader socio-political context, academics and commentators in the field of social work have identified how the cultural pre-occupation with risk combined with anti-austerity measures in recent years has meant that social workers have faced increasing levels of auditing activity and a reduction in face-to-face time with families (Hingley-Jones and Ruch, 2016). As a result of these ideological influences, the professional identity of social work has been associated with more 'authoritarian' than 'compassionate' practice; it is argued that social workers often lack the capacity to conduct the 'relationship-based' work required to overthrow these perceptions (Hingley-Jones and Ruch, 2016).

As illustrated by the quote above, this led to a discussion of peer support workers, who were viewed positively as having the potential to offer more 'friendly' and 'down to earth' support (Gemma). To my surprise, there was an openness and enthusiasm in regard to receiving counselling from peer support workers amongst all but one participant with limited concern around the lack of 'professional expertise'. These perspectives on peer support will be explored in greater depth in the following section. There was only one participant (Monika) who expressed a clear preference for a health professional:

"Mental health support, I think, this is best like doctor or someone professional …definitely mental nurse - for this moment I prefer someone who is professional with good experience. I think [training peer support workers] it's good because everybody needs to learn some things everybody needs to get some experience when they start doing proper job so is good for them as well and good

for us. Everybody learn some things, how to help people. Because no one is perfect, so everybody needs time to learn these things."

(Monika, early forties)

Whilst expressing support for training peer support workers in principle, she makes it clear that she would prefer to receive counselling from someone with professional expertise. Conversely, Mae felt that having someone with less professional expertise means that they would have 'fresh ideas' and new ways of looking at things. These examples demonstrate how participants' perspectives on feasibility can be shaped by their prior interactions and preconceptions of individuals representing particular professional groups. The scope of this study is too small to generalise but this could indicate that women's perspectives are also influenced by cultural background and differences between health systems in the UK and countries of origin – this has been documented in the wider literature (Sime, 2014).

The final aspect discussed in relation to the format was whether IPC was delivered virtually, over the telephone or face to face. Whilst initially designed to be delivered in-person, IPC has been adapted for delivery over the telephone with broadly positive but somewhat mixed outcomes (Badger et al., 2004; 2005a; 2005b; 2007; 2011;2013;2020; Neugebauer, 2006; 2007). The fieldwork for this study was conducted during the COVID-19 pandemic, an event that has been described as 'an evolutionary catalyst for developments in online counselling and psychotherapy' (Hanley, 2021: 494). Video conferencing platforms are reported to have been the most popular option for therapists during this time (Tomaino et al., 2022). Whilst there does not appear to be research focused on the virtual delivery of IPC, evidence suggests that the majority of counselling shifted to an online format (Ioane et al., 2021). Wider stakeholders involved in the delivery of IPC confirmed that their sessions had indeed moved online.

I asked participants to draw on their experience and consider the different formats for IPC, namely in-person, over the telephone or online using a platform like Zoom. Four participants expressed a preference for online formats such as Zoom that allowed you to see people's faces. The first reasons for this appeared to relate to establishing trust and clear communication. Gemma, for example, said that seeing someone's face would "feel more real", Mae felt it was important to see each other's reactions and Monika felt that seeing and hearing someone made her feel "more secure". The women in group 2, who were not native English speakers, also explained that it could be hard for her to understand someone over the phone, pointing to the importance of body language where there are language barriers. The other proposed benefit of online counselling was that it negated the need to leave the house. Kim, who experienced agoraphobia, said that attending counselling

sessions in-person would feel "daunting" and she would feel much safer at home. Monika also described her house as her 'safe zone' and reflected that online counselling would help to avoid moving between different spaces; she recalled feeling embarrassed for crying on the bus on the way back from an in-person therapy session. The same participants had previously referred to the practical benefits of receiving counselling online as it can negate the need for childcare but suggested that, for those with small children who could not be left alone, it could be beneficial to have sessions in the evening. Peer support workers interviewed from the local, third sector organisation also referred to the practical benefits of delivering IPC online for the people they were supporting who geographically dispersed over a large area. The brief nature of IPC meant that travel was hard to justify, with some clients travelling two hours for a thirty-minute session. They believed the option of video consulting platforms had therefore improved engagement.

Given the emphasis on 'safe space' as a benefit of video-mediated platforms for participants, it is interesting to note the concerns of therapists as to the risks associated with online counselling. Peer support workers, for example, suggested that a major challenge in delivering IPC online is maintaining privacy and confidentiality:

"You get the kind of family interference in the background and you sometimes don't get people's full attention just because somebody does walk in the room … somebody asks them a question and stuff while you're mid-session…you know you'll get to the end of a session and then they start talking to their wife whose been in the room the whole time – w*hen you've kind of tried to make it clear at the start that it's one to one"*

(Peer Support Worker, Third sector organisation)

Another wider stakeholder interviewed (Counsellor, Third sector organisation) who had experience conducting online counselling sessions (not IPC) with single mothers on low incomes posited that maintaining privacy and confidentiality was a particular problem for women with young children who would come in during sessions and want to interact with the screen. They argued that this could be very distracting for the clients and limit the ability to conduct "proper therapeutic work". Authors reflecting on the mainstreaming of video-conferencing software in therapeutic practice during COVID-19 have posited that therapists can experience a 'loss of control' when counselling online as they are unable to manage the therapeutic environment (Shklarski et al., 2021; Smith and Gillon, 2021). Here we see the potential for differing priorities in the constitution of 'safe therapeutic space', typically understood to be somewhere private, quiet and free from distraction. The concerns of therapists towards privacy and confidentiality may be

warranted in particular circumstances, for example, where a lack of personal space and problematic power dynamics with other adults living in the same household present ethical issues (Shklarski et al., 2021; Tomaino et al., 2022). However, the preferences of participants described above support a growing body of research suggesting that being able to access counselling from home can lead to increased feelings of 'safety' as the setting feels more natural and comfortable to clients (Maier et al., 2021; Smith and Gillon, 2021). Interestingly, clients receiving online counselling have reported feeling *more* in control as they can decide how much or little to share of themselves and less self-conscious (McKenny et al., 2021; van Kessel et al., 2022).

Conversely, in a qualitative study, Smith and Gillon (2021) found that therapists experienced an increase in self-consciousness due the lack of available client information when counselling online (Smith and Gillon, 2021). This appears to link back to the concerns of a third sector stakeholder explored in the previous chapter as to the formality of office spaces that may feel more appropriate to therapists but can feel clinical and intimidating to clients, particularly those from marginalised groups who may have had negative interactions with professionals (*See* Maier et al., 2021). Numerous studies have found that online counselling can feel 'less confronting' due to the 'safe distance' provided making it easier to disclose difficult experiences and emotions (Simpson et al., 2021). Whilst counsellors interviewed for this project emphasised the potential for interference within clients' homes, research has demonstrated that this is not one way and disruption for either party (e.g. pets, children, postmen, internet connection) can humanise the process (Shklarski et al., 2021). It has been suggested that online counselling can therefore create a more 'neutral therapeutic environment' which 'may facilitate transference reactions that are more reality based and meaningful' (Simpson et al., 2021: 413). The women in the project expressed a clear preference for approaches which were 'more relaxed' and 'informal'. Authors have argued that online counselling presents somewhat of an opportunity for more collaborative working relationships as therapist and client must navigate more fluid boundaries and new ways of working (Simpson et al., 2021). As collaboration is said to be at the heart of IPC, this feels particularly relevant to this study. Hanley (2021) posits that this has the potential to reconceptualise the way that therapists work, as the ecosystem for online system expands and develops. Finally, of relevance to Monika's concern about moving between spaces for counselling, removing the need to access counselling in public has been argued to increase privacy, anonymity and reduce the potential of stigma (Barker and Barker, 2022; Maier et al., 2022).

Whilst online counselling had been found to encourage self-disclosure for some, it is important to note that this has not been the case for others (Tomaino et al., 2022). This was reflected in the perspectives of two participants involved this study. As Caitlyn reflected:

"I'm better over the phone to be honest. I usually open up more if it's over the phone because it's less intimidating … I'd be more likely to say more…"

(Caitlyn, late twenties)

Conversely, Yvonne explained that she "actively avoided the phone" and that she would be most likely to attend if she had committed to an in-person, face to face session as long as these were suitably flexible. As evidenced in wider research, these findings indicate that perspectives towards format were personal, involving a series of 'trade offs' pertaining to accessibility, safety and trust but also individual preferences regarding different modes of communication (*See* van Kessel et al., 2022). Thus, whilst the mainstreaming of online counselling during the COVID-19 pandemic appears to have the potential to increase the options available to people seeking IPC, it seems important that this remains a choice.

Reviewing the core concepts of IPC

"We can't be sick right?": The 'sick role' in IPC

IPC is underpinned by the 'medical model' for mental illness, a social construct that conceptualises mental illness as the interaction between inherited biological vulnerability and stressful life circumstances. Over recent history, this framework has been utilised in efforts to legitimise mental illness and challenge discourses that blame individuals for their symptoms. In Interpersonal Psychotherapy (IPT), mental illness is likened to other medical illnesses such as diabetes or pneumonia. In IPC, which tends to deal with less severe, more common mental health problems, these are compared to having the flu. At the beginning of IPC, clients are asked to adopt the 'sick role', an important component of the biomedical model. Clients are asked to acknowledge their symptoms as a treatable, medical illness and respond accordingly by temporarily setting aside activities (e.g. taking time off work) and relying on others for help so that they can prioritise rest and recovery (Kontunen et al., 2020). For the practitioner, the introduction and implementation of the 'sick role' is said to be an important part of the diagnostic process (agreeing symptoms) and encourage compliance, therefore improving the likelihood that the treatment will be effective.

I wanted to explore how the women involved in this study felt about the concept of the sick role which was described in the IPC information video shared prior to and during the workshops. In discussions during the 2-day IPC training course, members of the advisory group with lived experience expressed concern about this

concept. One member explained that she "[did] not get on with the medical model" as she felt it did not appropriately acknowledge the environmental causes of mental health problems and instead pathologised individuals. The NHS stakeholder leading the course, who had a wealth of experience in IPC, explained that the medical model "could really jar with people". However, contrasting the findings of other recent, qualitative research with single mothers on low incomes in the UK (*See* Stack and Meredith, 2018), participants in this project largely endorsed the medical model for mental illness as it "made it feel more real". I previously discussed how the medical model was perceived to legitimise their experience of symptoms and challenge anti-welfare rhetoric which stereotyped single parents on low incomes as lazy and scrounging (Dermot and Pomati, 2016). It is of course important to reiterate that the small number of women involved in this study were actively involved with mental health services; a broader range of perspectives may be captured by including women who are single parents on low incomes in Edinburgh who are not engaged.

Participants agreed that the sick role "made sense in theory" and that it was important to make time for yourself so that you could recover. Participants in group 2 felt that 'having the flu' was not an appropriate comparator to mental health problems as they felt that the latter was more challenging and took longer to address.

"We can't be sick right? We always must be healthy yeah even like especially with this weather … I get a little bit better and then I get the cold again, but I must be you know be strong and then looking after myself looking after the kids oh my God it's not easy…"

(Mae, mid-thirties)

Participants frequently deprioritised their physical health issues and were unlikely to take time off for colds and viruses indicating that this might not be an appropriate metaphor for single mothers on low incomes. As the medical terms 'symptoms' and 'relapse' were referred to in IPC resources, I also sought to understand how they felt about these. There was some agreement in group 1 that the term 'symptoms' made mental illness seem more 'acceptable' by demonstrating that it's 'not normal', speaking again to concerns about legitimacy. However, the term 'relapse' was more divisive:

*"**Caitlyn:** Things like relapse. You hear those words like with drink and drugs. I've not heard it so much with mental illness … relapse is kinda like negative… sorta thinking the person's gonna fail.*
***Gemma**: I don't agree with the word relapse. I use relapse quite a lot um due to a physical illness that my Mum has … so my mum has MS so we would use the word relapse quite a lot… I'm*

probably a bit more comfortable with it than what Caitlyn sounds to be. Just because we use it d'you know and I just it in a different way to how Caitlyn's describing."

This exchange suggests that individuals might have alternative associations with specific terms based on their prior experiences. Given the propensity for this to induce feelings of shame and hopelessness, this highlights the value in early collaborative work with clients to identify terminology that feels appropriate and meaningful. Participants in group 2 were both in the process of learning English and did not appear to have particular associations with these words.

Whilst participants agreed with the sick role in principle, there was broad consensus that this was 'easier said than done'.

*"**Monika**: There is no help in the house like you can take a few hours you know. You need to do by yourself, everything, so no matter how you feeling, you need to get up, you need to make children food, you need take them to school, you need to go work or whatever.*
***Mae**: You need to clean.*
***Monika**: Yeah you need to clean, you need to cook. You can't just lie down in bed and don't care about anything to get better that's not how the single parents dealing, you know, especially when you don't have family around or even friends, because everybody busy… everybody got own life, own problems, so you left totally alone with everything by yourself, so you need to be strong."*

The inability to escape the everyday responsibilities of single parenthood was a point emphasised by participants across both groups. This same concern had been raised during the IPC training course by advisory group members and the course leader had suggested that this can involve supporting someone to lower the expectations they have for themselves. Gemma suggested that lowering expectations is something single mothers on low incomes "know we should be doing" but do not always feel comfortable or able to do so. However, there was agreement that certain tasks, particularly related to childcare, were non-negotiable. Furthermore, participants in both groups flagged concern about not being believed by others. This included friends and family but also employers, pointing to the pervasiveness of perceived stigma:

*"**Caitlyn**: …when you've got a physical illness other people can see you're not well so they're like you need to rest…. you need to do this but if they can't see it they would probably think why are you resting? Why are you doing that?*
***Kim**: They'll think you're on the yarn… that you're kidding them on that there's something wrong wi' ya when they cannae see it … like it's just an excuse…*
***Caitlyn**: Yeah, and if you were like in a work environment and you take time off … they understand if you say you're physically unwell, but I don't know if it would be the same if you were mentally unwell. If people haven't been through it, they don't always understand."*

The requirement to 'ask others for help' was also critiqued for failing to recognise that there may not be anyone to fill this role. In line with wider research findings exploring the experiences of single mothers on low incomes in the UK (Carroll and Yeadon-Lee, 2021), for the women involved in this study, support networks were absent or had already been maximised. It seems pertinent here to draw on evidence that suggests IPC is more effective for women who have a spouse who can provide social support at home (Badger et al., 2005a; 2005b; Kontunen et al., 2020). It could thus be argued that the model is best suited to 'normative' households and could provide another example of the marginalisation of single mothers on low incomes in service design.

Whilst the medical model, endorsed by participants, recognises the significance of self-blame in the experience of mental illness, findings suggest that stigma may not be appropriately acknowledged as a barrier to the adoption of the 'sick role'. In previous sections, we considered how participants appeared to assert the role of 'good lone mother' as a response to anti-welfare stereotyping (Carroll and Yeadon-Lee, 2021). In essence, the 'sick role' asks women to relinquish the traits associated with 'the good lone mother', including independence, resilience and self-sacrifice (Carroll and Yeadon-Lee, 2021). This could feel challenging and require sensitivity. Women may require support to discuss the feared repercussions of sharing their struggles; the women involved in this study for example expressed serious concerns around child custody issues and employment sanctions (See chapter 4 and 5). Other issues related to employment should also be considered, for example, the likelihood that single mothers on low incomes will be in insecure employment with limited rights (Treanor, 2018). Participants explained, for example, that they already had to use sick leave for childcare.

Findings also suggest that women may need support to continue the practical, everyday day tasks where support networks are absent or limited. As some of the examples from the 'task-sharing' literature had involved those in CHW/peer support roles providing flexible, practical support (Verdeli, 2003; Ngo, 2019; Taylor et al., 2018), we briefly discussed the possibility of peer support workers helping with daily chores. However, there was some concern amongst participants about letting someone into their home. Working alongside single mothers on low incomes, researchers and/or practitioners could explore potential options for practical support in greater detail perhaps linking in with other local services. Overall, contributing to a recurring theme within fieldwork findings, it appears that paying greater attention to the representational and structural levels of women's experience could improve the feasibility of the sick role for single mothers on low incomes. More specially, this relies on the attunement of IPC practitioners as to the relevance of neoliberalism within their practice (La Marre et al., 2019).

"People just expect that…there's someone that can help": The feasibility of other tools used in IPC

As previously described, the first sessions of IPC might be described as a 'diagnostic process', wherein the counsellor and client work together to better understand the client's symptoms and connect these to interpersonal events to understand which 'focus area' would be most appropriate. There are a couple of tools that support this process; one of these is an exercise described in the version of the IPC manual used by NHS Lothian as 'making connections' (Fig. 6). Here, the client is asked to map the symptoms they are experiencing and any stressful or significant recent life events, drawing connections between these as depicted in the image below (Fig. 6). This appears to have dual purpose; the first to '[educate] the patient with regard to depression' and the second to provide more information that can be used to identify a potential focus area for future sessions (Kontunen et al., 2020: 471).

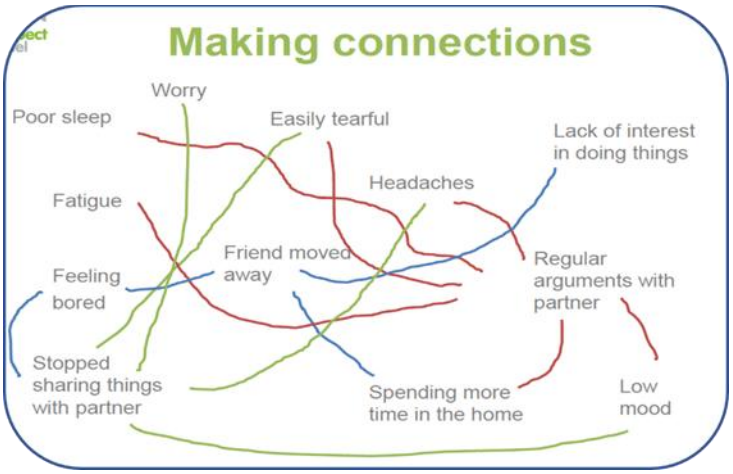

Figure 6: Example of completed exercise for 'making connections'

I presented an example of this exercise to participants, explained the purpose and asked them what they thought of the tool. For participants in group 1, there was agreement that this exercise 'made sense'. Gemma, who had shared a negative experience of CBT which she felt was didactic and struggled to understand, was particularly enthusiastic:

"I think it's a good idea, and it made sense to me … I had almost like a light bulb moment when I was watching [the IPC information video] that this… this would work for me, this is something that you know I could sort of engage with… yeah"

(Gemma, mid-thirties)

Gemma explained that she felt IPC seemed more 'down to earth' than other approaches. Whilst it is important to acknowledge the very small scope of this study, this supports other research findings indicating that IPC may be more accessible than similar alternatives and could allow for a more collaborative working relationship (Ingram et al., 2021). Participants in group 2 focused more on the specific examples provided in the image. Initially, I tried to explain that I was interested in what they thought about the usefulness of the exercise itself, however, given the rich discussion that followed (the insights of which have been worked into the analysis elsewhere), I decided not to interrupt. Upon reflection, for participants where there are language barriers (neither participant in group 2 spoke fluent English), it may be more effective to ask participants to complete the exercise and provide feedback. As I did not have a mental health professional involved in the delivery of sessions, this would not have been an appropriate option for this project.

Another important tool used in the early stages of IPC is the 'closeness circle'. This exercise has been designed to better understand the client's current interpersonal network, identify people who might be able to offer emotional, social and/or practical support and relationships that might be associated with depressive symptoms.

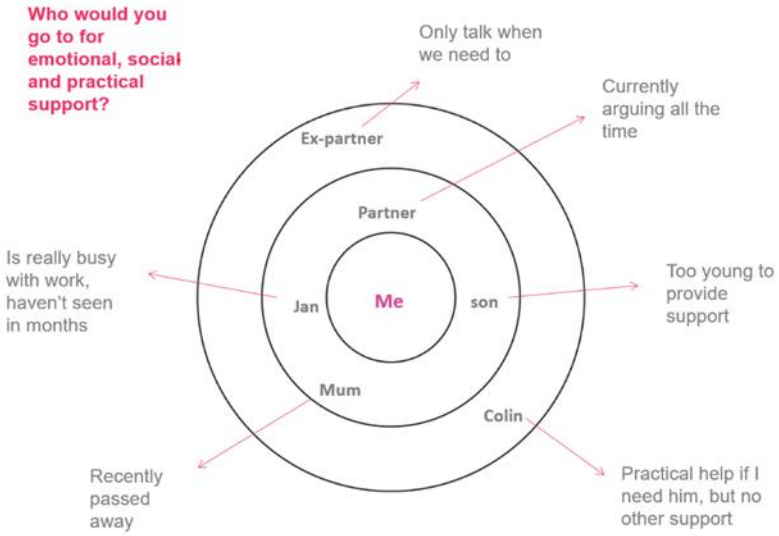

Figure 7: Example of completed exercise for the 'closeness circle'

As exemplified in the visual above (fig. 7), clients are asked to map significant people in their lives; indicating how 'close' the relationship is by their proximity to the centre of the circle. For each person, the client is asked to reflect on the relationship (this may include someone who has passed away) providing insights into potential interpersonal issues. Where relevant, they would be asked if they would like this person to be closer to the centre (i.e. opportunities for further support) or further away (e.g. a negative relationship). Three of four participants in group 1 responded positively to the 'closeness circle', suggesting that it would be a helpful exercise which could "open your eyes" (Caitlyn) to the people already in your life that might be able to help and those that are having a negative impact. Gemma also suggested that it could help to clarify who is not able to provide support. Advisory group members with lived experience also picked up on this point during the IPC training course, suggesting that this could be helpful for managing expectations of what family members or ex partners 'should' be doing and lead to greater acceptance of reality.

Yvonne however, was visibly annoyed by the exercise and felt that it failed to recognise her lived reality:

"I personally find it quite frustrating… I'm not sure how many people are in the same situation but like I have zero people in any circle… there is legit just me and whatever service like that I have to access, so yeah it just gets really frustrating 'cause people just expect that there's like someone that can help with something…"

(Yasmin, mid-twenties)

For Yvonne, the 'closeness circle' provided another example of health professionals failing to understand the context of her life. Participants in group 2 shared this sentiment, arguing that this was a particular issue for migrant groups who may not have family in the same country:

"Because everybody have own problems in their life…everybody dealing with different things…you from different country and here everyone dealing with own life, own problems, own struggling, but definitely I can say clearly I'm totally alone. If it was not my daughter, it would be nothing… there's nobody."

(Monika, early forties)

Here, the process of mapping a 'network' that does not exist appears to risk reinstating feelings of isolation and loneliness. The women involved in this study had already suggested that single mothers on low incomes are likely to feel 'unloved' and 'alone' at the point of help seeking (see chapter 5). The acceptability of specific tools and strategies utilised within standardised therapeutic models to clients appears to be underexplored in the wider academic literature and perhaps points to lack of space given to understanding negative personal experiences within

evaluative research (Hardy et al., 2017). Existing studies have tended to focus on the cultural feasibility for racially minoritised groups or ethical concerns related to trauma-informed practice (*See* Finucane and Mercer, 2006). Interestingly, the limitations of the 'closeness circle' for isolated women was raised as an issue by stakeholders with lived experience during the IPC training course. The course leader suggested that the circle could include people who had passed away, pets or local services but was unable to comment on the effectiveness of this for women who were single parents in low incomes. When I took this to the participants, most felt that this would not be particularly helpful. Mae did suggest that she would include services but acknowledged that these were both limited and temporary:

"*You know, I would maybe put some charity like [local organisation] which you have some support from them….you got maybe your doctor can give you some support mental health, but this is just a temporary people is just the limited time, while you have them. But in the 24 hours it's just you and your kids*"

(Mae, mid-thirties)

The deficit-oriented nature of the 'closeness circle' was posited by a peer support worker interviewed who had been given the autonomy to adopt an alternative approach. Rather than presenting one 'closeness circle', they opted to provide their clients with two versions. They used the first to indicate the current situation and another to agree with clients what they would like their future circle to be, focussing on the latter for the remainder of the sessions. It was suggested that this felt like a more positive approach. It is worth noting that the peer support workers with less experience appeared to adhere more closely to the original model. Importantly, when this example was fed back to the advisory group, senior mental health professionals working in IPT/IPC were unaware of such adaptations and remarked on how innovative this was. This raises questions about how much of the practice being (re)shaped by people with lived experience is being formally acknowledged within the field of IPC.

As with the 'sick role', discussions related to the tools used within IPC underscored the importance of acknowledging the emotional, social and material realities of women's lives in the design of therapeutic models. In previous sections, findings emphasised the knowledge, awareness, skills and confidence of the individual therapist or counsellor to account for the wider social contexts of people's lives and navigate the therapeutic process in sensitive and collaborative ways. Whilst this remains salient, the workshops focused on IPC also amplified the significance of tools and strategies built into therapeutic models. The issues identified by participants demonstrate the potential repercussions of neglecting lived expertise in the design and review of this approach. Findings suggest practitioners with lived experience (e.g. peer support workers) could be minimising negative impacts and improving the acceptability of tools utilising their own intuitive during practice.

However, this only seems possible where they have sufficient confidence and autonomy and this does not appear to be leading to substantive change, e.g. amendments to guidance and training. This feels particularly relevant to task sharing as less experienced practitioners are more likely to adhere closely to training materials (Kontunen, 2020). The lack of awareness of these adaptations amongst professionals in the field raises important questions about the opportunities available for knowledge sharing. An IPT research network exists which also covers work related to IPC but this is only accessible to 'qualified' professionals in IPT and thus not currently open to IPC practitioners from different fields and backgrounds (IPT-UK, 2023). The issue of power feels paramount here in terms of who is granted access to spaces which have the power to influence and the privileging of professional knowledge.

The perceived relevance of IPC focus areas to women who are single parents on low incomes

Participants were asked to reflect on the four focus areas of IPC and whether they felt any of these might be particularly relevant to the experience of women who are single parents on low incomes in Edinburgh. The four focus areas of IPC are:

- Life transitions requiring a change in social role (e.g. having a baby; retirement)
- Disputes (e.g. arguments with a partner, family members or colleagues)
- Grief (i.e. death of a loved one)
- Loneliness/isolation.

The women involved felt that all four areas were likely to be relevant and this part of the workshop generated rich discussion about the experience of single parenthood and implications for mental health and wellbeing. Whilst focus areas were prioritised differently by individual participants during workshops, certain topics generated more discussion. The interlinking nature of issues belonging to different focus areas was also emphasised.

Life transitions

The first focus area that was identified as significant by participants in group 1 was 'life transitions'. In fact, most of the examples provided and discussed by participants during this exercise related to this focus area. The clinical psychologist who led the IPC training estimated that 60-70% of clients they supported would focus on 'transitions'. This perhaps speaks to wider research evidencing life changes as a risk factor for loneliness and isolation (with negative implications for mental health and wellbeing) as transitions often involve changes to social groups and the potential loss of social identity (Evans et al., 2022). The first 'transition'

raised by participants was the process of becoming a single parent; the groups then went on to discuss the various transitions that they felt single mothers on low incomes could experience as their child(ren) got older each presenting unique challenges. It was therefore suggested that support to manage transitions could be valuable to single parents at various stages in their children's development.

"WANTIN' THE HAPPILY EVER AFTER": BECOMING A SINGLE PARENT

Gemma suggested that the experience of becoming a single parent was 'a huge transition in anyone's life', especially where this was not planned or expected. Interestingly, Amy conceptualised the transition into single parenthood as a form of grief.

***'Amy**: I was thinking like for some single parents they might be grieving what they thought their life would be like if they were married of whatever. They maybe grieving the relationship or whatever… they maybe thought they were gonna be in a relationship for life or whatever. So there's that part of it – they may be grieving their life or their relationship…*
***Gemma**: Yeah I think you're right you almost look back at the life you thought you were goin' to have compared to the life that you do have now*
***Amy**: That's true like what you pictured it was going to be like. Like you were gonna be in a relationship, have the child and be happy families sorta thing and if it doesn't work out you're sorta grieving that.*
***Kim** : Yeah – you're wantin' the happily ever after.'*

For Gemma, Amy and Kim, becoming a single parent marked the end of the life they had imagined for themselves; a transition that had to be processed. Authors have drawn attention to the 'adversity and strain' that can be associated with transitional periods; emotional distress, for example, has been found to be heightened in the initial years following a divorce, but the stabilisation of family roles and relationships can improve wellbeing over time (Brown and Moran, 1997; Taylor and Conger, 2014). Referring to the whiteboards from previous sessions, the women involved in this study agreed that becoming a single parent could also provoke feelings of 'failure' (that they had not been able to give their children a 'full family') and 'shame' (prompted by an awareness of negative stereotyping).

Supporting the findings of other qualitative studies in the UK, participants had to '[adapt] to their reduced social status alongside reconciling their perceived failure to achieve the dominant myths and aspirations of heterosexual married monogamy' (Morris and Munt, 2019: 234). Jess reflected on this in the initial scoping interview, arguing that her status as a lone parent led to her 'feeling like a victim' for the first time, powerless to the systemic issues she encountered (see chapter 4). Monika also found it difficult to accept her status as a lone parent and

the subsequent need to apply for welfare payments, commenting that "I always work in my life, I never been on benefits in my life, I always have everything done by myself, without any help". A third sector stakeholder in this study also raised that some women they supported had no prior experience of the welfare system and experienced a difficult period of adjustment. In a qualitative study of middle-class single mothers in the UK, several participants, becoming a single parent had entailed applying for benefits and moving into council housing for the first time, invoking 'high levels of shame' (Morris and Munt, 2019: 239). Thus, it appears that the initial transition into single parenthood can also encompass changes in socioeconomic status that can be difficult to come to terms with.

Participants explained that the transition into single parenthood also involved a change to their social networks, as socialising became more challenging. Demonstrating the interlinking nature of IPC focus areas, the group agreed that this could lead to loneliness and isolation as they could be excluded from social activities that were either aimed at couples or required childcare to attend:

*'**Amy:** … like some of your friends might be in a relationship or be doing stuff at the weekend with their partners if some friends you've maybe had before, don't have children um they may invite you out and then you can't get the childcare and stuff. So I just feel like if you become a single parent you can sometimes lose friendships and then it can be sort of lonely at times.*
***Gemma:** I agree that for single parents… loneliness and isolation is quite a huge factor to me and my life.*
***Amy**: Yeah like if you've got a few friends without children, they just expect like you can drop your child and go out and meet them sorta thing. Um that's why I've found like since becoming a single parent most of my friends are single mums 'cause they kinda understand more and stuff.'*

Whilst loneliness and isolation had been described in previous workshops, the concept of 'transitions' helped to capture the disruptive impact of single parenthood on participants' social worlds and the need to recognise single parents on low incomes as multifaceted individuals with social identities before/beyond motherhood. Participants highlighted that this experience could be exacerbated by moving to a new area (Amy) or a new country (Monika and Mae). Friendships have been found to adopt a greater intensity and significance during times of transition, particularly, for those 'located on the boundary of heteronormativity' (Morris, 2019: 428). As described by Amy above and echoed by other participants throughout the research process, socialising with other single parents became appealing as it was felt that they were more likely to empathise with their situation.

For women who are single parents, friendships with women in similar situations can provide 'frameworks' to help navigate the insecurities and complexities of everyday life; friendships can also be instrumental in 'identity work' (Morris, 2019). The women involved in this project had spent significant amounts of time with

other single parents; as identified in other research, this appears to have helped them to come to terms with and in some cases embrace their status, reorienting their ideas for the future (Carroll and Yeadon Lee, 2021). However, it feels important to acknowledge the structural factors at play here; participants explained that their social lives were limited by the lack of affordable childcare. Whilst the value of peer support provided by those in similar situations is very apparent (discussed in greater detail in the following chapter), having reflected further on workshop findings, I have since questioned whether limiting social networks in this way could have negative consequences for mental health and wellbeing.

Adopting an intersectional framework, I have previously argued the women in this study (and single parents more broadly) have multifaceted identities, sitting across multiple, intersecting social locations (Anthias, 2012). They resisted the grouping of single mothers as an 'essentialised other'. With this in mind, could the potential narrowing of social worlds focused primarily on other single parents (and the emphasis on socialising with their children present) prohibit opportunities for women to assert other parts of their identities? And could this consolidate a sense of self-perceived 'otherness'? Mae for example, co-parented with her ex-partner; on nights where they stayed with him, she was able to meet a wider range of friends at the pub to play pool. She described how these nights made her feel "young again". In addition to the potential impact on social identity; authors have long argued that social networks are a form of 'social capital', a potential resource that can be drawn upon in times of need and a channel providing social and economic opportunities (Gilchrist, 2019). These of course are my own reflections; it would be interesting to explore this issue further with women who have lived experience and the potential of tools such as the 'closeness circle' (fig. 7) in helping to re-establish and broaden social connections.

Moral dilemmas and role strain: journeying through the welfare system

Participants in both groups agreed that single parents could go through a series of transitions as their child(ren) developed. For women in group 2, the point at which you are required to return to work represented a significant shift. Mirroring the findings of larger scale qualitative research with single mothers, this phase was said to be characterised by frequent calls from the job centre and difficulty finding employment that provided the flexibility required to work around childcare responsibilities. The welfare state is described by Zagel and Hübgen as a set of institutions upholding 'a particular idea of a normal life course, 'mending' … where it is interrupted by unemployment, health problems, accidents or family transitions' (2018:179). In this way, it is said to 'influence the temporal patterns of life', by defining eligibility based on different life stages, the child's and/or the mother's age (Leisering, 2003: 205 as cited in Zagel and Hübgen, 2019). For single mothers on

low incomes, the point at which they return to or enter employment is therefore largely dictated by welfare policy. For Monika, the requirement by the DWP to return to work when her daughter was five years old conflicted with her own ideas about good mothering and she bemoaned the pressure placed upon her from the job centre to 'take any job':

"[I would like] not be forced get any job but just manage job that you really want to and suitable for your situation. Suitable for your time. Because it's really heart breaking when you see parents …their children missing parents, because they are at work, then not building relationship because none of them have this time, you know."

The shift into employment appeared to involve practical challenges all of which related in some way to the lack of social support or affordable childcare. This included the stress of battling rush hour traffic knowing that no one else was available to pick up their child from school, having to take time off to care for sick children and working late into the evening to catch up on work they had missed. However, as captured by the quote from Monika above, this transition also appeared to entail what authors have described as 'incompatible mothering ideals and workplace pressures'; attempting to negotiate the pressures of a strong 'ideal worker norms in the UK with what I have already identified as that of the 'good lone mother' (Radcliffe et al., 2022). These moral dilemmas can result in role strain for single mothers and reduced control, which may in part explain why entering employment can also involve a deterioration in mental and physical health (Jun 2015; Campbell et al., 2016; Moilanen, 2019).

Whilst some felt that entering employment was positive for their mental health (Mae) and enjoyable (Caitlyn and Kim), these jobs tended to be part-time, insecure contracts which led to multiple transitions in and out of work and more interactions with the job centre which could be stressful and frustrating. Wider qualitative research suggests that entering paid work does have the advantage of absolving single mothers of the stigma associated with being unemployed and on benefits (Jun, 2015; Radcliffe et al., 2022). It therefore seems that there is an opportunity to support single parents to both reflect on the practical challenges involved with returning to/entering employment and any emotional stress related to conflicting ideals.

"Other worries": children developing their own social identities

In addition to issues associated with having very young children such as isolation and loneliness (captured in previous findings chapters), the topic of 'life transitions' prompted other insightful examples. Mae for example talked about her eldest son

reaching an age where they began to show awareness of 'normative family structures':

"They so young, but they understand this life, you know? Mummy and Daddy not together - it's different with the other kids. They see their parents not stay together, they must deal also with the whole situation… it's a big challenge for us, you know? But I find my kid is like mature and they try to be older from their age …but the situation confusing – it's hard for them… emotional."

(Mae, mid-thirties)

Here, Mae expresses concern that as her son made friends at school, he compared their family situations and felt different to others, arousing difficult emotions. Her son's perception of difference and emotions towards being part of a blended family (Mae co-parents with her ex-partner) was a source of worry for Mae. Whilst Mae talked about feeling proud of her children for their mature outlook, the fact they needed to 'be older' to deal with the family situation also appeared to evoke feelings of sadness. Mae expressed that it would be better for her own mental health and wellbeing if she did not have contact with her ex-partner but worked to maintain communication with him as '[her] kids still need their daddy'; she said she always tried to stay calm to show the children that 'everything was good'. Similarly, Monika felt that as her daughter got older, she became aware of how much other children had and began comparing this to her own situation:

"My daughter growing up, so it's other worries as well coming, you know, her mental health because she can see, sometimes I struggle with a lot of things and I need to say 'No, sorry we can't buy that" … "Sorry, you can't go there" and then "Mommy, but the other children go!" …so it's… it'sheart-breaking."

(Monika, early forties)

Monika worried that her daughter's increased perceptiveness towards their financial situation and tendency to compare to others will be bad for her mental health. She described taking on additional shifts as an uber driver to earn the money required to pay for a soft play party for her daughter's birthday. Both accounts point to transitional periods in children's development where they begin to compare themselves to peers. For Mae and Monika, this seemed to cause worry, guilt, and sadness. Both women appeared to deal with this by adopting practices that involve an element of self-sacrifice. This speaks to previous discussions of the 'good lone mother', the distinct maternal identity' found to be adopted by single mothers on low incomes who tend to display independence, resilience and self-sacrifice in response to feeling judged and inadequate (Carroll and Yeadon Lee, 2021). A final topic to be mentioned as part of this discussion between Mae and Monika, who had both migrated from countries outside of the UK, was instilling cultural practices and traditions:

'When kids growing up, this is the big challenge but especially when you in different country – the language. If they're born here, it's a little bit different, but you still want to give a little bit of yours…where you come from to learn with the kids like traditions, some culture things …'
(Monika, early forties)

Both agreed that, as their children got older, they felt a desire and responsibility to introduce and maintain some of the traditions from their own cultures. Monika suggested that this could be challenging when you were on your own in a different country, especially where ex-partners were not respectful and supportive of these decisions. She explained that she tried to spend time with other Polish families, coming together to celebrate cultural events. Literature on social integration has tended to focus on the adoption of the culture in the receiving country, however, reflecting on qualitative research with 40 Polish migrants in the UK, Grzymala-Kazlowska concluded that practices facilitating the maintenance of ethnic identity could support 'socio-psychological stability' and effective functioning in a new setting (2018: 255). It should be noted that the intersection between single parenthood and migrant status remains underexplored (Shutes, 2022). Again, it appears that support to process and navigate the emotional challenges associated with children's development could be valuable.

'Beginning a new life': Children receiving a diagnosis

Following the theme of child development, two participants in group 1 (Caitlyn and Kim) referred to the point at which their children received diagnoses for neurodivergence as a significant transitional period in their lives:

***Kim**: If your child gets diagnosed with autism or ADHD or a kinda illness that's a transition as well…*
***Caitlyn:** I know – I never thought of that one, actually! That's true… 'cause like before you don't think the child has anything wrong with them and then when they do finally get the diagnosis it's like your sorta… new sorta life. You're sorta tryna get your head round it…'*

Following this exchange, the women recalled the exact length of time that had passed since their children were officially diagnosed with autism marking the significance of this transitional experience. As represented in the quote above, both women explained that diagnoses needed to be processed and accepted. They went on to discuss the implications of diagnoses, namely having to find specific services that could accommodate their children's needs, requiring a reorientation of how they navigated the service landscape, but also meet with professionals involved in the school system (described in greater detail in a later section). They reflected on the time intensive nature of these activities which required them to 'adapt [their] life around it' (Caitlyn), reducing the amount of time they had available for themselves. The notion that participants began a 'new life' (Caitlyn) post diagnosis

is reflected in the findings of other qualitative studies with parents of children with autistic spectrum disorders (ASD). In two Australian studies for example parents described a loss of things associated with 'normal life' and a change to their sense of selves (Cashin, 2004; Woodgate et al., 2008).

Within the wider literature, parents of children with ASDs have reported experiencing social stigma (*See* Jackson et al., 2020), greater dependency of their children for care and, connectedly, additional financial strain (Woodgate et al., 2008; Ludlow et al., 2012). Woodgate et al. (2008) found that parents adopted more 'intensive' parenting practices to protect their children whilst also trying to deal with 'systemic' issues. In the initial, one to one interview, Kim referred to times where she felt her neighbours had misinterpreted her son's behaviour, resulting in heated exchanges as she defended his actions. As they are most often primary carers, authors have suggested that mothers of children with ASDs are at greater risk of psychological distress (Bromley et al., 2004), whilst others have drawn attention to the disproportionate impact upon single mothers and those on low incomes for whom pre-existing issues (e.g. lack of social support; economic hardship) can be compounded (Olssen and Hwang, 2001; Harper et al., 2016; Brewer, 2018).

A final example related to transitions was put forward by Kim, who was the only parent to an adolescent. She reflected on the difficulty of adjusting to life with a teenager. She highlighted the propensity for arguments as teenagers tested boundaries and how this could be more stressful for lone parents as 'there's not another parent at your back or anybody to help' (it was agreed this could also be assigned to 'disputes'). Furthermore, Kim's son had struggled with mental health problems as he moved into adolescence which became a source of worry and concern for Kim. Research exists to demonstrate the rise in mental health problems amongst young people and the correlation with socio-economic status which is stronger in Scotland than elsewhere in Europe (Mowat, 2019). Other factors, such as having additional support needs (ASN), intersect to increase the risk of mental illness (Mowat, 2019). Importantly, Kim reflected on these challenges in relation to losing her mother who had adopted a 'co-parenting' role but had recently passed away. This highlights the importance of avoiding assumptions as to the type of support deemed to be lacking; for Kim, it was maternal support rather than support from a partner that was lamented.

"I don't know many single parents that don't have an issue with that": Disputes

Of the remaining three focus areas, the first to be discussed across both groups as being relevant for women who are single parents was 'disputes'.

'*I suppose disputes with like the children's other parent .... I don't co-parent but if you've got issues with co-parenting. Or like in my situation tryna deal with an almost absent father who doesn't really care… so yeah I suppose dealing with another adult who either you're wanting to be there or not… that can be really challenging… I don't know many single parents that don't have an issue with that in one form or another.*'

(Gemma, mid-thirties)

There was consensus across both groups that disputes with children's other parent was a common issue and could negatively impact mental health and wellbeing. As this had already been discussed at length, we returned to the maps from previous workshops which included examples of domestic abuse, arguments with ex-partners and their families over child custody arrangements and dealing with the emotions felt towards ex-partners who did not want to be in their children's lives. It was therefore suggested that tools and strategies to help process, accept or manage such disputes could be helpful.

There were however other examples of disputes that had not previously been discussed. Kim and Caitlyn referred to the potential for challenging interactions with professionals during child planning meetings (CPM) for their children with additional support needs[14]:

***Kim**: Here's an example - I was on a Teams [CPM] meeting today and the headteacher said something… it wasn't appropriate…. I told him that… I says 'You shouldn't be saying that – I don't like it' and I hung up on them in the middle of the meetin' because I was like 'you're not speaking about my child like that. That's the good thing aboot bein' on [Teams] – I was like that Nope! [Gestures leaving] and I came off cryin' … I'm usually a bit tougher …And it's not as though I've got somebody else to take my place - I had to go back and face the situation… in situations like that, you've not got somebody else to sort of step in … If I don't like anything, I will stand up and say it. Before, I would just let everybody talk over me and be walked over and now I'm like that 'No! You're not getting away with it! I don't think it's right'. So yes, I have a dispute with the school [laughs]. Caitlyn, I'll go to your meetings wi' you hen! [Laughter] I'm actually trained for CPM meetings.*
***Caitlyn**: Oh are you?*
***Kim**: Ah 'cause of my job – I've been trained for it aye. And child protection.*
***Caitlyn:** Aye mine are over Teams just now and I'm kinda glad because I feel like they're not as intimidating…but I think if I actually had to go into the school like with the teacher and all the other people…*

[14] Under Scottish child protection legislation ('Getting it Right for Every Child' or GIRFEC), children identified as needing additional targeted support will be referred for child planning meetings (CPM). CPM bring together the child's parent(s) or carer(s), people that work with the child and sometimes the child or young person themselves, to begin developing a plan for what this support should be, who and how it should be delivered

***Kim**: Mm… like professionals*
***Caitlyn**: It's not just like you and their teacher… it's like different professionals…it can be quite overwhelming when it's just you yourself there and then all these people with different views.*
***Kim**: [Nodding] Exactly. Just remember if you don't agree just stand up and tell them.*
***Caitlyn**: And it's not like you've got someone else to go with you… like fight your corner sorta thing.*
***Kim**: Fight your corner – that's right. I mean I was lucky. One of my meetings – my boss went wi' me …but yeah, you've got to have people… you need to have people to have your back…*
***Caitlyn:** But there isn't anybody 'cause you're fighting on your own. That's the hardest part of being a single parent.*

Whilst lengthy, this exchange between Kim and Caitlyn provides several important insights that are worth unpacking. Primarily, Kim's depiction of being 'talked' and 'walked' over and Caitlyn's sense of 'intimidation' denotes unequal power dynamics between themselves and the other attendees. Both women emphasise that these attendees are 'professionals'; the implication that it might be difficult to challenge points that they do not agree with points to a knowledge hierarchy wherein lived experience (here the women's own understanding of their children) appears to have been devalued. In a Scottish study comparing the experiences of middle class and working-class parents of children with additional support needs, the authors concluded that working class parents 'lacked the social and cultural capital to engage with professionals on equal terms' (Riddell and Weedon, 2017: 47). In contrast, middle class parents shared a 'cultural register' with the professionals they encountered, sought help from networks of professional contacts and had better access to resources (Riddell and Weedon, 2017).

The combative language used by the women here ('stand up'; 'fight') also feels significant and links to earlier discussions related to the welfare state and employment policy (see chapter 4). The 'enduring quality of the fight' has been picked up in other studies of mothers in the UK whose children have ASD and is said to reinstate a lack of trust in the system (*See* Jackson et al., 2020: 540). Riddell and Weedon (2017) found that the insistence and anger of working-class parents was often interpreted by professionals as aggressive rather than assertive. It is interesting to note Kim's reference to becoming more assertive over time and to the training she received; this mirrors wider findings wherein 'becoming more direct' and 'learning all you can' was seen to be an important part of going into 'battle' with the system (Woodgate et al., 2008). In this depiction of a 'battle ground', it is perhaps not surprising that both Kim and Caitlyn emphasise the feeling of being 'alone' and the value of having social and emotional support/advocacy. Riddell and Weedon suggested that 'the institutional architecture of Scottish schools and local authorities prioritises the voices of

professionals'; for the women in this study, CPM meetings were not only a source of stress and anxiety but appear to form part of another system within which single parents on low incomes can experience structural and cultural marginalisation (2017: 47).

A final point to note here is the significance of the format for meetings in relation to power. As explored in discussions around therapeutic space, the virtual format (Teams) appears to give both women a greater sense of control. Kim found it easier to leave the meeting if she was not happy, signalling her objection without having to verbally articulate her position. Meanwhile Caitlyn found the prospect of meeting professionals online less intimidating than face to face. Thus, overall, the women involved in the project felt that single mothers on low incomes were likely to enter into disputes as a result of dealing with problematic relationships, childcare arrangements and the school system.

Other focus areas in IPC

"Nobody to turn to": Grief

The next focus area to consider is 'grief'. Apart from Caitlyn who depicted the process of becoming a single parent as being akin to grief, only one other participant (Kim) referred to this focus area without being prompted. As previously described, Kim had recently lost her mother with whom she had been very close and played an important role as 'co-parent' to her son.

*'**Kim**: I think grief is another one because if you're a single parent and say only got one parent left that's even harder… If you've got no siblings or anything like that. You've sorta nobody to turn to. 'Cause I've not got … well I have got friends… but during lockdown, I couldn't see anybody after my Mum passed away. I had to do deal with it all on my own. I couldn't have my friends around… I couldn't do anything…so grief's a big one when you're on your own. You've got your child whose gonna be grieving as well plus yourself.*
***Gemma**: You don't have anyone to share the load with for anything.*
***Kim**: You don't…. you don't. Especially if you've got to organise everything yourself.'*

Kim 's depiction demonstrates how the loss of her mother compounded her sense of being 'alone' and the absence of a familial network. Kim also reflected on how the lockdowns imposed by the COVID-19 pandemic had impacted on the ability of her friends to provide emotional support. Furthermore, Kim refers to managing her son's grief whilst dealing with the bureaucratic processes that had to be addressed following her mother's death by herself.

This example links back to prior discussions about the potential for intensified relationships between women on low incomes who are lone parenting and their own mothers (see chapter 2 and chapter 4). A longitudinal study of 385 children in the UK, highlighted the importance of maternal grandparents to single parent families (Bridges et al., 2007). Authors have discussed the way in which grandmothers can act as replacement partners and parents (Harper, 2010; Buchanan and Rotkirch, 2018). Research indicates that emotional support from grandmothers can be a protective factor in the parenting stress of mothers of children with developmental disabilities (Trute et al., 2008), whilst studies also suggest that emotional support from grandmothers may reduce the distress and adjustment difficulties experienced by adolescents in single parent families (Schwartz et al., 2009; Schwartz and Buchanan, 2018). Whilst representing the experiences of just one participant, this perhaps exemplifies the unique nature of grief for single parents losing family members adopting co-parenting roles. Kim explained that she had received a course of grief counselling shortly after losing her Mum which was very helpful but that ongoing support to manage the new reality of life without her would be beneficial. Kim appreciated the exercises used within IPC, such as bringing photos and objects to sessions, to help process grief.

Loneliness and isolation

During the IPC training, the lead explained that loneliness and isolation should only be used where it cannot be associated with an issue in each of the other three focus areas (Author's own notes and research diary). Women in both groups were keen to emphasise the relevance of 'loneliness and isolation' as characterising the experience of single parents on low incomes. As detailed above, many of the examples provided by participants could indeed be allocated to other focus areas and thus emerged as a recurring theme in the discussion of these issues. However, there were other examples of loneliness and isolation that were somewhat distinct.

'I think the loneliness and isolation ones quite a big thing. Just kinda like being a single Mum…

(Caitlyn, late twenties)

The women explained that the cost of childcare, time poverty and limited support networks impeded on their ability to socialise with other adults, leading some to feel 'trapped'. Rather than simply a 'transitional' experience as they became single mothers, this appeared to be an ongoing struggle. Wider research has documented the negative impact of financial hardship on the social interactions on single parents and the 'corrosive' effect this can have on mental health (Stack and Meredith, 2017). Another factor raised in relation to this focus area was defined more as feeling 'alone'. This appeared to relate more to a sense of 'otherness' and a lack of

perceived understanding between themselves and family members, friends, colleagues and the professionals they encountered in various settings.

Conclusion

Overall, in the workshops focused on IPC, participants were able to draw on their lived experience, engaging critically with the structure, language, concepts and tools used within an evidence-based method to consider how accessible and feasible this might be for women who are single parents on low incomes. Workshop exercises also surfaced additional insights into the experiences of the women involved in this project which I do not believe I would have gleaned through more conventional research methods (e.g. interviews). There were aspects of IPC that participants appeared to view favourably, for example, the relative accessibility of the content as compared to other approaches they had encountered (e.g. CBT). The influence of this on perceptions indicated that this was about more than simply 'grasping' the ideas. The reflection that this felt 'more down to earth' (Gemma) points to the potential of complexity to influence the perceived formality (previously identified as a negative feature of mental health services by participants) of the approach. Models such as IPC which are grounded in everyday experiences (interpersonal issues) thus appear well placed to position clients as 'experts'; this could avoid a more didactic dynamic requiring substantial explanation by therapists and thus privileging 'professional knowledge'. The lengthy and rich discussions related to the four topic areas of IPC indicated that these were relevant to the experiences of participants, who were able to provide, in some cases, multiple examples from their own lives.

However, whilst the central concepts of IPC are grounded in the social context of client's lives, broader socio-economic factors do not appear to be incorporated into the design of the model. Participants accounts underline the importance of acknowledging pressing material stressors for client's to be able to focus on a specific interpersonal issue. Participants were able to identify potential issues with the accessibility and feasibility of tools and strategies for women who are single parents on low incomes (and others affected by similar issues). This included the normative assumption that a partner could take on domestic duties to allow a client to adopt the 'sick role'; as such, this appears to ignore the lived reality of single parents on low incomes and the absence of affordable childcare. Connectedly, discussions indicated that the 'closeness circle' also denied the reality of many single parents. Whilst some felt it could be useful to learn how to maximise social networks and identify negative relationships, there does appear to be a risk of undermining the emotional labour performed by single mothers in skilfully utilising the limited resources available to them or the sheer level of isolation experienced by some. This was captured in the frustration expressed by Yasmin. It seems that this exercise had the potential to perpetuate the feeling of 'being alone' and of 'not

being understood', thus impacting the development of a trusting relationship with the IPC practitioner. The lack of available evidence on this points to a wider gap in evaluative research on the personal experiences (and potential harms) of people receiving talk therapies.

The reflections of peer support workers delivering IPC indicated that individual practitioners were mitigating potential harms by adapting the tools within their practice. However, these small-scale findings suggest that this relies on the intuition and confidence of IPC practitioners and the level of autonomy they are granted. Crucially, innovative practices do not appear to be fed back to the wider professional community with the power to influence change, seemingly limiting opportunities for lived experience to (re)shape practice. Furthermore, it seems likely that IPC practitioners receiving only two days of training will adhere closely to the existing guidance and tools. Workshop findings also raised questions around the compatibility of IPC with a 'participatory' or 'client-led' approach. The requirement to select one focus area and the pre-defined allocation of certain issues to a particular focus area may limit the opportunities for women to fully define their own experiences.

The preferences expressed by participants as to the format and delivery of IPC appeared to be shaped by their prior experiences of accessing mental health services. Gemma for example, who had described feeling overwhelmed by the 'choices' presented to her during the referral process felt that having six sessions would feel 'manageable'. In contrast, Caitlyn, who had felt frustrated by the limited availability of her CBT therapist and the inconsistency of sessions, suggested she would feel 'pressurised' by this prospect; this seemed to reflect a sense of distrust in being able to access the support she would need within and beyond sessions. Thus, whilst neoliberal features of the current context for provision, namely the complexity and fragmented nature of the landscape and the emphasis on short-term interventions, emerge as relevant in both accounts, how the women interacted with these aspects of the system and the way in which this shaped their perspectives differed, leading to contrasting individual preferences.

The issue of trust (in professional relationships) and a desire for informal and relaxed approaches were also central in shaping perspectives related to how and by whom IPC should be delivered. These themes could be linked back to experiences of stigma, socio-economic distance and unequal power dynamics within professional relationships and the (in)ability to access meaningful support. However again, preferences were shaped by personal experiences, notions of 'safety' and ideas about different 'professions'. These findings both demonstrate the relevance of systemic factors in shaping the perspectives of participants, whilst reminding us that women who are single parents on low incomes are unique individuals with specific preferences, requiring (genuine) choice and flexibility.

Finally, of particular relevance to the topic of 'task-sharing', the openness to receiving IPC from a peer support worker was another important discovery gleaned through workshop discussions and exercises. I sought to consider this in greater depth in the final workshop, the findings of which are discussed in the following section.

Introduction

The final workshop focused on the topic of peer support. Peer support emerged as a theme at each stage of the research process and has thus been a subject of discussion throughout each of the preceding chapters. I shall therefore begin by summarising the discussion related to peer support so far before outlining how this was built upon in the final workshop (and thus reported in this final chapter).
The women involved in this research project were clear from the beginning that whilst experiences differed, the challenges associated with being a single parent on a low income, were something you could only get, 'if you'd been there'. This type of 'lived experience' appeared to be lacking in the health professionals they encountered including GPs and therapists, who they felt could struggle to understand their situations. I previously discussed the prevalence of social class in the UK and the ways in which people ascertained 'sameness' including the language people used, their accent and the adoption of a 'formal style'.

Where participants had developed strong, trusting relationships with health professionals, this tended to be the result of continuous engagement and actions that demonstrated 'genuine caring' both of which could be limited by service pressures. Wider stakeholders referred to the lack of awareness, training, and guidance around the psycho-social feasibility of therapeutic approaches in relation to factors such as social class, race, ethnicity, gender identity and sexuality. It was suggested that this often resulted in greater reliance on informal peer support amongst minority populations who would disengage once it became clear that a mental health professional was not educated on such matters. The absence of clearly defined peer support roles within the services accessed by participants also seems to have led to a reliance on informal peer support, facilitated and encouraged by well-meaning but under resourced third sector staff. This appeared to work well in supporting the development of relationships between women and in managing the dynamics between people in different groups. However, participants had inadvertently been placed in situations where they felt ill equipped to deal with the issues being brought to them by other group members. I argued that this could perpetuate the feeling of 'not being good enough' and speaks to the gap in training and supervisory support for peer work raised by wider stakeholders and within the wider literature on the topic.

I went on to discuss peer support in relation to interpersonal counselling (IPC) and seemingly groundbreaking work of a third sector organisation supporting veterans who had been training peer support workers to deliver sessions. Where peer support workers had the confidence and autonomy to work 'off script', responding flexibly to the needs of the people they were supporting, this had resulted in several

innovative adaptations. Strikingly, these had not been fed back to the relevant IPC research networks highlighting a potential gap in knowledge sharing which acknowledges the value of lived expertise in shaping the development and impact of the approach. Finally, participants were generally enthusiastic about the prospect of receiving counselling from a peer support worker (PSW); only one person expressed a preference for a mental health 'professional'.

In the final workshop, I therefore sought to develop a deeper understanding of the potential of peer support from the perspective of participants, further exploring the meaning of 'lived experience' to the women involved and how they perceived its role in the counselling space. I also sought to have early conversations around potential features of a peer led counselling service. As with previous workshops, this involved referring to the outputs from previous sessions (to build on knowledge) but also exercises to stimulate discussion and new ideas. I began by asking the women what qualities they felt would be important for a PSW to have, mapping their suggestions onto the whiteboard. I then introduced the women to two projects wherein people in peer support roles had been trained to deliver talk therapy; the first was the project at a third sector organisation supporting veterans which has already been discussed (see chapter 6) and the second was a project called the 'Friendship bench' in Zimbabwe identified when reviewing the 'task-sharing' literature on low and middle income countries (LMIC) (see chapter 3). I felt these examples would be complimentary; the former was based locally and involved IPC which had already been a focus of this project and previous workshops. The latter project involved older women (described as community grandmothers) and presented an alternative, arguably more informal, format for delivery which I felt could aid comparison and prompt creative thinking. Finally, we considered how participants felt about the idea of becoming a PSW to better understand how the role is perceived, any concerns and potential barriers to recruitment. Included within this final section are my own observations of peer support that occurred organically between the women during workshops.

Qualities of a peer support worker

The first quality to be added to the whiteboard in both groups was being a 'good listener':

"Someone that will not interrupt me while I talk but listen to me exactly what I say, let me finish and then discuss the things."

(Monika, early forties)

A central theme to emerge throughout the early interviews and workshops was not feeling heard or understood by health professionals, speaking to wider evidence highlighting the act of listening as fundamental in engagements with women experiencing marginalisation (Goodman et al., 2012). Time restrictions in GP

appointments and counselling sessions had made some feel rushed and unable to fully open up (see chapter 5); Monika's reflection above appears to speak to this, emphasising the need to create space, so that people can speak freely and openly. However, later suggestions indicate a distinction between feeling listened to and heard or understood. Participants agreed that having someone who had 'been through similar' (Caitlyn) would be helpful as they were likely to be empathetic and may be able to offer advice and 'tips'. Mae felt that people with life experience, as opposed to professional qualifications, would be better able to help in finding solutions to problems. Thus, the importance of listening appeared to be not only about being heard but also to support effective action. This is consistent with the preference for action-oriented approaches amongst the women involved in this study who preferred to feel that they were doing something to address their situations rather than 'just talking' or 'going around the houses'.

Supporting prior discussions of the potential for social distance between women on low incomes and the health professionals they encounter, Gemma expressed a preference for someone 'down to earth' and 'less professional', as they would be more likely to be 'on [her] wavelength'. Consistent with this theme of commonality, Yasmin indicated that she would like to be supported by someone who was the same age. Examples of 'commonality' led to discussions around 'safety'; Monika suggested that people who have experienced domestic abuse may feel more comfortable being supported by a woman. Participants in group 1 felt it was important to have someone that you could 'put your trust in', whilst those in group 2 talked about being put at ease, having someone with a 'a nice voice that gives you a good feeling' (Monika). It is worth noting that for Monika, who had previously expressed a preference for 'professional' counselling, 'safety' was contingent with professional knowledge:

"Gender or age, for me personally, it not matter … you just need to feel safe with this person… you must know that this person knows exactly how to help you."

Reflecting on existing projects

Lived experience, role clarity and boundaries

The first observation made about the examples projects by participants was that the counsellors in both projects had 'real life experience' (Gemma) of the issues faced by the people they were supporting. Participants reiterated prior assertions that this would help them to better understand what they might be going through, and their ability to provide useful advice, drawing on their own experiences. In a review of published research on the process of peer support, the 'use of lived experience' was identified as the strongest mechanism (Watson, 2019). Participants in this study felt however that personal preferences would differ and not everyone would want or need their counsellor to *share* their own experiences. Whilst this

connection was not made directly by participants during this workshop, this could link to points made earlier in the research process. For example, the (in)ability) to 'take other people's stuff on' and valuing time just to focus on themselves, given that this is rarely afforded. What was clear however was that the sharing of experiences was regarded as potentially valuable only in so far as it related to problem solving (i.e. helpful tips and advice); this is perhaps not surprising given the repeated emphasis on 'action-oriented' approaches. Otherwise, the emphasis did appear to be on relatability and the propensity to understand their everyday lived realities.

The discussion around lived experience also surfaced concerns about role clarity and boundaries.

"Cause sometimes you might ask them [a PSW] and you think 'Ah, should I be?!' They may not want to talk about their own personal circumstances and you might think 'Ah! I shouldn't have asked that!'"

(Caitlyn, late twenties)

This quote from Caitlyn points to the potential risk of uncertainty when establishing a working relationship with a peer counsellor. For those that are already experiencing mental health difficulties, it seems there could be potential for feelings of regret, anxiety or rumination if the boundaries of the relationship have not been clearly discussed and agreed before sessions. Mancini highlights that the 'inherently personal' nature of the peer relationship requires professional boundaries that are more fluid (2018: 135); this is complicated further by substantial variation in peer support roles and the ways in which 'peer support' is defined within different settings (Puschner et al., 2019; Moore and Zeeman, 2021). Much has been written about the importance of role clarity for peer support workers in mental health settings, particularly in relation to wellbeing and reducing burnout (Davis, 2015; Mancini, 2018; Abraham et al., 2022). However, there appears to have been limited consideration of the impact of role clarity on those receiving peer support, who have been marginalised in existing research (Watson, 2017). The available literature on PSWs' experiences highlights how they can be placed in a 'paradoxical situation of being expected to provide support on the basis of lived experience whilst being instructed not to include subjects that might have played a key role in experiences of mental distress' (Llewellyn-Beardsley et al., 2022: 1834). The same authors speak of the 'vigilence' required by PSWs when sharing their stories, navigating the conflicting values of honesty and authenticity and the avoidance of harm (Llewellyn-Beardsley et al., 2022).

However, participants involved in this project were also aware of harm avoidance in relation to what PSWs felt obliged to share (as articulated by Caitlyn above) and hear (as described by Yasmin below):

'Recently, I've been acutely aware of how paranoid everyone is about triggering other people. Obviously, sometimes you say something when you're stressed, and you've not meant it, but then you've triggered something for someone else. And obviously that's really helpful to know because it might be something that they've dealt with before even if they are professionals, it might not be the easiest for them to deal with… It's never really clear if you're allowed to say something.'

(Yasmin, mid-twenties)

Here, Yasmin reflects on inadvertently causing distress in the process of expressing her emotions and suggests that it would be helpful to know in advance where there is a risk that someone might be triggered by a topic. Thus, it seems that those seeking support may face similar conflicts; the women involved in this study emphasised the value of speaking freely and feeling heard whilst, it seems, holding a sense of responsibility for how this may impact others. This sense of responsibility seems particularly concerning when it comes to single mothers on low incomes who have been found to deprioritise their own needs. More broadly, these findings point to potentially gendered responses to interactions within mental health services; existing research on this topic appears to be outdated and warrant further investigation, including exploration of intersecting influences such as race, ethnicity and class (Rogers and Pilgrim, 2021). These findings also raise interesting questions around the topic of 'self-disclosure'. Feminist therapy theorists have argued that boundaries, which includes self-disclosure, are closely linked with the distribution of power, and that the lack of reciprocity within professional counselling can be disempowering to those receiving support (Pugach and Goodman, 2015). Connectedly, some have asserted that any form of training, payment or titles offered to PSWs leads to inevitable differences in power and that these things should be avoided to preserve mutuality (Mead et al., 2001 cited in Repper and Carter, 2011).

In the local third sector project explored with participants, PSWs receive a salary and adopt boundaried roles; they do not share their own experiences unless asked directly. As discussed previously, it was suggested by one PSW interviewed that it was enough for those seeking support to know that PSWs had experience of serving in the armed forces and that this provided a shared language and facilitated mutual understanding. Reflecting on this project, Gemma suggested:

'I suppose 'cause the people there are paid so it's not like a peer support worker they're professional as well. So… having the balance of not sharing experiences I kinda get it in that respect… I do kinda understand it. Erm yeah, so having that balance … it's having that right balance isn't it?'

(Gemma, mid-thirties)

This finding supports wider research emphasising the significance of payment as a potential indicator distinguishing 'peer' and 'professional' roles; however, the influence of payment on the peer relationship is still poorly understood (Walsh et al., 2018). As previously mentioned, peer support incorporates a wide range of paid and unpaid roles. A stakeholder involved in managing a different peer support service for people with mental health problems in Edinburgh suggested that it was important for individuals receiving support that the PSW was not paid and 'that they were getting something out of it that wasn't money'. However, they also mentioned that many of the PSWs were 'secure-moneywise'. Importantly, participants in both groups responded favourably to the topic of payment, agreeing that it would provide opportunities for women who are single parents on low incomes to earn money and gain work experience.

Furthermore, Gemma's reflection that they are 'professional as well' demonstrates acknowledgment of a blended role which combines elements of peer and professional practice. This also points to what might be described as a false dichotomy; as Yasmin acknowledges in the quote above, 'professionals' may also have lived experience of the issues faced by those they support. Many organisations now actively encourage the recruitment of people with lived experience and this can be a motivating factor in wanting to support people affected by similar issues. PSW roles can serve as springboards to other 'professional' positions within relevant services. Almost all third sector stakeholders interviewed had lived experience related to, for example, single parenthood, poverty, mental health problems, racism and/or domestic abuse. Adding to this complexity, therapist self-disclosure has been a subject of ethical debate within the field of clinical practice; 'clinical neutrality' was said to be endorsed within the psychoanalytic tradition to mirror the ethos of the physical sciences and has been maintained for range of reasons such as preventing blurred boundaries and 'overburdening' clients with the therapist's problems (Sunderanic and Moodley, 2020). However, not all agree with this stance; feminist therapy theorists amongst others have argued that 'careful self-disclosure' can actually enhance and strengthen the therapeutic relationship (Pugach and Goodman, 2015). Therapist self-disclosure has been found to demonstrate authenticity even where the issues experienced differ whilst over-identification has been perceived to minimise client's experiences (Henretty et al., 2014; Hume, 2021).

Another aspect of the local, third sector model that sparked discussion was the allocation of multiple PSWs for different issues; for example, one PSW would focus on welfare issues, whilst another delivered IPC sessions. Yasmin felt that this could be advantageous:

"I think that the different peer support worker to deal with different issues is a really good idea…because usually it's just one person who will be like 'we can't deal with this or this or

this or this' and a lot of the time there isn't somewhere else you can go so you're just carrying that…It means you can focus and stress less because you know it is gonna be sorted so you know. Like I said like previously you'd just be like dealing with one thing and then it's like 'Oh we'll signpost, signpost, signpost' but you go around in circles… So it's good that there's actual, specific people for different things, and then you know actually it's okay to just deal with one [issue] at a time…"

(Yasmin, mid-twenties)

Yasmin reflects here on previous experiences of being told by a counsellor that they are unable to help her with the poverty-related issues causing her distress and instead signposting her (unsuccessfully) to alternative services. Speaking to wider research with single mothers on low incomes (Stack and Meredith, 2018), Yasmin describes 'carrying' issues with her; without support to address the issues causing her immediate distress, she found it difficult to focus within counselling sessions. As previously discussed, research with women on low incomes has demonstrated the importance of acknowledging the social context of women's lives; authors have argued that creating 'relational spaces where poverty-related issues can be recognised and addressed' is key to developing empowering therapeutic alliances (Pugach and Goodman, 2015). This has also been said to challenge traditional ideas around therapeutic boundaries; examples of 'poverty aware' practices adopted by therapists include advocacy, phone calls (e.g. to address welfare issues) and making accommodations in response to financial stressors such as childcare (Thompson et al., 2012).

What is striking about Yasmin's account is the sense of being left *alone* to deal with problems; a feeling that featured heavily in workshop discussions (Llewellyn-Beardsley et al., 2022). Research has found that 'compulsory positivity' sometimes pushed by organisational agendas can distract from the social injustice and systemic inequalities underpinning issues experienced by peers (Llewellyn-Beardsley et al., 2022). It is argued that where peers can acknowledge systemic factors, this can help to demonstrate authenticity and support connection (Llewellyn-Beardsley et al., 2022). Interactions with people who share (or in this case have shared) stigmatised statuses can take personal problems and transform them into problems of the collective (Llewellyn-Beardsley et al., 2022). Ultimately, participants felt it was imperative that counsellors, or others in the same service, acknowledge poverty-related stressors even if this challenged the boundaries of conventional practice. This feels particularly important for approaches like IPC wherein clients are expected to maintain focus on one topic (e.g. life transitions) whilst potentially being weighed down by pressing material concerns.

The environment for counselling: space, safety and power dynamics

One of the features of the Friendship bench project in Zimbabwe (an example of 'task-sharing' from the wider literature) was that people receive a form of talk

therapy on benches outside in the local community. Photographs of the project show some women being supported with their children around them, either sat on their knee or playing nearby.

"One thing that I noticed. I know it's probably got nothing to do with it but there are kids I think in all of the photos…For me, it's kind of (…) so it's like less restrictive because you know if you needed to then like they have their kids with them and they can still access the support. Like I said before sometimes you can't go to an appointment because you don't have someone to look after the kids."

(Yasmin, mid-twenties)

For Yasmin, the prospect of bringing her children to therapy sessions was advantageous as childcare issues had previously prevented her from attending appointments. Gemma agreed with this but emphasised the importance of finding child friendly environments which did not feel too formal.

*"**Gemma**: Hmm being in an informal surrounding… I'm thinking being in a child friendly environment. So I'm thinking maybe a library that's got sorta meeting rooms off it. You know somewhere that a child's not gonna feel sorta frightened to go in. Like you know yourself if you go into a clinical building or a hospital or whatever it just doesn't feel so nice and your child wouldn't want to go there or want to stay. So, if you were going somewhere with your child, you know somewhere a bit more friendly, a bit nicer…*
***Yasmin**: In a community garden …*
***Gemma**: Yeah, uhuh, something like that…*

This exchange reinstates the importance of the therapeutic environment. There has been growing interest in the use of outdoor spaces for talk therapy; whilst examples focused on peer-led approaches are lacking, the literature on 'professional' therapeutic practice explores themes relevant to this project. Research suggests that this approach can change the nature of the therapeutic relationship, mitigate power differences and lead to greater mutuality (Cooley et al., 2020), interestingly reflecting the principles of peer practice. Factors supporting this are said to include the 'neutrality' of space not owned by either party, giving clients greater control of where they go/choose to sit and a sense that therapists are more 'real' outside of professional buildings (Cooley et al., 2020; Revel, 2017). Studies suggest that being outdoors can positively affect the wellbeing of both therapist and client, and that clients can gain a sense of freedom that makes it feel easier to open up (Cooley et al., 2020; Revell and McLeod, 2017). One of the counsellors I interviewed who worked for a third sector organisation explained that they had offered their clients the option of walking through the botanical gardens for one of their sessions. They felt that this was particularly helpful for the client in negating the need for eye

contact, but this did not appear to be common practice. Walk and talk therapy has increased in popularity; studies suggest that this approach can feel less pressurising for clients (Cooley et al., 2017), support a collaborative relationship through shared activity and that being in motion can help to symbolise becoming 'unstuck' (Revell, 2017). This latter point feels particularly relevant to the experiences of the women involved in this project who described feeling 'stuck' and 'unable to see a way out' (See fig. 4). Another potential benefit of this approach is that it could free up clinic rooms (Cooley et al. 2020); a third sector stakeholder explained that they were limited as to how many counselling sessions they could offer at their centre as they only had one meeting room.

However, speaking to earlier discussions, in addition to more obvious practical considerations (e.g. weather), the use of outdoor spaces presents challenges to professional boundaries. The unpredictability of the outdoors can make it difficult to control the variables required by ethical practice guidelines (Cooley et al., 2020). It has been argued that the dominance of the biomedical model within mental health systems, particularly clinical settings, has led to a preference for controlled environments with 'repeatable therapy models' (Cooley et al., 2020). In outdoor settings, therapists are expected to hold the 'therapeutic frame', remaining accountable for issues such as boundaries and confidentiality (Revell, 2017). The lack of support from professional bodies and formal training/guidance for practitioners have been cited as barriers to the development of this work (Cooley et al., 2020; Revell and Mcleod, 2017). The challenge of maintaining confidentiality was also raised by Monika as she reflected on the Friendship Bench project:

"You don't want the other people hearing your problems, maybe you will be crying during the chat and get too much emotional… so you won't have a private, comfortable place which make you feel safe enough to talk about that. If there is no people around and it's not too much noise it's OK to have session outside. Like the [Friendship Bench] pictures … it's not privacy. Is not respectful…. You can sit on a bench outside as long as it's a safe place to talk."

(Monika, early forties)

Monika's concerns here about finding private spaces where people feel safe to broach sensitive topics and express difficult emotions provide support for the development of ethical guidance on counselling in outdoor settings. However, whilst Monika made clear that she would not wish to bring her daughter to counselling sessions, this contrasts with the preferences expressed by Yasmin and Gemma above and illustrates the subjectivity of 'ethical safety' as something that needs to understood and negotiated at the individual level.

"I've got a lot to give": perspectives on becoming a peer support worker (PSW)

Having reviewed the two examples of 'task-sharing', I asked participants how they felt about the prospect of becoming a PSW and whether it was something that would interest them. Both Gemma (group 1) and Monika (group 2) sought to develop careers in support work and saw the PSW role as a good opportunity to gain relevant experience. Mirroring previous discussion about the qualities that were important in a PSW, they also felt that they had a lot to give the role, including relevant life experience, being a good listener and a desire to help others. With the exception of Monika who sought to work for Women's Aid, an organisation that supported her in the past, the notion of 'giving back' to services did not emerge elsewhere. As captured above, the focus was on helping other women who are single parents on low incomes:

"I feel like I've got a lot to give, I feel like I've got a lot of experiences and different things that I could support people going through it. I'm sort of considering looking into different qualifications to do it, maybe possibly as a job. I'm not sure if I can do it yet…I've got a young child and I can't study but it's definitely something even at the moment, more ad hoc that I'd be okay doing... I just kind of feel like I like to help people you know? I want to help people…"

(Gemma, mid-thirties)

"I got a lot of experience with the life, so I could share my experience and how I [dealt with things] during that time … that will be helpful. I'm a very good listener, I can really deeply listen and put myself in the people's shoes if you know what I mean? And I can see how they must feel when they are talking about that because I think it is very important get them feeling that you can understand really well. You can't be a cold person."

(Monika, early forties)

In the quote above, Gemma suggests that she would only be able to commit to a flexible arrangement whilst her son was young. The issue of childcare was also raised by Kim who felt that this would need to be considered in the development of a peer support model for women who are single parents on low incomes. Others in the group recognised the importance of peer support but felt restricted by a lack of confidence:

***"Yasmin**: I'd do it as well and I think it's really important. I think that the thing that I lack in that regard though because I've got it all there like mentally and I'm like 'Yes! I've a plan', but I just don't have the confidence to pull it off and I just put it to the side and even though it's like I feel like it's really important. I have tried to set things up in the past, and then I'm just like 'nope can't do it' and run away again which is not helpful.*

***Natalie**: Yeah, so you know that you have the qualities to do it and it's something you'd like to do but it's just having that confidence to go for it? [Yasmin nods] What about you Caitlyn? Is this something you'd ever think about?*
***Caitlyn**: I'm kinda the same as Yasmin - it's the confidence... maybe if it was over the phone or online, but I think I would just lack the confidence face to face or I'd probably take on their problems more myself… like I don't know if I'd start like start dwelling on what they're going through and take it on myself so that's my only worry. Like if people offload stuff to me I kind of want to help them, but like I feel like kind of stuck because I'm sort of taking it on and this will affect my mood. But I would like to do it if I could feel confident enough to do it…*

The issue of self-esteem was raised by stakeholders; as previously discussed, increased exposure to stressful life circumstances beyond individual's control (e.g. financial hardship) has been said to contribute to lower levels of self-esteem amongst single mothers (Copeland and Harbaugh, 2010). Inconsistent social support has also been found to negatively impact self-esteem amongst mothers on low incomes (Copeland and Harbaugh; 2019). These findings suggest that self-confidence could be a barrier to the recruitment of women who are single parents on low incomes into PSW roles. PSWs have emphasised the value of training as a first step in building the confidence (Machin, 2019). However, evidence also suggests that with supportive supervision, confidence continues to be built in the fulfilment of the role (McLean et al., 2009; Repper and Carter, 2011).

Caitlyn also expresses concern that she will 'take on' other people's problems and that this will negatively impact her own wellbeing. Firstly, this underscores the need to ensure the PSW role feels right for individuals at that time, taking account of the wider context of their lives. People should not feel pressurised if this is not something they feel able or wish to do. Two participants for example (Kim and Mae) expressed disinterest in the PSW role. Caitlyn however was more conflicted. Reflecting on prior discussions, it feels possible that Caitlyn's perception of the PSW role was negatively influenced by her experience of being expected to provide informal support without training or supervision to someone whom participants agreed required 'professional' help (see chapter 5). This could also partly explain her earlier concerns around role clarity and boundaries when working with a PSW. It also appears to relate to the (in)ability to problem solve as a recurring theme within workshops. With enough distance and time, a PSW will ideally be able to draw on their life experiences to support others to deal with and address issues, instilling hope and motivation. However, issues related to systemic inequalities may not be feasible to address within the context of peer support. One study for example described the 'anger' that can be experienced by PSWs as they connected to experiences of 'oppression and domination' (Mancini and Lawson, 2009: 11). Projects have demonstrated the value of activism as a component of peer support services, providing opportunities for people to take collective action in response to structural problems. However, it is interesting to note that where 'activism' has

been found to be a core component of CHW roles internationally (e.g. 'change agent' CHW model discussed in chapter 2), this has not be found to be the case in the UK (Taylor et al., 2018).

"I've got ya": Peer support during the research process

I would like to end this section by reflecting on the peer support I observed occurring between participants during workshops. Peer support was expressed in multiple ways. Participants often appeared to lack confidence in the insights they shared prefacing reflections with disclaimers such as 'this is probably nothing' (Yasmin). The women often stepped in to support and encourage one another in the expression of points as exemplified in the following exchange between Kim and Gemma:

*"**Kim**: It's like we've got to try and work our social lives around the kids. Does that make sense? My brains not even working [laughs]*
***Gemma**: I understand what you're tryin' to say… their social activities come before our social activities.*
***Kim**: That's it! That's what I'm tryin' to say Gemma. I'm so sorry – my brain is just not functioning at all.*
***Gemma**: I've got ya [laughter]"*
***Kim**: Honestly [laughs] That's 'cause you know me!"*

As indicated by Kim, pre-existing relationships between some of the women appeared to help here. I did wonder about the impact of this on Yasmin, the only person in group who did not know the other participants before joining the project. It did appear that Yasmin was not addressed directly by other participants in the same way and perhaps provides an example of the 'cliques' that Yasmin herself referred to within services aimed at women who are single parent on low incomes (see chapter 5). Other examples of peer support included offering to advocate for each other in meetings, the acknowledgment of challenging situations and advice:

*"**Monika**: She's [Monika's daughter] got heavy chest infection… she's on antibiotic and needs to stay until Sunday in the house so I didn't sleep well from last two days, because she's coughing waking up crying.*
***Mae**: Yeah, it's not easy when the kids sick you know.*
***Monika**: But I'm still here!*
***Mae**: Yeah… that's why I asked. Try to forget everything… cuddle your daughter… get sleep… get rest.*
***Monika**: That's what I'm going to do… thank you so much."*

In a later workshop, Monika can be seen to provide the acknowledgment and reassurance to Mae, perhaps representing the reciprocity which is said to be fundamental to peer relationships (Scott, 2011; Moore and Zeeman, 2021), the

CHW role (Van Iseghem et al., 2023) and informal networks for women who are single parents (Radey et al., 2022).

***"Mae**: …so, it's making me prove… make me feel 'yeah sure everybody I'm good mum' you know? Even though I'm single. You know this motivation for me.*
***Monika**: Think of this a different way, you are great Mum."*

These moments led me to reflect on the possibilities of relationship building between peers within research spaces involving repeat engagements; the potential implications of this are explored further in the following chapter.

Conclusion

During the workshop focused on the potential of peer support, which included more general discussions about the topic, I introduced participants to two projects wherein PSWs provided talk therapy. I sought to understand how they felt about this concept. Such roles might be said to represent a merging of peer and professional practice. Authors in the field of peer work and stakeholders involved in this study have argued against any form of 'professionalisation' (e.g. through training, titles and payment) as it is perceived to be disruptive to the peer relationship, creating distance and impacting mutuality. However, insights from participants highlighted multiple ways in which clearly defined roles, training and supervision could potentially enhance the peer relationship whilst also protecting the wellbeing of PSWs and those receiving support.

Workshop findings however indicate that confidence could be a barrier preventing women who are single parents on low incomes from going for peer roles. Participants involved with an organisation had previously described being asked to provide informal peer support (via a WhatsApp group) without training or supervision and a stakeholder interviewed explained that this was in part due to a lack of funding for peer roles. It seems that such experiences, wherein people feel unable to help and burdened by the issues brought to them, could also impact on their perceived ability to fulfil a PSW role. Research studies of the experiences of PSWs have underscored the importance of training and supervision in making PSWs feel valued and for developing confidence (Machin, 2019). Funding is also required to address the material barriers to recruitment including childcare and salaries; this seems imperative to ensuring the sustainment and feasibility of a peer counselling model. Whilst more research is needed exploring the influence of payment on peer relationships, within this small-scale project, participants involved perceived this positively as creating opportunities for women on low incomes.

It also appears that pre-conceived expectations amongst participants around 'professional' and 'peer' work created some uncertainty about relational

boundaries. Participants agreed that the lived experience of PSWs meant they would be uniquely placed to understand the context of their lives and perhaps offer useful advice. However, this element of identification and connection raised questions about what PSWs would be expected to share and concern that PSWs may be triggered by what they disclose. Participants had been used to tightly bounded relationships with mental health professionals; the 'peer counsellor' role might be said to represent a new form of professionalism which may be confusing to navigate. It seems that organisational resources such as role descriptions could help to clarify relational boundaries for PSWs *and* those they are supporting, whose perspectives have been neglected in existing research on 'task-sharing'. The implementation of supportive supervisory structures (which of course require funding) could also support the development of systems designed to protect the wellbeing of PSWs. An important finding of this research however is the sense of responsibility held by participants as to what they share with others; it seems imperative to ensure that those receiving support are aware of the systems and processes in place to protect PSWs. Doing so could help to remove this burden, which may lead to rumination and negatively impact mental wellbeing.

Reflecting on a peer project in a different context, drawn from the task-sharing literature on LMIC, led to an interesting discussion about the environment for counselling presenting another opportunity to challenge normative practice. There was enthusiasm amongst participants for accessing non-clinical spaces, such as community gardens, where they would feel comfortable to bring their children. As research suggests that offering counselling outdoors and engaging in collaborative activities (e.g. walking) can enhance mutuality, it seems that his could help to rebalance power differences said to be 'inevitably' introduced by training, titles and payment. It does seem however that training and guidance around the potential ethical implications (e.g. maintaining confidentiality) would help to ensure that spaces felt safe for both parties to share their experiences. Discussions indicated that conceptions of ethical safety are subjective. For example, participants appeared to have different perspectives on privacy and confidentiality, and this may best be negotiated at the individual level. Furthermore, individual preferences surfaced regarding expectations of PSWs, the ideal location for counselling and the appeal (or not) of the PSW role. This served as a final reminder as to the heterogeneity of women who are single parents on low incomes, the importance of options and flexibility.

In summary, counter to the advocations of authors seeking to protect the 'authenticity' of peer relationships, workshop discussions with the women involved in this study suggest that whilst there is a place for informal peer support (as witnessed between participants), there could be many advantages to structured peer support roles. Situating these fieldwork findings within wider research on 'task-

sharing' in mental healthcare, it seems that training/guidance, supportive supervision and payment are all important components in the creation of potential new roles that merge the best of professional and peer practice. I would argue that these systems and processes mean that organisations are better placed to protect PSWs' wellbeing and help to ensure that the role feels empowering. Communicating this effectively with those *receiving* support could also provide the reassurance required to speak freely and feel heard, maximising the potential of peer relationships.

Introduction

This thesis sought to explore the potential of 'task-sharing' to improve the mental health support available to women are single parents on low incomes in Scotland. It addresses a research gap within the literature on 'task-sharing' focused on the Scottish landscape for mental health policy and practice. A unique contribution of this study was the effort made to gather learning from different geographic settings and time periods; this included low- and middle-income countries which are frequently excluded from discussions around the potential of task-sharing for more advantaged settings. Furthermore, it responds to the lack of participatory research which involves mental health professionals and creates space for people with lived experience of marginalisation to engage critically with evidence-based methods of mental health practice. Crucially, it contributes new insights related to the maximisation of peer roles within mental health services.

Within this final chapter, I reflect on the overall research findings and make three conclusive arguments. Firstly, the importance of recognising that people in marginalised groups, such as women who are single parents on low incomes hold multiple, intersecting social locations which means that they will have points of connection and divergence from one another. Acknowledging this not only helps to avoid essentialism, which can lead to othering practices, but also facilitate more nuanced understandings of lived experience as a resource within mental health research and practice. Secondly, the findings of this study demonstrate the potential of people from marginalised groups to apply their lived experience in shaping the design and delivery of evidence-based methods of mental health care. However, I argue that the potential of this form of 'task-sharing' will only be realised through the commitment of mental health professionals to democratise medical knowledge and tools, working in new ways that challenge existing culture and practice.

Finally, in recognising the socio-economic, cultural and political context of mental health experiences, I argue that efforts should be made to create opportunities for collective action against injustice as part of the provision of mental health support to marginalised groups. There is much to be learned from the existing literature on participatory methods which could help to dismantle power structures within the field of mental health and support collaborative work that feels both meaningful and empowering.

I will now outline these conclusive arguments in greater detail and consider potential implications of these findings for mental health research, policy and practice.

Acknowledging multi-dimensionality and avoiding essentialism in understanding the mental health experiences of women who are single parents on low incomes

'Lived experience' emerged as a central theme in the task-sharing literature (e.g. a core characteristic of CHWs) and a resource that could be drawn upon to improve mental health service provision for marginalised groups. However, oversimplified conceptualisations of lived experience, resulting from an apparent lack of dialogue with people providing and receiving support, led to issues of overidentification and othering in the task sharing approaches discussed in chapter 2. Beginning the fieldwork with discussions about identity and exploring women's own understanding of the mental health issues they had experienced helped to build trust and develop a shared language which contributed towards the creation of a collaborative research environment. This was verified through the survey responses of research participants who repeatedly confirmed that they felt able to contribute their knowledge and ideas.

The application of a multi-level intersectional, feminist framework then helped to illuminate the multidimensionality of women's experiences, identifying points of connection *and* divergence. The women involved in this project connected on the experience of structural (i.e. financial hardship) and cultural marginalisation (i.e. stigma). This translated into subjective feelings of 'powerlessness', 'helplessness' and 'being alone' and appeared to form part of a 'collective experience', one that you could 'only truly get' by becoming a single parent. However, individual experience and everyday realities were shaped by the different social locations they held (e.g. ethnicity; migration; age) and the resources available to them, most notably, familial support networks. This aspect of 'divergence' evoked strong feelings amongst participants, contributing to their feelings of not being seen or understood, whilst also pointing to the potential for overidentification in peer support for women who are single parents on low incomes.

I therefore contend that multi-level intersectional frameworks have the potential to advance understandings of the meaning of 'lived experience' as a resource in task-sharing projects. The comprehensiveness of this framework could also help to address the 'culturalist lens' I identified within the existing 'task-sharing' literature which overemphasises cultural difference, contributing to the othering of racially minoritised groups and masking broader systemic issues. I have argued that this is reflected in the marginalisation of CHW activities, for example bounded tasks (e.g. translation) and 'outreach' work, which limit opportunities for CHWs to leverage their lived experience and protects the status quo of mainstream practice. Applying an intersectional framework to the literature review and my own fieldwork findings, for example, drew attention to the

importance of 'gender' and 'social class' (as well as issues related to 'culture') which I found to be neglected within current research in the field.

Following the theme of othering, accounting for the multiple, intersecting social locations held by the women in this project, revealed that they could maintain positions of disadvantage (e.g. poverty) and privilege (e.g. 'Whiteness') simultaneously. Adopting a *multi-level* intersectional, feminist framework which distinguished between structural, representational and individual levels of experience, helped to demonstrate the 'deficit-oriented' nature of the structural identity category of 'single parent' (or 'single mother') which, I have argued, is framed through normative ideals. Importantly, workshop findings demonstrated that there were aspects of single parenthood that participants felt had been positive for their mental health, for example, leaving abusive relationships and the close bonds they had with their children. Participants also recognised their own strengths in dealing with the challenges associated with single parenthood, such as resilience, independence and communication skills. This presents a challenge to practices of 'benevolent othering' evidenced within mental health services emphasizing the vulnerability of marginalised groups.

In summary, these findings evidence the need for more nuanced frameworks for understanding lived experience as a resource within task-sharing approaches to improve mental health support and as a tool to identify, and challenge, othering practices. The implications of the over-simplistic and/or deficit-oriented explanations of lived experience for the future of task-sharing will be considered in the final section of this chapter.

Dismantling knowledge hierarchies and merging lived and professional expertise in mental health care

One of the features of task-sharing approaches in mental healthcare identified within the existing literature was the involvement of people with 'lived experience' in reviewing the feasibility of talking therapies. However, such approaches tend to be justified on the basis of cultural difference, for example targeting communities in low and middle income countries (LMIC) or racially minoritised groups in higher income settings, and thus imply that the existing approach is appropriate for the 'majority population' (which I have argued is itself a social construct). This project makes a unique contribution to the task-sharing literature by exploring the feasibility of a therapeutic approach owned by the medical profession (interpersonal counselling) with a marginalised group using an intersectional framework which accounts for the multiplicity of social locations held by participants, whilst avoiding culturalism in the interpretation of findings. Adopting a participatory approach to research with substantial involvement from a clinical

psychologist in the field, research participants involved in this study were able to draw on their lived experience and engage critically with the concepts and strategies within interpersonal counselling (IPC). An unexpected finding from discussions was the preference amongst participants for a biomedical model for understanding mental health. This can however be understood as a response to 'social' issues in that it was seen to legitimate their mental health experiences which were felt to be questioned by stigmatising discourses related to single motherhood (e.g. lazy; 'benefit scrounger'). Whilst participants perceived IPC to be broadly relevant and useful, they drew attention to the 'deficit-oriented' nature of certain tools and potential issues with the feasibility of implementing strategies in the context of their lives. Reflecting on discussions, I have argued that such tools have the potential to perpetuate stigma, for example, highlighting the experience of being 'alone'. Some of these issues had been recognised by a peer support worker interviewed who delivered IPC and had adapted tools to have a more positive framing and better meet the needs of their clients.

Crucially, stakeholder interviews indicated that these innovations had not been fed back to IPC research and practice networks, pointing to the existence of a knowledge hierarchy and the exclusion of practitioners deemed to sit 'outside' of the profession. Reflecting on these research findings, I have argued that leveraging lived experience has the potential to improve the feasibility and effectiveness of IPC for marginalised groups. However, whilst IPC has been designed to democratise access for those outside of the medical profession, my own experience of fieldwork was that it required significant professional expertise (here a clinical psychologist) to further simplify the content. There also appears to be a role for mental health professionals as 'insiders' who understand governance structures and processes, and hold positions of influence, to pass on this knowledge and help to ensure it has material impact (e.g. adaptations to manuals used by IPC practitioners). This feels like an important opportunity for task-sharing that merges lived and professional expertise to improve mental health support.

The concept of 'safety' featured prominently in discussions about the delivery of talk therapy. Factors that were said to invoke feelings of safety amongst participants might be said to challenge conventional approaches to ethical practice. This included a preference for an informal style and receiving counselling at home or out in nature. Unique to this study was the use of examples of task sharing from LMIC discussed in chapter 2 of this thesis to aid discussion and new thinking. Given evidence of bias against literature from these settings, this was my own attempt to address a knowledge hierarchy within the field. There was interest in approaches that challenge existing practice but have the potential to overcome practical barriers to engagement like the option for single parents to receive counselling at the park whilst their children are playing. Contrary to the concerns

of stakeholders regarding acceptability, there was an openness amongst participants to receiving counselling from someone in a peer role.

Discussions about delivery also underscored the importance of acknowledging the wider socio-economic, cultural and political context of people' lives when supporting people from marginalised groups with mental health problems. As such, I have argued this attests to the relevance of a social model of health. The lack of focus on material stressors within IPC was seen, to some extent, as a limitation and participants felt it was important to address these (e.g. welfare issues) as part of the same service, so that women had the head space to focus on interpersonal matters. Yet, the prevalence of cognitive behavioural therapy (CBT), which focuses on individual thoughts, feelings and behaviours and a perceived pressure amongst participants to take antidepressant medication signify the continued institutionalisation of the biomedical model within the Scottish mental health service landscape.

At an interactional level, findings suggested that an 'innate' understanding of people's life worlds can be communicated between peers with similar experiences (something I have elsewhere referred to as 'embodied knowledge'), again calling attention to the potential value of 'task-sharing' in mental healthcare to improve mental health support. It seems that mental health professionals who are socially distant (e.g. different socio-economic and/or cultural backgrounds) to their clients may have to work harder to demonstrate this. Participants' previous experiences of counselling, ('they don't get it', 'going around the houses', 'didn't care'), indicate either a dismissal or avoidance of topics that women felt were central to their experience of mental health problems. I referred to evidence of mental health professionals avoiding seemingly 'taboo' subjects (e.g. class; race) in counselling sessions, which, I have argued, undermines the potential of counselling to dismantle stigmatising discourses influencing self-perception and protect against internalisation. People from marginalised groups are well placed to inform training here, raising awareness of these issues and how to broach sensitive topics.

Opportunities for participatory and collective action

In line with acknowledging wider socio-economic, cultural and political context of peoples' lives, research findings underscore the importance of creating opportunities for collective action against injustice. The women involved in this study sought to *do* something in response to structural and representational marginalisation; opportunities to come together and contribute towards policy and practice addressing these issues could help to address the feelings of powerlessness, helplessness and isolation that appeared to define their collective experience. I posit that this should be regarded as part of a broader response to improving the mental health support of women who are single parents on low incomes (i.e. in addition to methods such as counselling). It is important to note the policy and campaign

work already happening within third sector organisations trusted by, and representing marginalised groups, such as One Parent Families Scotland who are well positioned to mobilise social capital. However, research findings highlighted the risk of 'offloading' responsibility onto underfunded organisations that exist on the peripheries of health systems (something I have categorised as 'task-*shifting*').

This study has demonstrated the value of participatory principles in working to dismantle knowledge hierarchies. However, according to a stakeholder within NHS Scotland, participatory approaches could still seem 'other worldly spaceship' to those working in public health, suggesting there is a need to promote the use and value of such methods in these arenas. I also found evidence that power differentials can be realised intersubjectively through interactions.

Overall, this study revealed a tendency towards binary thinking in the field of 'task-sharing' in mental health, for example, biomedical or social models of health; professional or peer; extension agent or change agent. There is more work to be done to explore what is possible by testing these boundaries and dismantling knowledge hierarchies within mental health research and practice. Doing so should help to harness the different, yet equally valuable, knowledge and expertise required achieve transformative change and improve the mental health experiences of marginalised groups.

Implications of research findings for policy, research and practice

Implications for policy

The multi-level intersectional framework applied within this thesis helped to organize findings across multiple levels of experience which interacted and fed into each other in important ways. Reflecting on these findings, I contend that current UK policies related to employment and welfare have been designed to support the normative ideal of the nuclear family. 'Single parents' have been reduced to an essentialized 'other' (structural level), making it possible for anti-welfare rhetoric (representational level) to fuel the stigmatisation of this categorical identity with specific implications for the mental health of women who are single parents on low incomes and how they engage (or not) in mental health services. Supporting wider research findings, the women involved in this project responded to stigmatising discourses by enacting the 'good lone mother' ideal, de-prioritising personal needs and delaying help seeking; there was also a lack of trust in relation to health and social care professionals. In responding to these issues, third sector organisations have inadvertently employed deficit-oriented discourses emphasising the 'vulnerability' of marginalised groups in calls for funding. These framings underestimate the strength, skills and capabilities of people from marginalised

groups, like the women involved in this project, who knew they had 'so much to give' but weren't given access to the spaces within which they could enact change.

Findings therefore point to the value of participatory approaches to policy making, working alongside people from marginalised groups to identify biases and assumptions related to categorical identities and move towards a more nuanced and inclusive approach to identity issues relevant to mental health, such that people feel better represented and understood. This not only relates to 'mental health policies' but the full range of policies (e.g. welfare) that impact mental health experiences. This speaks to the interest of participants within this study to engage in work that makes an impact and the 'change agent model' for CHWs discussed in chapter 2. Another aspect of a policy-focused role for people with lived experience of marginalisation could be in shared-decision making around what the priorities should be, and where funding should be invested, in mental health services.

In the latest mental health and wellbeing strategy, the Scottish Government commit to 'ensur[ing] policymaking is informed by the voices of those with lived experience of accessing support and services' (2023: 44). Furthermore, there has been a commitment to working alongside people with lived experience 'to identify and share evidence of the benefits and impacts of peer support and the settings where this will have the most impact' (Scottish Government, 2023*b*: 14). Adopting a participatory approach, this thesis provides novel insights on possibilities for new types of 'peer roles' which involve task-sharing in mental health services. It has also demonstrated that there are important methodological considerations to make when embarking on such work to maximise opportunities for shared learning and protect the wellbeing of people from marginalised groups. I will now move on to consider these implications below.

Implications for research and practice

Broadly speaking, this research project has found that there are a range of tasks which, if shared with people who have lived experience, could have the potential to improve mental health services for women who are single parents on low incomes as a marginalised group. This relates to policy making (described above), reviewing the feasibility and effectiveness of therapeutic approaches in mental healthcare and the delivery of simplified versions of talking therapy. However, this is a small-scale study; to fully understand the implications for mental health practice, further research is required, adopting this approach to exploring the feasibility and effectiveness of evidence-based methods (e.g. talking therapies) with a larger number of participants and other marginalised groups. This also applies to the perceived feasibility of receiving counselling from a peer support worker; more needs to be understood about the influence of payment on the peer relationship and the negotiation of boundaries for those providing and receiving support.

Interviews with professional stakeholders (e.g. clinical psychologists) indicated that there could be some resistance to peer-led counselling. Given the integral role of mental health professionals in these approaches, more research is required to understand their perspectives on the potential of task-sharing and the implications for their own roles.

Progressing this work thus requires the bringing together of people with a range of expertise including people with lived experience, mental health professionals and academics with research expertise. The issues of distrust (towards health professionals) documented within this thesis and the potential of formal environments to intimidate, suggest that thought needs to be given to development of these research communities to ensure that people with lived experience feel confident and comfortable to share their knowledge and expertise. There is much to be learned here from the growing literature on co-production in mental health research; this includes practical guidance around shared decision making and the creation of safe, inclusive spaces (Jakobsson et al., 2023; Hopkins et al., 2024). Authors have highlighted the challenges associated with conducting co-production research in universities which are innately hierarchical and not set up to support participatory processes (Faulkner and Thompson, 2021). A limitation of this project was that participants were not involved in shaping the research focus which was pre-determined and shaped by the interests of the project partner. In developing work on this topic and fostering equal partnerships, it is crucial that people with lived experience are involved from the outset, have the space to reject the approach entirely and take the research in new, perhaps unexpected directions.

Similar implications apply in relation to the development of 'task-sharing' within mental health practice. Focusing on emergent work in the field of interpersonal counselling (IPC), I have argued that such approaches appear to have been developed through an 'operational lens' focused on managing the increasing demand for mental health services in the context of limited funding. The brief training provided to IPC practitioners and time-limited sessions reflect the prioritisation of efficiency. However, evidence suggests that time (i.e. given by CHWs and lacking in engagements with health professionals) is the one of the most important components of the support provided through task-sharing projects for marginalised groups. Furthermore, the findings of this study indicate that people from marginalised groups who are new to working in professional work environments are likely to lack confidence and thus require additional support as they settle into new roles. It thus follows that greater investment is needed in the training and guidance documents for IPC practitioners, drawing on the expertise of PSWs like those interviewed as part of this project. Given the evidence of exploitation and mistreatment of CHWs recruited into health systems, which, like universities, are inherently hierarchical, it is crucial that these risks are considered in the design of new projects to protect the wellbeing of those involved.

Finally, as this project was underpinned by the principles of 'participatory action research', it feels pertinent to outline my own commitment to 'doing something' with the research findings. Specifically, I intend to utilise the contacts I made during fieldwork within IPC research networks to explore avenues for mutual learning between health professionals and IPC practitioners with 'lived experience'. More broadly, I will continue to liaise with members of advisory group, research participants and wider stakeholders to consider possible dissemination activities and ways to take actions forward.

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APPENDIX 1: PARTICIPANT INFORMATION SHEETS AND CONSENT FORMS

a. Participant information sheet and consent form for women who are single parents on low incomes

Participant Information Sheet for women who are single parents on low incomes in Edinburgh.

Name of department: School of Social Work and Social Policy
Title of the study: Improving mental health support for women who are single parents on low incomes in Edinburgh**.**

Introduction

My name is Natalie Dewison and I am a PhD Student at the University of Strathclyde. This project was inspired by the amazing women I met whilst working as a researcher looking at the impact of financial strain, isolation, and loneliness on mental health. The project is funded by the University of Strathclyde, NHS Lothian and the Centre for Mental Health Innovation at the City University of New York (CUNY).
After reading this information sheet, if you have any questions or would like to find out more, please get in touch with me using my email address is natalie.dewison@strath.ac.uk and we can chat over email or arrange a time for a phone call.

What is the purpose of this research?

This research will look at:

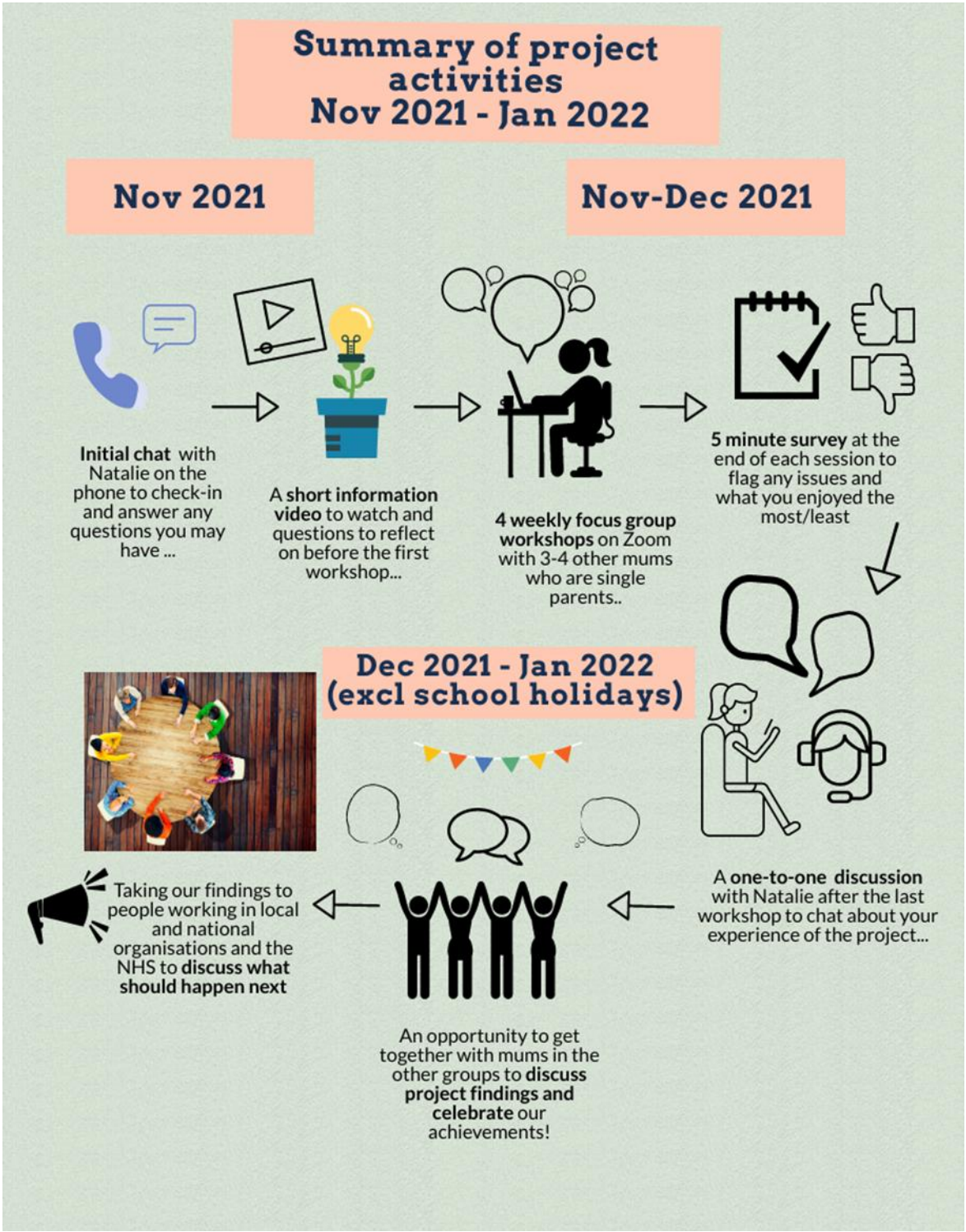
- How mental health support could be improved for women who are single parents on low incomes in Edinburgh;
- How people with lived experience can be involved in designing and providing mental health support in Edinburgh in ways that are enjoyable, meaningful and empowering.

Do you have to take part?

No, participation in this project is **entirely voluntary**. After learning more about the project, you may decide that this is not for you and you do not need to do anything else. If you would like more information about the project before deciding whether you would like to take part, please get in touch using the email address above.
If you decide you do want to take part and later change your mind, **you have the right to withdraw from the project at any time.**

What will you do in the project?

Throughout the Summer of 2021, I have had in-depth, one to one conversations with six women who are single parents on low incomes who have helped to shape the plan outlined on the following page. I am very grateful to these women for their time and honest feedback.



More information about each stage is provided over the following pages…

November 2021: Phone or Zoom call

If you decide you would like to take part, the first step will be to **arrange a phone or Zoom call**, so we can get to know each other (or just check in for those of you I know already!) and answer any questions you may have about the project. During this call, we will **be going through some questions** to think about what you want to get out of the project and make sure you have everything you need to take part. Equipment such as tablets can be loaned, where needed, until the end of the project, free of charge. We will also run through the main functions of Zoom or arrange another time to do this before the first workshop. This call could last between **10-20 minutes** depending on what we cover.

November-December 2021: Workshops

I am looking for 8-10 women who are single parents on low incomes - we will form small groups of three or four which will meet for **weekly workshops which will be conducted remotely on Zoom**. Workshops will be relaxed and supportive and will last for 90-minutes with a short break in the middle. As some people will find it easier to meet in the day and others in the evening (e.g. once little ones are in bed), both options will be offered. We can agree the day and time together based on the availability of all group members. You will be given a **£20 Love2Shop voucher for each workshop** to compensate you for your time. There will be **four workshops** in total.

During the workshops we will be **reflecting on a type of mental health support** (I will send you a video explaining more about this) and discussing how likely it is to meet the specific needs of single parents on low incomes. Through group discussions and exercises, we will first be reflecting on the mental health support currently available to single parents on low incomes and you will be asked to decide, as a group, what is important and where are the gaps based on your experiences of mental health care. In the following sessions, I will be asking for your opinion on some of the language used within counselling and the potential role of peer support. You will be sent a detailed description of the topics that will be covered in each workshop in advance.

The workshops have been designed to be **relaxed and supportive**. You are only expected to share your opinions and do not have to share personal experiences unless you want to. You will be asked to complete a **5-minute survey** at the end of each workshop - this will ask you what you enjoyed the most and least about the workshop and I will use this information to shape the next one to make the process as enjoyable as possible. You will also be encouraged to contact me directly with any concerns or questions.

I will be giving you some **questions to help you reflect between sessions** and you may wish to record your thoughts as a voice note or in writing, especially if you have any thoughts or suggestions you want to bring to the next workshop. After the last workshop, I would like to put in some time for us to have **a one-to-one interview** lasting approximately 30-45 minutes either over the phone or on Zoom; this will be an opportunity to discuss your experience of the research process, so I can understand what you think worked well and any suggestions you have on how things could be improved. You will be given a **£15 Love2Shop voucher for completing this interview** to compensate you for your time.

December (2021): Findings workshop

During this final stage of the project, **you will be sent a summary of the findings from the workshops**. We will run a separate findings workshop to chat more about this, make sure that everyone is happy and agree any changes. This will be a chance

to meet the mums participating in other groups. This workshop might be opened up to a wider group of women who are single parents on low incomes so that they can hear about the project and share their thoughts. You will not be expected to do anything you are not comfortable doing (e.g. presenting) – just to come along if you can.

January (2021): Stakeholder event

At the end of the project, there will be an event to showcase what we have done in the workshops to people working in the NHS as well as national and local community organisations. This will be a chance to celebrate our work and discuss what should happen next. As above, no one will be under any pressure to do anything they do not feel comfortable with, and whilst it would be great if you could join us, attendance is not mandatory.

Depending on what you are interested in, there will be **opportunities for you to get involved in different parts of the research process** including writing vignettes, illustrating, writing or recording a blog/vlog, helping to analyse the group discussions and planning/running the findings workshop. There is however **no expectation that you do any of these things** – only that you come along to the workshops each week and share your thoughts! I also hope that workshops create an opportunity for you to connect with other women with shared or similar experiences in the local area.

Why have you been invited to take part?

Involving people with lived experience in projects and services greatly improves how effective they are. I want to understand how mental health support can be improved for women who are single parents on low incomes. To do this, it is crucial that I draw on the knowledge and insights of women who have experience of this first-hand. To protect your safety and wellbeing, it is important that you are not currently seeking treatment for mental health issues. It is also important that you are not in what is defined as the 'prenatal' or 'perinatal period' i.e. that you are not pregnant or have a child that is younger than 18 months old.

What are the potential risks to you in taking part?

Your safety and wellbeing is a priority, so all potential risks have been considered carefully. As we are going to be discussing mental health issues, there is a chance that discussions may trigger negative or difficult emotions. Other potential risks are that you feel offended by the words or actions of another participant in the group or feel that you have overshared information about yourself. We will be creating a group agreement at the start of the project with the aim of creating a supportive environment; you do not need to share anything about your personal experiences and can take a break or leave the session at any time. I am experienced in conducting focus groups on sensitive topics and will make sure you are happy to continue, offer the option of a break, or else change the topic of discussion. I will also seek to make sure that you know where to access support if you need it from one of the organisations involved in the project. A range of measure are in place to make sure that what you share with me during the research process is treated confidentiality and that you are not identifiable when findings are reported; these are described below.

If you would like to raise any issues or concerns with me privately, you can do this during the focus group workshop using the Zoom chat function (we will go over this in the first session) or by emailing me after the session. Alternatively, you can flag issues anonymously within the survey at the end of each session; I will review all responses before the next session.

What information is being collected in the project?

I will be keeping your contact details and the information gathered through our initial discussion in a password locked file on the University cloud – this will be deleted as soon as the research project has finished. The workshops on Zoom will be video recorded and transcribed; I will be reflecting on the group discussion and the decisions made by the group. Your responses to the survey will be anonymous and will be gathered each week. I will be recording and transcribing the one-to-one interview to reflect on your experience of the research process. Finally, I will be taking notes on the findings workshop. You will be given a 'fake name' to protect your identity in the transcriptions and in reporting (you are welcome to choose this!) and all potentially identifiable information will be removed. You will also be offered the option of reviewing the early findings report and final PhD thesis and can request to remove anything you think might be identifiable.

Who will have access to the information?

It is important that the workshops are safe and private spaces – I will be encrypting each workshop with a password which only you and the other group members have access to. We will work together to create a 'group agreement' to set ground rules related to confidentiality (e.g., other people being in the room during a Zoom call). Equipment such as audio headsets will be available to prevent others from hearing group discussions. All information shared within focus groups will be treated as confidential. If you or another member of the group want to review the transcriptions, you will be sent this in a password-locked file and asked to delete it afterwards. The only time that confidentiality may not be maintained is if you reveal that you are at risk of harm (physical, psychological or other) or that there has been illegal activity. In this situation, I will discuss this with you first on a one-to-one basis after the focus group.

All interview recordings will be stored directly to my own computer and uploaded immediately onto the University cloud in a password locked folder that only I have access to.

Where will the information be stored and how long will it be kept for?

Recordings will be stored securely until they have been transcribed and will then be deleted. The transcriptions and questionnaire responses (anonymised) will be stored securely on the University cloud in a password locked folder. It is important to note that Zoom is GDPR compliant but does collect and store some user-generated information during calls. More information can be found about this here: https://zoom.us/privacy

The findings of this research project will be reported through an early findings report; you will receive a copy of this to look over, if you wish to, before the findings workshop. The findings will also form part of my PhD thesis which you will also be offered the opportunity to review if you wish to before this is circulated more widely. Findings might also be included in other publications like journal articles and summary reports once the PhD project has finished, so transcriptions will be stored for this purpose. Once it becomes clear that they are no longer needed, these files will be deleted or else after a maximum period of eight years following the completion of the project (this means deleting all data including any backup copies).

Thank you for reading this information – please ask any questions if you are unsure about what is written here.
Please also read our Privacy Notice for Research Participants.

What happens next?

If you are interested in taking part or have any questions about the project, please get in touch with Natalie by emailing natalie.dewison@strath.ac.uk and we can arrange a time to chat.

Researcher contact details:
Natalie Dewison | PhD Student
Centre for Health Policy
University of Strathclyde
Lord Hope Building,141 St James Road
Glasgow G4 0LT
Email: natalie.dewison@strath.ac.uk

Chief Investigator details:
Neil Quinn | Reader in Social Work
Centre for Health Policy
University of Strathclyde
Lord Hope Building,141 St James Road
Glasgow G4 0LT
Email: neil.quinn@strath.ac.uk
Tel: +44 (0)141 444 8652

This research was granted ethical approval by the Ethics Committee at the School of Social Work and Social Policy (SWSP).
If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the SWSP Ethics Committee
Lord Hope Building, 141 St James Road
University of Strathclyde
Glasgow G4 0LT

Email: hass-swsp-ethics@strath.ac.uk

Consent Form for women who are single parents on low incomes in Edinburgh

Name of department: School of Social Work and Social Policy
Title of the study: Improving mental health support for women who are single parents on low incomes in Edinburgh**.**

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
- I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
    - Personal information gathered through the initial one to one phone or Zoom call
    - video recordings of workshops and interviews that identify me;
    - audio recordings of workshops and interviews that identify me;
    - Any personal information gathered through the surveys that identifies me
- I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.
- I consent to being audio and/or video recorded as part of the project
- I consent to the material produced during focus group activities, for example, illustrations and mind maps, being included within the final thesis for this project and journal articles.

(PRINT NAME)	
Signature of Participant:	Date:

b. **Participant information sheet and consent form for peer support workers**

Participant Information Sheet for peer support workers in mental health services in Edinburgh.

Name of department: School of Social Work and Social Policy
Title of the study: The potential of 'task-sharing' in mental healthcare: Improving mental health support for women who are single parents on low incomes in Edinburgh**.**

Introduction

My name is Natalie Dewison and I am a PhD Student at the University of Strathclyde. I am interested in how people with lived experience can be better involved in the design and delivery of mental health services of Edinburgh. This is part of a wider project looking at how mental health support can be improved for women who are single parents on low incomes in Edinburgh. The project is funded by the University of Strathclyde, NHS Lothian and the Centre for Mental Health Innovation at the City University of New York (CUNY).
After reading this information sheet, if you have any questions or would like to find out more, please get in touch with me using my email address is natalie.dewison@strath.ac.uk and we can chat over email or arrange a time for a phone call.

What is the purpose of this research?

This research will look at:

- How people with lived experience can be involved in designing and providing mental health support in Edinburgh in ways that are enjoyable, meaningful and empowering
- How to make the most out of peer support services in mental health care
- How this might improve the mental health support for women who are single parents on low incomes in Edinburgh.

Do you have to take part?

No, participation in this project is **entirely voluntary**. After learning more about the project, you may decide that this is not for you and you do not need to do anything else. If you would like more information about the project before deciding whether you would like to take part, please get in touch using the email address above.
If you decide you do want to take part and later change your mind, **you have the right to withdraw from the project at any time.**

What will you do in the project?

If you decide you would like to take part in this project, you will be invited to join a focus group discussion with other peer support workers from Edinburgh. This will be conducted on Zoom and you will be sent a link and password beforehand. You will also be sent a copy of the questions that will be covered during the focus group so

you can reflect on these beforehand and three short video clips of peer work projects in other countries (I will be asking the group what your impressions were of these). The focus group will last for 90 minutes with a break halfway through. The format for this will be relaxed and informal - I hope that this will provide a supportive space for you to share and discuss your thoughts and ideas.

Why have you been invited to take part?

Involving people with lived experience in projects and services greatly improves how effective they are. I want to understand how this can be built on to improve mental health care in Edinburgh. To do this, it is crucial that I draw on the knowledge and insights of people who have first-hand experience of providing peer support. I want to understand more about what motivated you to become involved in peer support, what you enjoy and find challenging about your role and your views on the role of peer work services.

What are the potential risks to you in taking part?

Your safety and wellbeing is a priority, so all potential risks have been considered carefully. As we are going to be discussing the topic of mental health, there is a chance that discussions may trigger negative or difficult emotions. Other potential risks are that you feel offended by the words or actions of another participant in the group or feel that you have overshared information about yourself. For focus group interviews, we will be creating a group agreement at the start of the session with the aim of creating a respectful and supportive environment for discussion; you do not need to share anything about your personal experiences and can take a break or leave the session at any time. I am experienced in conducting focus groups on sensitive topics and will make sure you are happy to continue, offer the option of a break, or else change the topic of discussion. I will also seek to make sure that you know where to access support if you feel that you need it from one of the organisations involved in the project. A range of measures are in place to make sure that what you share with me during the research process is treated confidentiality and that you are not identifiable when findings are reported; these are described below. If you have any issues or concerns, you can raise these with me at any time during the interview. You can do this privately during a focus group interview by using the Zoom chat function (we will go over before starting the session). Alternatively, you can email me after the session at natalie.dewison@strath.ac.uk .

What information is being collected in the project?

I will be keeping your contact details in a password locked file on the University cloud – these will be deleted as soon as the research project has finished. Interviews conducted on Zoom will be video recorded and transcribed so that I can reflect on our individual or group discussion. I will also be recording sessions using a physical recording device as a backup.

Who will have access to the information?

It is important that the focus groups are safe and private spaces – I will be encrypting each workshop with a password which only you and the other participants have access to. All participants will be asked to join the call from a private, safe space. I will be confirming with all focus group participants that this is the case before the beginning the session. Where necessary, participants will be asked to use earphones/headphones to protect the confidentiality of others in the group. All

information shared during an interview will be treated as confidential and this will be discussed and agreed with all focus group participants at the beginning of sessions. The only time that confidentiality may not be maintained is if you reveal that you are at risk of harm (physical, psychological or other) or that there has been illegal activity. In this situation, wherever possible, I will discuss this with you first privately on a one-to-one basis.

All interview recordings will be stored directly to my own computer and uploaded immediately onto the University cloud in a password locked folder that only I have access to.

Where will the information be stored and how long will it be kept for?

It is important to note that Zoom is GDPR compliant but does collect and store some user-generated information during calls. More information can be found about this here: https://zoom.us/privacy

Recordings will be stored securely until they have been transcribed and will then be deleted. The transcriptions (anonymised) will be stored securely on the University cloud in a password locked folder. Once it becomes clear that they are no longer needed, these files will be deleted or else after a maximum period of eight years following the completion of the project (this means deleting all data including any backup copies).

The findings of this research project will be reported through an early findings report and will also form part of my PhD thesis which you will also be offered the opportunity to review if you wish to and request to remove any information you think might be identifiable. Findings might also be included in other publications like journal articles and summary reports once the PhD project has finished, so transcriptions will be stored for this purpose. You will be referred to as 'Peer Support Worker, Edinburgh' in reporting to protect your identity unless you have a preferred title or feel concerned that this may identify you and we can agree an alternative option.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

Please also read our Privacy Notice for Research Participants.

What happens next?

If you are interested in taking part or have any questions about the project, please get in touch with Natalie by emailing natalie.dewison@strath.ac.uk and we can arrange a time to chat.

Researcher contact details:
Natalie Dewison | PhD Student
Centre for Health Policy
University of Strathclyde
Lord Hope Building,141 St James Road
Glasgow G4 0LT
Email: natalie.dewison@strath.ac.uk

Chief Investigator details:

Neil Quinn | Reader in Social Work
Centre for Health Policy
University of Strathclyde
Lord Hope Building,141 St James Road
Glasgow G4 0LT
Email: neil.quinn@strath.ac.uk
Tel: +44 (0)141 444 8652

This research was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde
Graham Hills Building
50 George Street
Glasgow
G1 1QE
Telephone: 0141 548 3707
Email: ethics@strath.ac.uk

Consent Form for peer support workers in Edinburgh

Name of department: School of Social Work and Social Policy
Title of the study: The potential of 'task-sharing' in mental health care: Improving mental health support for women who are single parents on low incomes in Edinburgh**.**

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
- I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
    - contact details
    - video recordings of workshops and interviews that identify me;
    - audio recordings of workshops and interviews that identify me;
- I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.
- I consent to being audio and/or video recorded as part of the project
- I consent to being referred to as 'peer support worker, Edinburgh' in reporting OR [insert alternative title]

(PRINT NAME)	
Signature of Participant:	Date:

c. Participant information sheet and consent form for wider stakeholders

Participant Information Sheet for wider stakeholders in mental health services in Edinburgh.

Name of department: School of Social Work and Social Policy
Title of the study: The potential of 'task-sharing' in mental healthcare: Improving mental health support for women who are single parents on low incomes in Edinburgh**.**

Introduction

My name is Natalie Dewison and I am a PhD Student at the University of Strathclyde. I am interested in 'task sharing' i.e., how people with lived experience can be better involved in the design and delivery of mental health services of Edinburgh. I am particularly interested in how mental health support can be improved for women who are single parents on low incomes in Edinburgh. The project is funded by the University of Strathclyde and is part of a strategic partnership between NHS Lothian and the Centre for Mental Health Innovation at the City University of New York (CUNY).

After reading this information sheet, if you have any questions or would like to find out more, please get in touch with me using my email address is natalie.dewison@strath.ac.uk and we can chat over email or arrange a time for a phone call.

What is the purpose of this research?

This research will look at:

- How people with lived experience can be involved in designing and providing mental health support in Edinburgh in ways that are enjoyable, meaningful and empowering
- How to make the most out of peer support services in mental health care
- How this might improve the mental health support for women who are single parents on low incomes in Edinburgh
- What the broader implications are for the health and social care workforce and mental health policy strategies

Do you have to take part?

No, participation in this project is **entirely voluntary**. After learning more about the project, you may decide that this is not for you and you do not need to do anything else. If you would like more information about the project before deciding whether you would like to take part, please get in touch using the email address above.

If you decide you do want to take part and later change your mind, **you have the right to withdraw from the project at any time.**

What will you do in the project?

If you decide you would like to take part in this project, you will be invited to join a focus group discussion with other people involved in providing mental health services in Edinburgh. This will be conducted on Zoom and you will be sent a link and password beforehand. You will also be sent a copy of the questions that will be covered during the focus group so you can reflect on these beforehand and three short video clips of peer work projects in other countries (I will be asking the group what your impressions were of these). The focus group will last for 90 minutes with a break halfway through. If you are unable to join the focus group discussion, you may be offered the option of an individual interview either on Zoom or over the phone lasting between 45 minutes -1 hour.

Why have you been invited to take part?

There is a wealth of research to show that involving people with lived experience of health issues in projects and services greatly improves how effective they are. I want to understand how this can be built on to strengthen mental health care in Edinburgh, particularly for women who are single parents on low incomes. To do this, it is crucial that I draw on the **professional knowledge and insights** of people who have **first-hand experience of designing, managing and/or directly providing mental health (or associated) services**. This research seeks to start a conversation about the opportunities and challenges presented by 'task sharing' in the Edinburgh context and the potential impact for the health and social care workforce.

What are the potential risks to you in taking part?

The safety and wellbeing of all participants involved in this research project is a priority, so all potential risks have been considered carefully. You are being asked to respond in a professional capacity and will not be expected to share personal information or experiences. You may feel concerned about expressing particular views and opinions in case colleagues or managers can trace this back to you. A number of measures will be put in place to ensure that interviews are confidential and findings are reported anonymously, including ensuring that all participants are in private spaces (or at least use headsets to ensure confidentiality for others). Please see answers to the questions below for further measures. You will also have the option of choosing the role title used within reporting, i.e. how identifiable this is. Another potential risk is that you feel upset or offended by the words or actions of another participant in a focus group. We will be outlining some group principles at the

start of the session with the aim of creating a supportive, respectful environment for discussion. I am experienced in conducting focus groups with a wide range of groups with different professional backgrounds and will make sure you are happy to continue, offer the option of a break, or else change the topic of discussion.
If you would like to raise any issues or concerns with me privately, you can do this during the focus group workshop using the Zoom chat function (we will go over this before we start) or by emailing me after the session.

What information is being collected in the project?

I will be keeping your contact details in a password locked folder on the University cloud, which only I have access to, until the project has finished. Individual or focus group interviews will be video recorded on Zoom and transcribed so that I can reflect on the group discussion. I will also be recording this using a physical recording device as a backup.

Who will have access to the information?

It is important that the focus groups are safe and private spaces – I will be encrypting each workshop with a password which only you and the other participants have access to. I will make sure before we start that everyone is safe to continue. All information shared within focus groups will be treated as confidentially.

The only time that confidentiality may not be maintained is if you reveal that you are at risk of harm (physical, psychological or other) or that there has been illegal activity. In this situation, wherever possible, I will discuss this with you first privately on a one-to-one basis.

All interview recordings will be stored directly to my own computer and uploaded immediately onto the University cloud in a password locked folder that only I have access to.

Where will the information be stored and how long will it be kept for?

It is important to note that Zoom is GDPR compliant but does collect and store some user-generated information during calls. More information can be found about this here: https://zoom.us/privacy

All recordings will be stored securely until they have been transcribed and will then be deleted. The transcriptions (anonymised) will be stored securely on the University cloud in a password locked folder. Once it becomes clear that they are no longer needed, these files will be deleted or else after a maximum period of eight years following the completion of the project (this means deleting all data including any backup copies). The findings of this research project will be reported through an early findings report and will also form part of my PhD thesis which you will also be offered

the opportunity to review if you wish to before this is circulated more widely. Findings might also be included in other publications like journal articles and summary reports once the PhD project has finished, so transcriptions will be stored for this purpose. You will be referred to as a non-identifiable title e.g. 'mental health professional, NHS Lothian' in reporting to protect your identity unless you feel that this may identify you and we can agree an alternative option – you may also prefer that we use your professional title.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

Please also read our Privacy Notice for Research Participants.

What happens next?

If you are interested in taking part or have any questions about the project, please get in touch with Natalie by emailing natalie.dewison@strath.ac.uk and we can arrange a time to chat.

Researcher contact details:
Natalie Dewison | PhD Student
Centre for Health Policy
University of Strathclyde
Lord Hope Building,141 St James Road
Glasgow G4 0LT
Email: natalie.dewison@strath.ac.uk

Chief Investigator details:
Neil Quinn | Reader in Social Work
Centre for Health Policy
University of Strathclyde
Lord Hope Building,141 St James Road
Glasgow G4 0LT
Email: neil.quinn@strath.ac.uk
Tel: +44 (0)141 444 8652

This research was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde
Graham Hills Building
50 George Street
Glasgow
G1 1QE

Telephone: 0141 548 3707
Email: ethics@strath.ac.uk

Consent Form for wider stakeholders

Name of department: School of Social Work and Social Policy
Title of the study: The potential of 'task-sharing' in mental health care': Improving mental health support for women who are single parents on low incomes in Edinburgh**.**

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
- I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
    - Personal information gathered
    - video recordings of individual or focus group interviews that identify me;
    - audio recordings of individual or focus group interviews that identify me;
- I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.
- I consent to being audio and/or video recorded as part of the project
- I consent to being referred to using a non-identifiable title [please state] **OR** I consent to using my full professional title [delete as appropriate]

(PRINT NAME)	
Signature of Participant:	Date:

APPENDIX 2: TOPIC GUIDES

a. Scoping interview topic guide for PAR participants

Pre-group, structured interview for PAR participants

Intro: During this discussion, I will be asking you some questions to make sure that this research project is right for you. I will also be asking a few questions to help me to understand what your interests are and what you would like to get out of the project.
Another important reason for having this initial discussion is to make sure that you feel clear about what is involved in the project and have everything you need to take part.
The information that I record in this form will be saved securely in a password locked folder in the Strathclyde University cloud and deleted once the project has been completed. If you do not end up participating in the project, this document and any other information already collected such as contact details, will be deleted immediately. You do not have to answer any questions you do not want to.

Part 1: Study criteria

Can you confirm that you are a single parent and you have experience of mental health issues?
To protect your safety and wellbeing, it is important that you are not currently experiencing mental health issues. **Can you confirm that you are not experiencing mental health issues at the moment or seeking treatment for this?**
We are focusing on mental healthcare for women after the perinatal period (from the point of pregnancy up until a child is 18 months old). **Can you confirm that you are not pregnant and do not have a child who is younger than 18 months old?**

This project involves meeting for weekly workshops on Zoom which will happen once a week and there will be four workshops in total**.** If you are unable to attend a workshop due to unforeseen circumstances (e.g. childcare/illness), this is no problem and you will be sent a summary of what has been discussed. **Can you confirm that you are able to commit to attending to four weekly workshops each lasting between 75-90 minutes?**

Part 2: Contact details and additional demographic information

In this section, I will be asking you for some contact details so that I can send you any resources and equipment you need for the workshops and so that I can send you links for Zoom.

We are asking each person in this study to provide the contact details of someone they trust that works at the organisation that referred you to the project. This is so we can get in touch with them if we have any concerns about your safety, for example if you were to let us know during focus groups that you were not safe. I will always discuss this with you privately before contacting anyone.

Finally, I will be asking for some demographic information to give us a sense of how representative our group is of the local population. Remember you can always say 'prefer not to answer' to any of these questions.

Name:
Postal address (for posting vouchers):
Email address: _____
Phone number: _____
Trusted contact name and work phone number: _____
Year of birth: _____
Ethnicity (i.e. White Scottish; White British; White Polish; Indian; Pakistani; Asian; Other…):
Relationship status (i.e. single, partner, cohabiting, divorced, married, civil partner, widowed):
Do you have any disabilities or health conditions that you would like me to be aware of before starting the project? If so, please include here:

Part 3: Focus group workshops

What days and times would work best for you for attending a workshop on Zoom?
We may wish to send you refreshments for the focus group sessions. **Do you have any dietary requirements or food allergies within your household?**

Would you like to choose the name that will be used for you in reporting (pseudonym)?

Part 4: Opportunities to apply or build skills

What interested you about this project? [Prompt for things you think you might enjoy and things you don't think you will enjoy as much]

Do you have any questions about the project?

Are there any skills you would like to apply or develop through the project?
Remember you are only expected to join the group and share your views – [

i.e. writing; illustrations; making a video; note taking; leading workshop; presenting; analysing the recordings]

Part 5: Equipment

Do you have access to a tablet, iPad, laptop or desktop PC?

What is the quality of the internet connection like where you will be joining the calls?

Do you have access to headphones to use for extra privacy during calls?

Have you used Zoom before for video calls?

How confident do you feel about using Zoom?

Do you require any assistive technologies to support you to take part in the focus groups on Zoom?

Do you have any other concerns about taking part?

b. Topic guide for interviews with peer support workers

Topic guide for peer support workers

This topic guide is for individual and focus group interviews with peer support workers within statutory and third sector mental health services.

Introduction: This research project is looking at the potential of ***'task-sharing' for mental health care,*** *i.e., how tasks that might have once been completed by medical or social work professionals can be shared with a wider range of people. Acknowledging how important and valuable peer work is in mental health care, I am particularly interested how people with lived experience can be better involved in the design of mental health services and how these are provided to people. I am keen to understand how task sharing might be able to improve the experiences of women who are single parents on low incomes in Edinburgh.*

*Within this interview, which should last approximately [****90 minutes if focus group or 45 minutes if individual interview]****, I am keen to learn more about your experience of being a peer support worker, the work that you do and your views on peer work services. You do not need to answer any questions you do not want to. If you need to pause or take a break at any time, just let me know.*

Section 1: Your role

Q1 Can I start by asking you a little bit about your peer support worker role(s)?

Follow-up questions/prompts:

- How would you describe your role(s)?
- Which organisation(s) are you based in?
- What are your main responsibilities?
- What types of people do you support?
- Is the role paid or unpaid?
- How many hours do you work per week?
- Would you describe your role(s) as flexible or do you work at set times?

Q2 Do [any of] you support any women who are single parents on low incomes? If NO, move on to section 2.

Follow-up questions/prompts:

- What do you think the biggest causes of mental health issues are for women in this group? [Prompt for examples]
- In your experience, what is important to consider when it comes to supporting women in this group?
- What have your experiences been of supporting this group?

Section 2: Your experience

In this section, I am interested to hear more about your experience of being a peer support worker…

Q3 What made you want to become a peer support worker(s)?

Follow-up questions/prompts:

- How did you find out about the role?

- What motivated you to become a peer support worker [or equivalent title]?
- Did [any of] you have any concerns about the role before you started?

Q3 How have you found the experience of being a peer support worker?

- What does being a 'peer support worker' [or equivalent role title] mean to you?
- What do you enjoy about the role?
- What is challenging about the role?
- Is the role what you expected it to be?
- Is there anything else that would improve your experience?

Section 3: Participatory approaches

Q5 Have you been involved in the organisation you work/volunteer for in any other ways?

Follow-up questions/prompts:

- Have you been involved in planning/designing services? If YES: In what ways? How did you find this?
- Have you been involved in decision-making through board meetings or committees? If YES: In what ways? How did you find this?
- Have you been involved in reviewing the effectiveness of services? IF YES: In what ways? How did you find this?
- IF NO: Have you been given the opportunity? Is this something you would have been interested in getting involved with?

Section 4: The role of peer work in mental health care…

Q6: *What qualities and skills are needed to be a peer support worker?*

Follow-up questions/prompts:

- What personal qualities are important to have to be a peer support worker? Why?
- Is there anything else that is important related to someone's background that is important to being a peer support worker?
- What skills are important for a peer support worker to have? Why?

Q7 *How important do you think peer support is in mental health services?*

Follow-up questions/prompts:

- What is the role of peer support workers in mental health services compared to mental health professionals?
- What type of organisations do you think should offer peer work services?

Section 4: Looking to the future

Q8 *How would you like to see peer support work develop in the future?*

Follow-up questions/prompts:

- How long would you like to be doing peer support work?
- How would you like to see your role(s) develop?
- Is there anything else you would like to do following your involvement in peer work, for example, a new or different career path?
- What do you think about the future of peer support work? How would you like to see it develop? Is there anything you think needs to change?

Q9 ***Before the interview, I asked you to watch three short videos about some projects running in other countries. What did you think about these?***
Follow-up questions/prompts:

- What was your impression of these projects?
- Is there anything specific you liked or did not like about the approaches?
- How relevant do you think these approaches were to your local area?

Q10 Finally, is there anything you think I should have asked but did not?
Natalie to sum up the main points made by the participant(s) to confirm understanding

[End of topic guide]

c. Topic guide for wider stakeholders

Topic guide for wider stakeholders (not including peer support workers)

This topic guide for interviews with wider stakeholders which includes local community organisations and NHS services that deliver peer work services. There is a separate topic guide for interviews with people in peer support worker roles.

Intro: This research project is looking at the potential of ***'task-sharing' for mental health care****; 'task sharing' refers to the reallocation of tasks within existing health workforce teams but also the involvement of people with lived experience. I am particularly interested in the way that task sharing might be able to improve the experiences of women who are single parents on low incomes.*

Within this interview, which should last ***approximately [90 minutes for a focus group or 45 minutes for individual interview]****, I am keen to learn more about your organisation and understand your perspective on what matters in the provision of mental health support in Edinburgh. I would also like to hear your thoughts on the potential of 'task sharing' in mental health care and how you see mental health services developing in the future. If you need to pause or take a break at any time, just let me know. Do you have any questions before we start?*

Section 1: Nature of organisation and existing mental healthcare provision

Q1 Can I start by asking you a little bit about your role(s) and your organisation(s)?

Follow-up questions/prompts:

- Where is the organisation based and what is the geographical area covered by services?
- What is the nature of the client groups supported by the organisation?
- What type of services are offered?
- What is the scale and scope of the organisation (i.e. staffing structure; number of clients supported at any one time)?
- What is your role within the organisation?

Q2 In what ways do women who are single parents on low incomes with mental health issues engage with your services? If there is no engagement with this population group, skip to Section 2.

Follow-up questions/prompts:

- Do you have any specific services or programmes aimed at people from this group? If not, does your organisation collaborate with any other organisations that do deliver tailored interventions?
- [If relevant] which services would you say a used most frequently by women from this group?

Q3 What would you say are the main triggers of mental health issues for women who are single parents on low incomes in Edinburgh?

Follow-up questions/prompts:

- What do you think the biggest causes of mental health issues are for women in this group? [Prompt for examples]
- Are there any other factors to consider in understanding the range of potential mental health support needs of this group?

Q4 What do you think works well when it comes to providing mental health support for women who are single parents on low incomes?

Follow-up questions/prompts:

- What is important in terms of the support available and why?
- How available is this support?
- What is important in terms of the way that support is delivered and why?
- Are these factors specific to this population group or do they have broader relevance?

Q5 What kind of things do not tend to work well when it comes to providing mental health support for women who are single parents on low incomes?

Follow-up questions/prompts:

- Why do you think these things are not effective?
- Are the reasons outlined specific to this group or do they have broader relevance?
- Do the factors outlined present any operational challenges when it comes to providing services?

Section 2: Participatory approaches

Q5 Have communities been involved in the design and implementation of services within your organisation?

Follow-up questions/prompts:

If **yes**:

- Which type of services?
- In what ways have communities been involved i.e. specific activities?
- What was the reason for this involvement?
- How well do you think that this has worked? What have the challenges been?
- What impact (if any) has this made?

If **no**:

- Are there reasons why communities have not been involved?
- Is this something that might be considered in the future?

Section 3: The role of peer work in mental health care

Q6: ***Is peer support currently part of the services provided by your organisation?***

If **yes**:

Follow-up questions/prompts:

- What is the nature of this support? Who are the beneficiaries of the peer support service?
- What is the background of people providing peer support? Are they from the community? How are they recruited?
- What do you look for when recruiting a peer worker? Why does these things matter?
- What specific functions do peer workers have? Are they 'volunteers' or 'employees'? Are they paid or unpaid? What do you think the functions of a peer worker should be?
- What are the benefits of delivering peer work services? What are the drawbacks or challenges of delivering peer work services?
- Do any peer workers in your (or a partner) organisation provide counselling support? If yes, can you tell me more about this? What training do they receive?

If **no**:

Follow-up questions/prompts:

- Do you think there could be a place for peer workers in your organisation?
- How would you describe the role of a peer worker in mental health care?
- Are there any barriers to involving peers in the delivery of services provided by your organisation?
- What would you say are the ideal 'qualities' of a peer worker?
- What do you think the functions of a peer worker should be?

Q7 ***What is the role of peer work in mental health service provision?***

Follow-up questions/prompts:

- How would you distinguish between the current role of medical professionals, mental health professionals and peer workers or other volunteers?
- What is the significance of peer work to women who are single parents on low incomes?
- Where do you think peer work should 'sit' in the service landscape? What type of organisations are suited to providing peer work services?

Section 4: Looking to the future

Q8 ***Before the interview, I asked you to watch three short videos summarising approaches to recruiting lay people elsewhere. What did you think about the approaches adopted?***

Follow-up questions/prompts:

- What did you think of these projects?
- How does this compare with the approaches taken in Edinburgh?
- How relevant were these projects to the Edinburgh/Scottish context?
- If you were going to draw inspiration for a new service, where would you look to?

Q9 ***How do you see mental health care developing over the next 5-10 years?***

Follow-up questions/prompts:

- How do you see the services your organisation provides developing over the next 5-10 years?
- More broadly speaking, how do you see mental health care developing in Scotland? What role will different sectors play (e.g. community based services, primary care services etc)? Is this the role you think they should play? Are there specific implications for women who are single parents on low incomes?
- What do you think about the on the Scottish Government's mental health policy agenda around involving people with lived experience? Or (if not familiar) the role of the Scottish Government/mental health policy more broadly?
- How do you see the roles of different care providers developing (e.g. medical professionals, support workers, volunteers, families…)? Is this the role you think providers should play? Are there specific implications for women who are single parents on low incomes?

Q10 Finally, is there anything you think I should have asked but did not?

Natalie to sum up the main points made by the participant to confirm understanding

[End of topic guide]

APPENDIX 3: OTHER RESEARCH MATERIALS

a. Outline of workshop with PAR participants

Initial, detailed outline for fieldwork stage 2
1. Pre-group phase (November 2021)
Recruitment
All prospective participants will be sent an information video explaining about the project and a project information sheet. The 6 participants interviewed at the scoping stage and expressed an interest will be contacted directly with this information and asked if they would still like to participate. Wider stakeholders at [names of organisations removed] will support the recruitment of another 6-10 participants. Having four separate groups with fewer participants (3-4 in each) should help to open the project up to a wider range of experiences and address concern raised in scoping interviews about joining a large group of people participants did not already know.
One-to-one, pre-group check-in
One-to-one telephone/Zoom calls with each of the 12-16 focus group participants (approx. 10-20 minutes). **Objectives**: To introduce myself as PAR researcher to those participants I have not met. To go over the plan for the group phase and answer any questions; to gain verbal informed consent. This is also an important opportunity to get to know each participant, understand their motivations for participating and the skills they might like to develop or acquire; to identify any barriers to engagement/accessibility requirements; for participants to raise any concerns about the project.
Equipment testing
All participants will be invited to have a one-to-one test call with Natalie to go over the main functions of Zoom. This will include signing in and out of Zoom; muting their microphones; turning their video cameras on and off again; changing their name whilst in Zoom to their first name only or a pseudonym; using a background; typing in the chat function; using reactions e.g. 'thumbs up'. If possible, this will be done during the pre-group check-in. **Objectives**: Ensuring that participants feel able to use the main functions of Zoom prior to the first focus group session will be fundamental in providing participants with as much control as possible over how they engage with the research environment, including how much they share with others.
Pre-group exercise
Participants will be sent an information video about IPC and asked to begin thinking about any questions, thoughts, or reflections ahead of the first session. Participants will also be sent a detailed plan of the first session to look over beforehand and a link to the presentation slides. Participants will be encouraged to contact Natalie if they have any concerns or questions about the content that they would like to address before the focus group workshop. **Objectives:** This exercise is designed to ensure that the approach is accessible, that participants do not feel 'put on the spot' and have time to digest information prior to the focus group session. Watching the IPC information video beforehand should also give more time for group discussion without making sessions unnecessarily long.
2. Group-phase: Focus group workshops (November-December 2021)
Through weekly focus groups using a combination of ***activity-based questioning, projective techniques, group discussion and reflective practice****, the groups will building on the findings of the scoping research, explore the concepts and principles of IPC and discuss the potential role of peer work.*

Focus group 1 on Zoom - Introduction (90 minutes with break)
Research questions explored: Q1 How are mental health issues experienced by women who are single parents on low incomes and what are their perspectives on mental health support? Q2 How can communities influence the design of an Interpersonal Counselling (IPC) intervention in ways that feels meaningful and empowering?
Participants will each be provided with a pack (sent in the post) which includes a copy of the IPT manual so this can be reviewed and annotated, hard copies of the exercises covered and diaries. Outline of session: The session will start with informal introductions and Natalie will outline the research project and opportunities for participants to take more leading roles. Participants will have the opportunity to raise any concerns or questions before beginning the exercises. **Part 1**: Natalie will present the findings from the scoping research and discuss these with the group. The group will be asked to reflect on their own experiences of mental health issues and support (no obligation to share these) in relation to the findings of the scoping research, building on/claarifying the themes that emerged. Suggestions will be mapped freely on the whiteboard and then ranked collectively (facilitated by questioning from Natalie), creating priority list for formal and informal mental health support (i.e. what is important and where are the gaps?). What is the role of peer work? **Part 2**: During this session, Natalie will also introduce the concept of IPC and discuss the information video, answering any questions (or recording these to take to the advisory group) and having an open discussion about initial impressions of the approach. If we run out of time, part 2 will become part 1 of focus group 2. Natalie summarises main discussion points for the session and puts this back to the group to discuss, correcting any misunderstandings/adding anything that might have been missed. The group discuss the setup up for recording any reflections.

Evaluative component: 5 minute survey for session 1	Reflective component
Close to the end of the session, Natalie will post a link to Qualtrics survey which includes a short number of closed and open-ended questions. The survey is an opportunity to provide feedback on the focus group session anonymously and to log technical issues. If participants do not require to do either of these things, they will not be required to fill out the survey.	Participants will be asked to reflect on the discussions throughout the week recording anything they would like to bring to the next session in whatever format is most convenient (quick note; voice note). Natalie will also keep a diary after each session. The aim of this exercise it to encourage self-reflection on the ideas discussed and the experience of the research process. Participants will not be expected to submit their reflections but can share these verbally at the beginning of focus group sessions if they wish to.
Focus group 2 on Zoom - Exploring IPC concepts and principles (90 minutes with break)	
Research questions explored: Q1 How are mental health issues experienced by women who are single parent on low incomes and what are their perspectives on mental health support? Q2 How can communities influence the design of an Interpersonal Counselling (IPC) intervention in ways that feels meaningful and empowering?	
Outline of session: The session starts with reflections on the previous week, however there is no obligation to share here. Participants are encouraged to share any thoughts and ideas including what they enjoyed/disliked about the session and anything they found challenging. The group will also review the whiteboard from the previous session to recap and to provide participants with an opportunity to add anything new. The group will then discuss the aims of session 2. **Part 1**: The group will discuss the core concepts and principles of IPC. This will cover the 'sick role', the terms 'symptom', 'stress', 'distress' and 'relapse' and the 'interpersonal inventory'. **Part 2:** The group will be asked about the structure of IPC. This will cover the length and duration of sessions, one-to-one format and how they feel about the option of face to face or over the phone. The group are encouraged to reflect on their own experience and refer back to the whiteboard. Natalie summarises the main discussion points for the session and puts this back to the group to discuss, correcting any misunderstandings/adding anything that might have been missed. The group is reminded to complete diary entries after the session.	
Evaluative component: Survey for session 2 (as above)	Reflective component: Reflections on session 2 (as above)
Focus group 3 on Zoom- Vignettes (90 minutes with breaks)	
Research questions explored: **Q1** How are mental health issues experienced by women who single parents on low incomes and what are their perspectives on mental health support? **Q2** How can communities influence the design of an Interpersonal Counselling (IPC) intervention in ways that feels meaningful and empowering?	
Outline of schedule: The session starts with reflections as described above and discuss the aims of session 3. **Part 1**: The group will be asked how they feel about the four focus areas and their relevance in addressing the challenges faced by single parents on low incomes, referring back to the whiteboard. **Part 2**: Using projective techniques, the group will be supported to create a vignettes for one or more of the focus areas, reflecting on their own experiences (whilst not having to share these) and referring back to the whiteboard. Natalie summarises the main discussion points for the session and puts this back to the group to discuss, correcting any misunderstandings/adding anything that might have been missed.	
Evaluative component: Survey for session 3 (as above)	Reflective component: Reflections on session 3 (as above)
Focus group workshop 4 on Zoom – the role of peer support (90 minutes with break)	

Research questions explored:

Q1 How are mental health issues experienced by women who are single parents on low incomes and what are their perspectives on mental health support?

Q2 How can communities influence the design of an Interpersonal Counselling (IPC) intervention in ways that feels meaningful and empowering?

Outline of schedule:

Following the same format of the previous sessions (reflections, exercises, summary and reflections), the group will focus on the delivery of IPC in the final session.

Part 1: The group will review the whiteboard from the previous three sessions.

Part 2: The group will be shown examples of projects involving peer support workers and, through group discussion, will be asked to consider the role of peer work in improving mental health support for single parents on low incomes. Returning to the whiteboard, participants will be asked what role there might be for peer support workers in IPC for single parents on low incomes. How would they feel about receiving counselling from a peer support worker? Is this something they would be interested in doing? What would be the motivations? What other roles might there be for peer workers Discussion points will be added to the whiteboard.

Part 3: Before the end of the last session, the group will reflect on the past four weeks, review the whiteboard, pulling out the main findings and draft some recommendations. Finally, we will consider anything that hasn't been addressed, potentially forming wider recommendations for future work. Would participants like to continue with the group for a different purpose (this can be picked up on again in the findings workshop)?

Evaluative component: Survey for session 4(as above)	Reflective component: Reflections on session 4 (as above)

3. Post-group phase (December 2021)

Follow-up interviews with participants (evaluative and reflective component)

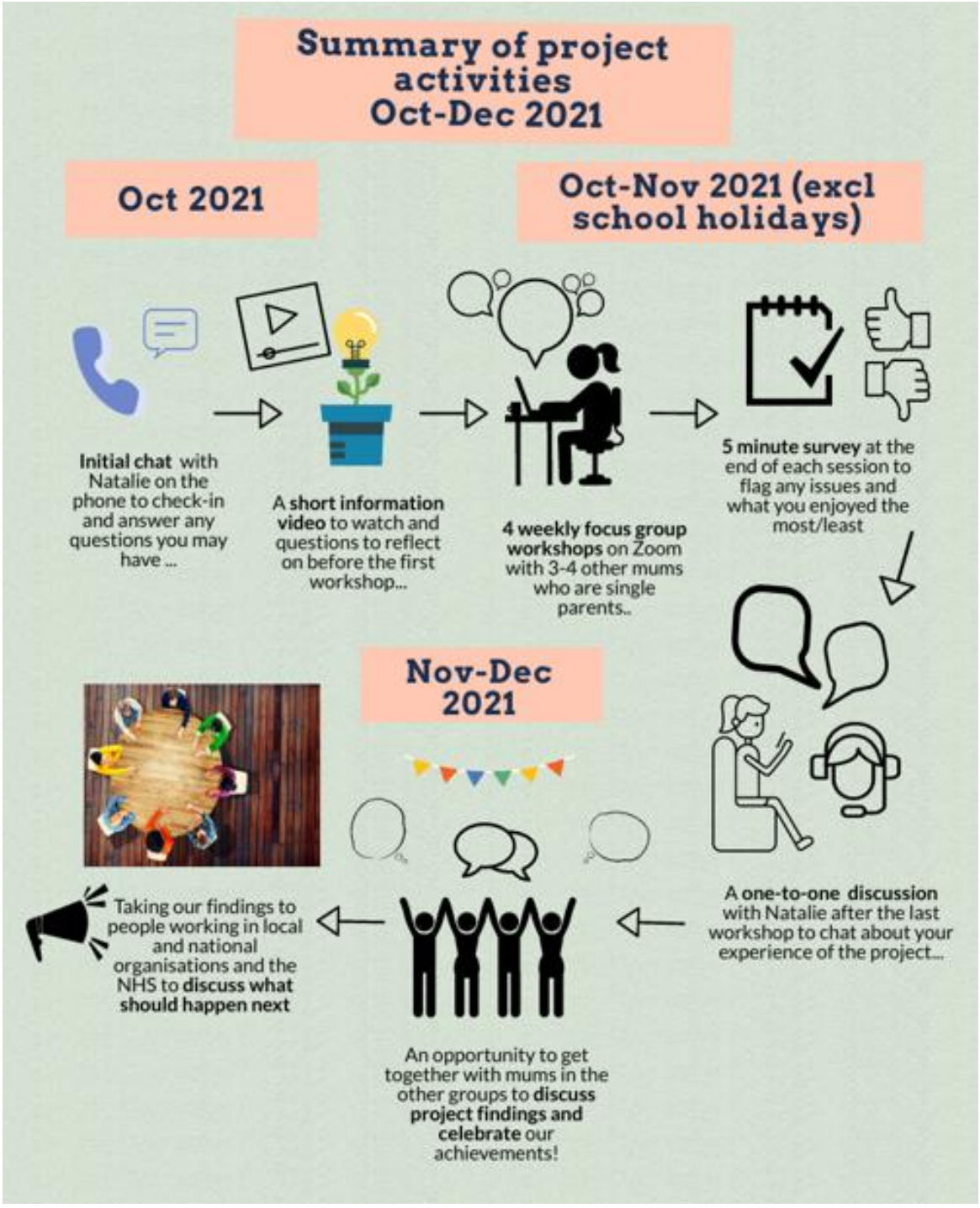
Main research question explored:

Q2. How can communities influence the design of an Interpersonal Counselling (IPC) intervention in ways that feels meaningful and empowering?

Outline of method: *Natalie will conduct one-to-one interviews with each of the participants via Zoom or over the phone about their experience of the research process. Participants will be encouraged to reflect on their diary entries prior to the interview.*

Findings workshop (Zoom or face to face)
Research questions explored: **Q1** How are mental health issues experienced by women who are single parents on low incomes and what are their perspectives on mental health support? **Q2** How can communities influence the design of an Interpersonal Counselling (IPC) intervention in ways that feels meaningful and empowering? **Q3.** According to women who are single parents on low incomes, what opportunities (if any) are there for 'peers' in an IPC intervention? **Q4.** What are the implications of collective approaches for women who are single parents on low incomes, professionals and wider communities?
Aim of workshop: As it is unlikely that all findings will be developed during focus group sessions, this will be an opportunity to present initial findings for review and validation by participants. It will also provide an opportunity for focus group participants to meet other mums involved in different groups and share the story of their involvement. There will also be an opportunity to discuss and plan the stakeholder event and identify anyone who is keen to get involved with the running of the event. Format for workshop: This is likely to involve a combination of presentations and breakout discussions. This may be opened up to a wider group of women who are single parents on low incomes in order to test the wider applicability of findings. This will also provide an opportunity to thank participants for their work. Given the potential risk of 'Zoom fatigue' and the fact that the workshop will be later in the year (November/December 2021), if government guidelines permit and there is appetite for this amongst participants, this may be conducted in person at a local venue. This would also provide an opportunity for participants from the 'group-phase' to meet each other in person. If the former option is possible, all health and safety guidelines provided by the Scottish Government related to COVID will be adhered to in the design and planning of the event. If developments with COVID render this unsafe, this will be conducted remotely on Zoom.
Stakeholder event (TBC)
Research questions explored: **Q1** How are mental health issues experienced by women who are single parents on low incomes and what are their perspectives on mental health support? **Q2** How can communities influence the design of an Interpersonal Counselling (IPC) intervention in ways that feels meaningful and empowering? **Q3.** According to women who are single parents on low incomes, what opportunities (if any) are there for 'peers' in an IPC intervention? **Q4.** What are the implications of collective approaches for women who are single parents on low incomes, professionals and wider communities?
Aim of workshop: This event will be an opportunity to present the research findings to wider stakeholders involved in the research and acknowledge the achievement of participants. It will also provide an opportunity to consider the implications of the findings and next steps for the project. Focus group participants will be encouraged to take leading roles in the planning and running of the event if they wish to do so. Format for workshop: This is likely to involve a combination of presentations and breakout discussions using a 'world café' approach. Given the potential risk of 'Zoom fatigue' and the fact that the workshop will be later in the year (November/December 2021), if government guidelines permit and there is appetite for this amongst participants, this may be conducted in person at a local venue. If the former option is possible, all health and safety guidelines provided by the Scottish Government related to COVID will be adhered to in the design and planning of the event. If developments with COVID render this unsafe, this will be conducted remotely on Zoom.

b. Summary of feedback & changes sent to PAR participants



Thank you for taking the time to chat with me last month. Your feedback on the plan for the next part of the research project was really helpful. I have included some detail below outlining exactly how your feedback has shaped what we will be doing…

Summary of feedback and what has changed

Feedback: Given how busy participants are likely to be, it might be difficult to make it to eight weekly focus groups. It would be easier to join a Zoom call than travelling to a venue/finding childcare.
The number of focus groups will be reduced from eight to four weekly focus groups which will all be on Zoom. Participants will only be asked to reflect between sessions – there will be no worksheets or additional exercises.

Feedback: Joining a large focus group could be intimidating, especially if you are going to be expected to talk about personal experiences.
It is very important that focus groups feel relaxed and supportive. The group size will therefore now be limited to three-four participants. Exercises in the focus groups have been designed so that you are only expected to share your opinion rather than personal experience (unless of course you would like to).

Feedback: Whilst there are common challenges experienced by single parents, these can vary depending on things like the age of children, the nature of support networks and job/housing security. Some participants prefer to use other terms like 'lone' or 'sole' parent.
It will be important to increase the number of participants in the research project to make sure there are a range of perspectives. The number of groups running each week will therefore be increased from one larger group to four smaller groups. People have mixed feelings about the term 'single parent' and this will be acknowledged and respected throughout the research process. We can chat about this topic more as a group in the first session.

Feedback: Some participants felt it would be easier to attend focus groups in the daytime during nursery or school hours, whilst others said that evenings would be better after work/when little ones are in bed.
There will now be groups running in the daytime and evening to try and make it as convenient as possible for all participants to attend.

Feedback: All participants wanted to get involved in the next stage of the project. The main reasons given for this was that this was an opportunity to do something that could raise awareness, make a positive change, and help other mums.
More time has been allocated to discussing what should happen with the findings and resources produced during the group workshops.

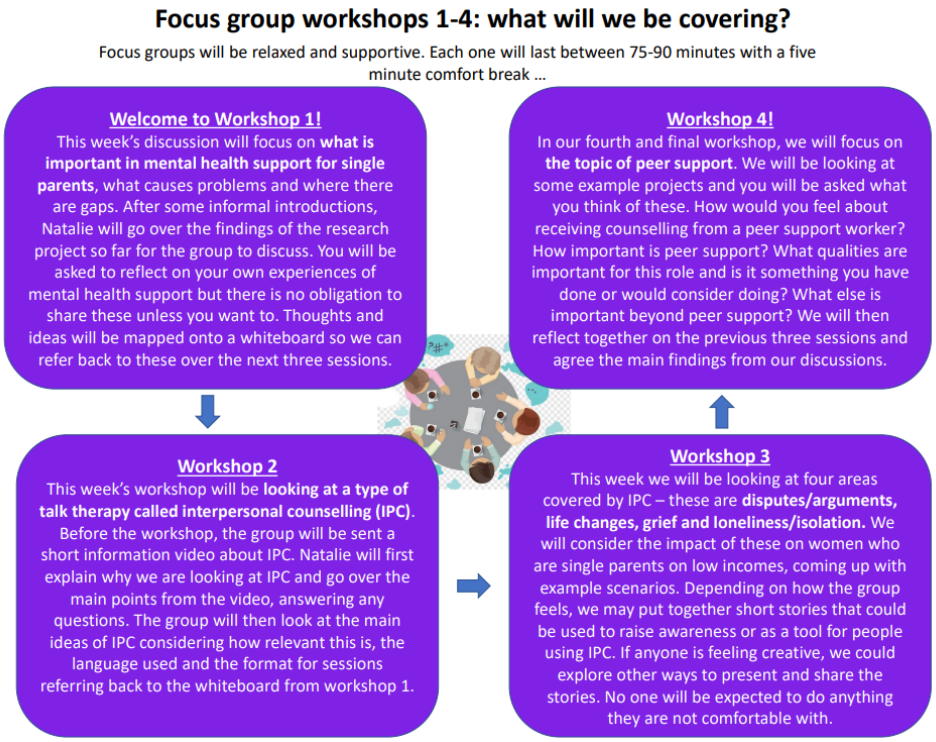
Feedback: There was some concern that participants would be under pressure to do things like present at the findings workshop at the end of the project.

It is very important that the research process is enjoyable- nobody will be expected to present or do anything they are not comfortable with. The findings workshop will now only involve the participants from the various groups and may be opened up to other mums living in Edinburgh. This will be a chance to look over and discuss the early findings gathered from all the groups together in a relaxed way and to celebrate our achievements. There will be a separate event that involves people working in the NHS and other organisations. All participants will be invited to get involved with the planning and running of this event, but this is entirely optional.

Feedback: Whilst the vouchers may not be the main reason for taking part – there was agreement that this was a bonus.

All participants will be compensated for their time and efforts through Love2shop vouchers. These will be provided for each focus group and for the follow-up interview.

c. Final outline for workshops (sent to participants)



d. Transcription protocol (see following page)

TRANSCRIPTION PROTOCOL	
Setup	
Recording and storage	Interviews and focus groups are to be conducted and recorded on Zoom and settings adjusted to ensure that audio and video files are to be saved directly to the researcher's computer in a password locked folder in the University cloud. A physical, digital recording device will also be used for back up purposes. This is to be saved separately to the main recording in a password locked file on the researcher's external hard drive.
Scheduling	It is suggested that it can take between 3-10 hours to transcribe a 1-hour recording. This is to be accounted for in project planning, ensuring that transcription activities are appropriately spread out to minimise the risk of mistakes and burnout.
Identification system	
Coding interviews and focus groups	Interviews with stakeholders will be coded as SHI1 (stakeholder Interview 1 to indicate the first interview); SHI2 Stakeholder Interview 2 (to indicate the second) etc. **OR** SHFG1; SHFG2 etc. (Stakeholder Focus Group 1; Stakeholder Focus Group 2). Interviews with peer support workers will be coded as PSWI1 (Peer Support Worker Interview 1 to indicate the first interview); PSWI2 (to indicate the second etc. OR PSWFG1 (Peer Support Worker Focus Group 1); PSWFG2 etc. Focus groups with women who are single parents on low incomes will be coded as PARFG1 (Participatory Action Research Focus Group 1); PARFG2 etc. Follow-up interviews with PARFG participants will be coded as PARFUI1 (Participatory Action Research Follow-up Interview 1); PARFUI2 etc.

Coding for participants	Participants will be given a unique three-digit code which will follow the code for the interview or focus group within transcripts marked by a single hyphen. *Example*: '#SHFG1-109#: I am not sure I would agree with that. #SHFG1-107#: Yeah, me neither to be honest.' Having the same three-digit code for each participant will support comparative analysis across transcripts and associated documents. It is imperative that the coding system for participants including contact details, codes and pseudonyms is stored in a different location to the transcriptions; this will therefore be saved in a separate, password encrypted folder on the University cloud.
Coding for interviewer/facilitator	The label used for the facilitator throughout will be '#Facilitator#'.
Coding for other methods and documentation	Data gathered through surveys is likely to be anonymous. However, if the participant wishes to be identified, their unique three-digit code will be used to support cross-comparison. The same coding system will also be applied to any data gathered through asynchronous activities and event notes from the findings workshop.
Formatting	
Text	Written text will be in the font Times New Roman, size 11, double spaced and the margin will be set at 'align left'.
Headers and footers	Headers will include the code of the interview or focus group for ease of reference. Footers will include page numbers in relation to the document as a whole i.e. 'Page 1 of 18'
Format for verbatim content	The transcription style will be linear and interviewer interventions are to be written in bold
Start and end of interviews and focus groups	The start and end will be indicated in upper case letters within the transcription. *Example*: START OF INTERVIEW. END OF INTERVIEW.
Verbatim content	
Transcription style	The style adopted will be 'naturalised' meaning that interviews and focus group

	recordings will be transcribed in full. This includes repeated words, abbreviations and 'filler' words.
Personal/sensitive information	Where personal information is shared that could be identifiable (i.e. a name, address, job title), this will be omitted and replaced with 'sensitive information removed' in square brackets *Example*: 'I actually live very close by on [sensitive information removed]' As the investigation is likely to cover sensitive topics, these will be left in the transcription unless a participant requests to withdraw this.
Intonation	Emphasis placed on particular words or phrases will be italicised. *Example*: Well, there were *fourteen* of them in total. Other features of speech will be noted in square brackets. *Example*: Well [slows down speech] there were *fourteen* of them in total.
Enunciations	Words and phrases are to be recorded as they are spoken including abbreviated and contracted forms and colloquial phrases. *Example*: I'm, didnae, wanna, coulda, would've, wouldn't, fae, oh aye, ya know
Interjections	Interjections or 'filler words' will be included in the transcription. *Example*: Um, ah, like, uhuh, hmm.
Pauses	Pauses will be indicated using three dots inside closed parentheses. *Example*: Well (*slows down speech*) there were fourteen of them (…) in total Pauses of more than 3-5 seconds will be recorded in writing. *Example*: Well [slows down speech] there were *fourteen* of them [longer pause] in total
Cut-off speech	Sentences or phrases that have been cut off will be recorded marked be a single hyphen.

	Example: Well [slows down speech] there were *fourteen*_– well, no actually I see where you are coming from (…)
Inaudible speech	If it is not possible to hear what is said, a word or phrase shall be replaced with [inaudible speech] in square brackets. *Example*: Well [slows down speech] there were *fourteen*_– well, [inaudible speech] I see where you are coming from (…) If a longer segment of the recording is inaudible this will be recorded in square brackets. *Example*: Well [slows down speech] there were *fourteen*_– well, [inaudible speech] I see where you are coming from [two minutes of interview missing]
Illegible speech	If it is not possible to understand what is said, a word or phrase shall be replaced with 'illegible speech' in square brackets. *Example*: Well [slows down speech] there were *fourteen* – well, [illegible speech] I see where you are coming from (…) If it is not completely clear what is said, this will be indicated with question marks and closed parentheses. *Example*: Well there were (?fourteen?) of them in total
Cross talk	Where multiple participants are talking at the same time this will be indicated by the phrase 'cross talk' in square brackets and will pick up with the next audible speaker. *Example*: E.g. Well [slows down speech] there were *fourteen*__– well, [cross talk] ##PARFG101##: I see where you are coming from (…)
Mispronunciations	Where it appears that a participant has mispronounced a word or phrase, an exact transcription of what was said will be followed by a proposal inside parenthesis marked by slashes.

	Example: They just end up procrasting /(procrastinating)/ and gettin' all frustrated at themselves
Nonverbal content	
Non-verbal sounds	Non-verbal sounds such as laughing, sighing, tutting, yawning and coughing will be recorded in parentheses. *Example:* (Eye roll) I won't be rushin' back tae it anyway (group laughter)
Visual bodily data	Physical expression such as nodding, head shaking, eye rolling, hand gesturing and other bodily expressions such as leaning forward or sitting back will be recorded in parentheses where it is felt to be 'expressive' i.e. adds meaning to what is being said or the interaction taking place between participants in focus groups. *Example*: #PARFG2-102#: I think it is pointless myself (…) they don't even deserve it. (#PARFG2-102# nods enthusiastically; #PARFG2-105# frowns and sits back) I mean why even bother? #PARFG102#: Hundred percent. If the participant's camera is turned off this will also be noted in closed parentheses immediately after the participant code. *Example*: #PARFG2-102#(camera off): I think it is pointless myself (…)
Background noises	As the method used within this project is being evaluated, background noises which might impact or distract participants provide useful data, for example white noise, sirens or a baby crying. This will be noted in closed parentheses. *Example*: #PARFG2-102#: I think it is pointless myself (sirens) [longer pause] they don't even deserve it. Background conversations and interactions will be treated as confidential and will not be recorded.

Review	
Editing	Recording should be listened to a minimum of two times and the notes should be checked for accuracy
External review	Ideally, it is recommended that someone else who is familiar with the project and transcription protocol review a recoding and transcript to check for accuracy (may not be possible in this study?)
Data management	
Data storage	Transcription files will be stored securely on the researcher's personal, password encrypted folder on the Strathclyde University cloud system. One the project comes to a close, the files will be moved to a new folder encrypted with a password on the researcher's personal OneDrive.
Data destruction	The transcription files will be stored securely for until dissemination activities have been completed and for a maximum period of eight years. After eight years, the files will be deleted.

e. Survey monitoring participant's experiences of workshops

End of session survey: your experience today

<u>Please note</u>: This questionnaire is for participants involved in the participatory action research (PAR) component of the project to be completed at the end of each focus group workshop. The questionnaire will be uploaded to Qualtrics, a user-friendly interface for online surveys; the University of Strathclyde has obtained a license for this software. Participants will be sent a link to the survey through the chat function in Zoom at the end of each session. The following is what will be uploaded to Qualtrics following discussions with the advisory group.**

How long will this take?

It should only take around **five minutes** to fill out these questions. We will be doing this at the end of each session. If you need to leave early or get cut off from the session due to technical or connection issues, you will be sent a link to the survey either by email or text which you can fill out in your own time.

Why am I being asked to fill this in?

Gathering your views and experiences helps me to make sure that:

- Your experience of taking part in this research project is as **supportive, enjoyable and engaging** as possible.
- You feel able to take advantage of all of the **opportunities** available within this research project.
- You have a space to **raise any concerns or flag issues** anonymously.

What will you do with my answers?

This survey is **anonymous** meaning that I will not know who has filled out questions unless you provide information that identifies you.
Your responses will be saved securely to the Strathclyde University cloud in a secure file and only I will have access to these.

I will be looking at the responses **every week** to help shape the next focus group session and make sure that any issues raised are appropriately addressed. I will also look at **these at the end of the research project** as I reflect on the overall process, for example, how often people experienced technical issues and whether views and experiences changed over time.

If you have any questions or concerns about this survey, please speak to Natalie before filling it in. If you encounter any issues filling in questions outside of focus group sessions, please get in touch with Natalie via email at natalie.dewison@strath.ac.uk
[Click to proceed]

Your experience of the focus group session today

Q1 *Please select the focus group session you attended today (please select one option from the drop-down list below):*
Week 1 Week 2 Week 3 Week 4 Week 5 Week 6 Week 7 Week 8 Not sure [drop-down list]

Q2 (a) *How has the focus group left you feeling today (please select all that apply from the list below):*
Tired Relieved Excited Anxious Relaxed Thoughtful Stressed Frustrated Happy Bored Upset Supported Confident Embarrassed None of these Other [option to add]

Q2 (b) Which words do you think best describe the group environment today (please select all that apply)?
Friendly Awkward Supportive Intimidating New Comfortable Tense Relaxed Uncomfortable Exciting Motivating Draining None of these Other [Option to add]

Q3 *How did you find the pace of today's session i.e. how quickly we moved through activities and discussion? Please drag the pointer below to indicate how you found the pace.*
X----------X----------X
Too slow Just right Too fast

Q4 *Which, if any, of the following statements represent your experience of the focus group today (please select all that apply)?*
I **felt able** to contribute my thoughts and/or ideas if I wanted to
I **wanted** to contribute my thoughts and/or ideas but **did not** feel able to
I felt pressure to share my thoughts/or ideas and I am **glad I did**
I felt pressure to share my thoughts/or ideas and I now **regret** it
None of these apply to me

Q5 a) *In the next focus group session, would you like… (please select one option):*
(i) More time spent on activities; the same amount of time spent on activities; less time spent on activities
(ii) More time spent for group discussion; the same amount of time for group discussion; less time spent on group discussion
(iii) More breaks; fewer breaks; the breaks were fine; longer breaks; shorter breaks
b) [Optional] Do you have any other suggestions for next week: [Open question]

Q6 (a) *Please select any of the issues listed below if you experienced these during today's session:*
I lost internet connection

There were delays when people spoke
I could not use my camera because of slow internet connection
I had issues with the audio/ I could not hear people properly
I did not feel able to use some of the functions of Zoom
I did not experience any technical issues
Other [open answer: please describe the technical issue you experienced today]

Q6 (b) *The open text box below is there for you to raise any other issues or concerns about today's session. This might be feeling unsafe or offended by something that was said during group discussions or any other issue that impacted your experience. If you would like to be identified, please include your name. If not, remember not to include information such as names and specific quotes.*
[Open text box] [Option to Skip]

[End of Survey]

Thank you for taking the time to fill in these questions! Remember that you can always contact Natalie directly (natalie.dewison@strath.ac.uk) if you have any questions or concerns