Competency-based training and supervision: development of the WHO-UNICEF Ensuring Quality in Psychosocial and Mental Health Care (EQUIP) initiative

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Globally, there has not been a standardised approach to ensure that the growing number of people who are not licensed clinicians but are delivering psychological interventions and mental health services have the competencies to deliver those interventions and services safely. Therefore, WHO and UNICEF developed Ensuring Quality in Psychosocial and Mental Health Care (EQUIP). EQUIP is a free resource with a digital platform that can be used to guide competency assessment. We describe EQUIP's 5-year development (2018–23) and the rationale supporting its contents and use. Development phases included establishing consensus for competency-based strategies; selecting foundational competencies; evaluating feasibility of assessments, role plays, and technology; piloting EQUIP when training non-specialists; and public dissemination and ongoing adaptations to increase scalability. From the public launch in March, 2022, through to March, 2024, EQUIP's digital platform has been used in 794 training programmes in 36 countries with 3760 trainees resulting in 10 001 competency assessments.

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Introduction

The current mental health-care workforce cannot meet the treatment and prevention needs of the global population.[1–3] To address this workforce shortage, national policies and international guidelines are calling for services to be delivered by people who are not licensed mental health clinicians.[3–7] Low-income and middle-income countries (LMICs), which have scarce access to specialist services, are particularly dependent upon non-specialists through task-sharing approaches,[8,9] and high-income countries are increasingly involving non-specialists to address service gaps and health system inequities.[10–13] In all countries, non-specialists are needed in education, child protection, and health sectors to address dire workforce shortages for child and adolescent mental health.[14] Mental health-care responses to the COVID-19 pandemic also showed the crucial role of non-specialists.[15–20] An essential requirement for sustaining and expanding the non-specialist workforce is ensuring these providers have the competencies for safe delivery of services.

Competency refers to "the observable ability of a person, integrating knowledge, skills, and attitudes in their performance of tasks".[21] The WHO Global Competency and Outcomes Framework for Universal Health Coverage outlines key competencies to achieve the vision of worldwide equitable access to quality health services.[22] The UK's National Health Service Talking Therapies programme, formally known as Improving Access to Psychological Therapies (IAPT), has an extensive series of competency frameworks for clinicians delivering services for the treatment of depression and anxiety.[23] Similarly, the Global Social Service Workforce Alliance has established competency frameworks, including for paraprofessionals.[24] These frameworks and other initiatives have defined key competencies relevant for all mental health care and psychosocial support.[25,26] Despite these and numerous other competency frameworks, there is not a globally standardised approach for how to assess competency.

For licensed or nationally registered clinicians, professional organisations typically establish discipline-based competency standards with a means of verification, such as knowledge tests, hours of clinical services, and objective structured clinical evaluations. However, non-specialist task-sharing strategies frequently use short-duration courses (eg, 1–2 weeks) with varied approaches to training and supervision,[27] and there are few opportunities to assess if adequate competency is reached. In humanitarian emergencies, rapid training and deployment are especially important.[28–31] Therefore, a brief and scalable competency assessment approach is needed for the diversity of interventions, settings, and backgrounds of non-specialists being trained.

To address the need for standardised and scalable competency assessment, WHO and UNICEF initiated Ensuring Quality in Psychosocial and Mental Health Care (EQUIP) in 2018.[32] EQUIP is a suite of competency assessment tools to ensure non-specialist and specialist helpers provide safe, high-quality psychosocial support and mental health care. EQUIP provides freely available resources for standardised approaches to assess competencies and facilitate competency-based training and supervision. EQUIP offers a digital platform with online and offline functionality and paper-based resources, and it includes competencies for common factors in psychological services and competencies for different treatment classes (eg, behavioural activation, cognitive techniques, motivational enhancement). EQUIP is not limited to a single intervention, competency framework, or sector, and it is intended to complement a range of frameworks and interventions based on the needs of the population and services provided. EQUIP

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For more on the **EQUIP digital platform** see www.equipcompetency.org

See **Online** for appendix

can be integrated into training courses ranging from a few days[33,34] to multi-year pre-service curricula.[35,36]

Here, our goal is to describe the first 5 years of EQUIP development from 2018 through to 2023. This information is intended for governmental and non-governmental organisations (NGOs), training programme directors and staff, mental health researchers, and other cross-sectoral stakeholders. With this information, they can implement competency-based approaches to strengthen the mental health workforce and other workforces delivering psychosocial and other services to adults and children. EQUIP's development is described in five phases: (1) development of a framework for competency-based training and supervision; (2) development of competency assessment tools and associated materials; (3) adaption of materials based on experiences in diverse global settings; (4) piloting EQUIP resources when training non-specialists to deliver psychological interventions; and (5) dissemination of EQUIP resources and ongoing monitoring of use and implementation (table 1).

Phase one: development of a framework for competency-based training and supervision

Beginning in 2018, theory of change workshops and consultations were held to build consensus on the scope and contents of the EQUIP initiative. Theory of change workshops use a structured approach to develop an impact statement and short-term and long-term outcomes.[37,38] Workshops lasted 1–3 days, and participants included psychological intervention developers, mental health researchers, and trainers based in LMICs (appendix p 2). The consultations addressed what is needed to promote a competent mental health workforce of specialists and non-specialists, which strategies would be feasible in low-resource settings (eg, areas with inadequate health-care services, infrastructure, and related social resources, including LMICs, workforce shortage areas in high-income countries, and humanitarian emergency contexts), and what evidence is needed to adopt standardised competency assessment tools and evaluation strategies. The strategy was not to create a new competency framework but rather to draw upon competencies frequently used across frameworks and supported by research, so that the EQUIP initiative could develop feasible ways of assessing competencies that were observable in direct interactions with clients. The resulting EQUIP theory of change emphasised the need for assessment tools for common and treatment-specific factors, guidance on conducting structured role plays, and best practices for adapting training and

	Objectives	Methods	Timeline	Outputs and outcomes
Phase one: development of a framework for competency-based training and supervision	To build consensus on the rationale and resources needed for competency-based training	Theory of change workshops; human-centred design discovery workshops; consultations with academics and implementers	2018–19	Theory of change model
Phase two: development of competency assessment tools and associated materials	To select competencies and associated harmful or helpful behaviours that can be assessed through direct observation in standardised role plays and actual clinical sessions	Literature reviews; free-listing exercises; consultations with experts and user stakeholders	2018–20	11 tools: foundational helping skills for adults (Enhancing Assessment of Common Therapeutic Factors); foundational helping skills for children and adolescents (Working with Children Assessment of Competencies Tool); group facilitation skills (Group Facilitation Competency Assessment Tool); Problem Management Plus tool; Thinking Healthy Program tool; six treatment-specific tools
Phase three: adaption of materials based on experiences in diverse global settings	To adapt tools and materials for optimal feasibility and acceptability	Feasibility and acceptability testing of role plays in six global settings with cognitive interviewing, qualitative data collection, and inter-rater reliability testing	2019–21	Standardised role plays; translation and cultural adaptation guidelines for tools and role plays
Phase four: piloting EQUIP resources when training non-specialists to deliver psychological interventions	To establish feasibility and acceptability of EQUIP competency-based training, and explore the potential benefit of competency-based training with different competency levels of trainees	Pre-training and post-training competency assessments in six sites including two sites with formal comparison of standard training *vs* EQUIP training	2019–21	Data visual representations on the digital platform; instructions on giving competency-based feedback
Phase five: dissemination of EQUIP resources and ongoing monitoring of use and implementation	To simplify strategies and resources for global dissemination, with ongoing feedback and monitoring of platform usage for quality improvement	Dissemination; Qualtrics survey; global training programmes with feedback	2022, ongoing	Simplified role plays; Foundational Helping Skills curriculum; WHO manuals for competency-based training in Problem Management Plus and Self-Help Plus

EQUIP=Ensuring Quality in Psychosocial and Mental Health Care.

Table 1: **Phases and methods used for the development of the EQUIP initiative**

supervision into competency-based approaches (figure). Five design criteria were selected to develop the EQUIP materials with a focus on directly observable helpful and potentially harmful behaviours (panel 1). The goal was for trainers, supervisors, programme managers, and other staff to adopt a competency-based approach with EQUIP resources, regardless of the specific interventions used.

Phase two: development of competency assessment tools and associated materials

As a starting point, the EQUIP consortium focused on competencies related to the common factors in psychological services and mental health care. Common factors cut across diverse types of interventions and include elements such as client factors, models and techniques, therapeutic relationships, and therapist qualities.[39–42] Common factors are observable as foundational helping skills (eg, verbal and non-verbal communication skills, rapport building, empathy, collaborative goal setting, promoting hope), and they contribute to beneficial client outcomes for interventions delivered by non-specialists in low-resource settings.[27] Common factors are present in most competency frameworks for psychosocial and mental health services. The WHO Global Competency and Outcomes Framework for Universal Health Coverage includes the need to show compassion, empathy, and respect for all people and maintain an approach to communication that is characterised by calmness, respect, sensitivity, and tact.[22] The Global Social Service Workforce Alliance competencies mention the need to show cultural competency through the correct use of body language, greetings, and who is addressed first, and through identifying the need for

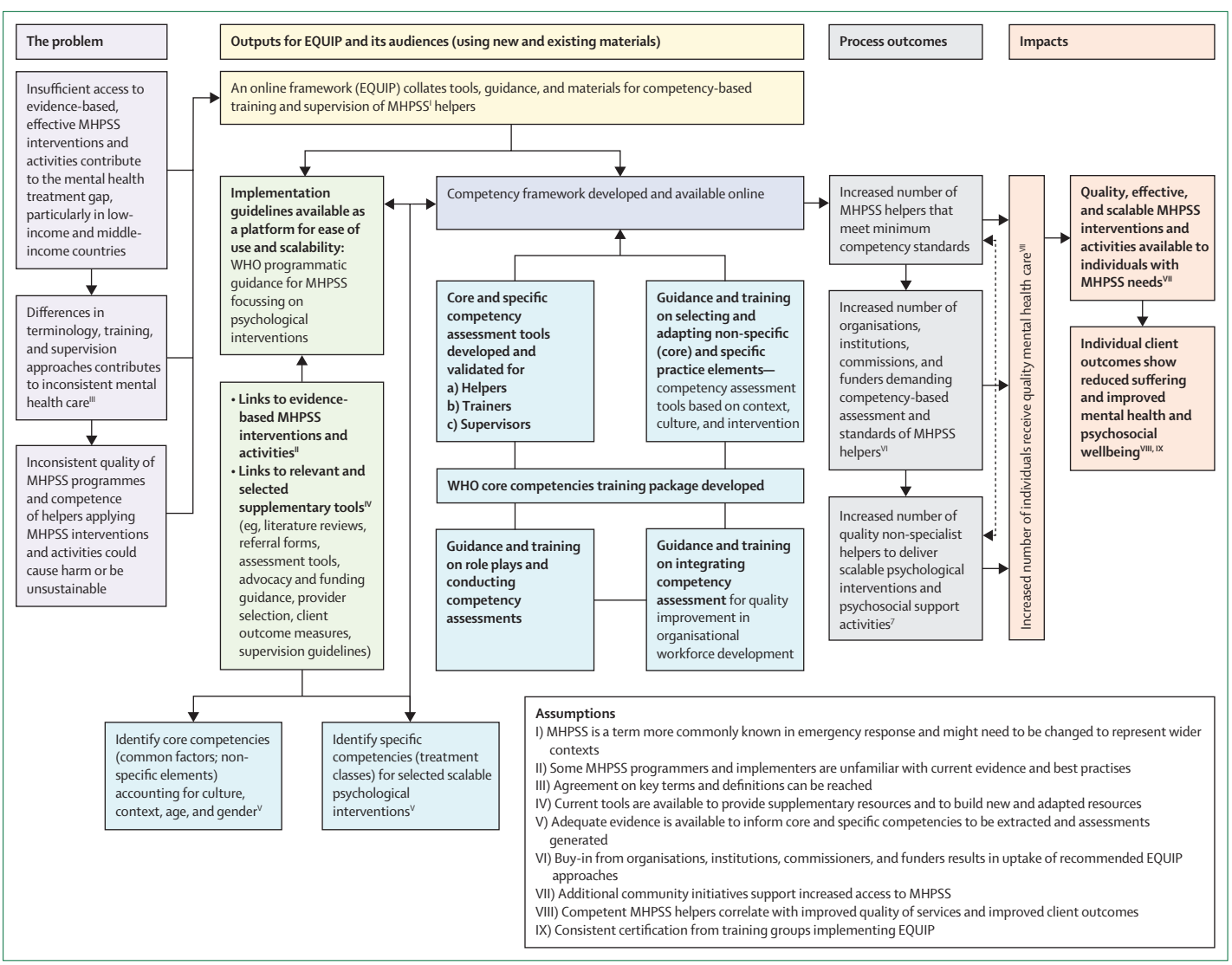

Figure: **EQUIP theory of change developed through WHO consultations**
EQUIP=Ensuring Quality in Psychosocial and Mental Health Care. MHPSS=mental health and psychosocial support.

Panel 1: **Design criteria for Ensuring Quality in Psychosocial and Mental Health Care (EQUIP)**

- EQUIP resources focus on the evaluation of observable behaviours related to direct interactions with people using services. Examples of directly observable behaviours include paraphrasing and summarising statements, allowing for silences, asking about suicide and self-harm, asking about a client's explanatory model, and praising a client for help-seeking in ways that are contextually relevant and appropriate. The resources do not include profession-specific competencies, such as organisational ethics or reporting guidelines, because these are specific to local regulations and national workforce composition, and aspects such as documentation might not be directly observable in client–helper interactions
- The observable competencies are grounded in the common factors in psychological and other mental health interventions. The agreed-upon base of foundational skills is relevant across interventions, programmes, and contexts. Treatment classes and specific manualised interventions build upon this universal foundation as needed
- Competency assessment tools capture potentially harmful behaviours in addition to helpful behaviours. Competency frameworks typically outline what skills should be displayed, but there is rarely a description of specific behaviours that should not be displayed, such as physical contact that would be culturally inappropriate, being dismissive of suicidal thoughts and behaviours, or expressing criticism about a client's coping strategies. Structured documentation of harmful behaviours through EQUIP helps trainers to identify if helpers display red flag behaviours that risk harming a client
- EQUIP resources provide guidance on how to conduct role plays for competency assessment. Instructions on feasible strategies to use contextually and culturally appropriate role plays are provided, in addition to guidance on competency ratings of real-world clinical sessions
- The resources provide instructions on how to adapt standard training into competency-based training and how to give competency-based feedback. These resources include information on what additional investments an organisation needs for competency-based training, such as teaching staff how to conduct role plays

psychosocial support and coping skills among clients.[24] Competencies related to management of key issues such as identification of self-harm and suicide risk are also typically included in foundational helping skills. The IAPT programme includes identification of individuals in high-risk groups for self-harm as a core skill for all helpers.[23]

Given the focus on common factors, the EQUIP consortium adopted an existing observation-based competency assessment tool—Enhancing Assessment of Common Therapeutic Factors (ENACT)—which had been developed in 2015 for the assessment of non-specialists delivering mental health services in low-resource settings.[43] Competencies in ENACT were selected through a literature review of strategies to assess common factors in psychology, mental health care, and patient–doctor communication, such as therapeutic alliance and empathy measurement tools.[43] The review was used to distil the common factors that could be feasibly assessed through role plays and session observations with non-specialists in low-resource settings. The resulting ENACT tool was co-developed with psychosocial counsellors and other mental health practitioners in Nepal, Liberia, and Uganda, and it has been applied in diverse projects across LMICs.[44–48]

Building on the experience of developing ENACT, the EQUIP team subsequently conducted literature reviews to refine the competency assessment strategy and expand the number of scalable competency assessment tools (table 2). We began with a review to identify best practices in using observational role plays.[56] Standardised role plays were selected because they are considered best practice for systematically evaluating skills in clinical psychology.[49,57] In competency-based education of health professionals, objective structured clinical evaluations use this standardised role play format.[58,59] In standardised role plays, a person acting as a service user has scripted statements (prompts) intended to elicit helping skills from the trainee. The review explored the structure of tools and types of observations (eg, role plays and live sessions with clients), and the association of competency measures with client outcomes.[56] A 2023 psychological intervention study with non-specialists has shown that role plays are a better predictor of client outcomes than traditional knowledge tests.[50] Based on this literature, we designed the structure and guidance for EQUIP role plays.

To further develop the original ENACT tool,[43] we did a review in 2018 to identify common factors used in existing manualised psychological interventions delivered by non-specialists in LMICs.[60] The goal was to find out how evidence-based, manualised psychological interventions identified and described common factors, and whether these common factors matched those identified in the initial 2015 review. As a result, three items were removed from the original 18 ENACT items because they were not consistently used across most interventions. The excluded competency items were assessment of drug and alcohol use and physical health needs, assessment of recent life events affecting wellbeing, and use of problem solving. Use of problem solving was moved to a treatment-specific tool for problem solving therapies. The other 15 items were retained, and descriptions were refined to reflect common and relevant terminology identified across the manualised interventions (appendix p 3).

Psychological interventions can also be delivered in groups, which is particularly helpful to increase

	Review sources	Associated activities	Findings, resources, or guidance developed for EQUIP
Role plays: to identify best practices for use of role plays in competency assessment[49]	61 studies and 39 competency assessment tools	Consultation with research experts and trainers working in LMICs	More research is needed of real-world implementation to evaluate associations of competency and client outcomes; approaches for evaluating the relationship between competency and clinical outcomes were identified, including setting an agenda for use of strategies based on role plays to measure competency and assess the relationship between competency and clinical outcomes in a non-linear manner (eg, competency as a moderator or mediator of client outcomes rather than a direct predictor)
Foundational helping skills: to identify common factors across psychological and mental health services that could be observable competencies[44]	56 tools with 1081 competency items associated with common factors and patient–doctor communication	Consultation with trainers and supervisors working in LMICs including free lists to identify additional competencies, a rating task for feasibility and importance, and piloting of the tool in Nepal, including evaluating inter-rater reliability for scoring competencies	Competencies were distilled to 18 items, resulting in development of the ENACT tool to rate foundational helping skills for working with adults
Foundational helping skills and treatment class competencies: to identify common factors used in psychological interventions delivered by non-specialists in LMICs; to identify frequently used competencies across treatment classes[50]	17 manuals including interventions such as the Thinking Healthy Program, Friendship Bench, Healthy Activity Programme, PM+, and the Common Elements Treatment Approach, totalling 973 competencies across the manuals	Review by experts involved in designing and delivering psychological interventions in low-resource settings	The original 18 competencies in ENACT were reduced to 15 core competencies; examples of treatment classes identified included behavioural activation, cognitive, interpersonal, motivational enhancement, problem solving, and stress management
Group facilitation competencies: to identify competencies needed for facilitation of group-based interventions with adults[51]	Eight manuals with group-based delivery and four assessment tools for evaluating group-based interventions	Review of competencies by trainers and supervisors implementing group-based interventions; piloting of the tool in Jordan and Nepal	Competencies were distilled into eight items that could be assessed through role plays or observation of group-based interventions to create the Group Facilitation Assessment of Competencies Tool
Child and adolescent foundational helping skills: to identify common factors when working with children and adolescents[52]	70 source documents (eg, academic articles, grey literature, tool competency frameworks), totalling 956 common competencies across the three sectors of child protection, mental health and psychosocial support, and education	Free-listing activities to identify additional competencies with training and supervision experts in LMICs; piloting of child and adolescent competencies in the occupied Palestinian territories	Competencies were distilled into 13 items addressing individual and group-based competencies for children and adolescents to create the Working Together with Children and Adolescents Assessment of Competencies Tool
Remote helping skills: to identify what modifications are needed for remote delivery (eg, voice or video calls) of psychosocial support and mental health interventions[53]	12 professional guidelines or academic training publications, including ten key remote skill domains related to foundational competencies	Qualitative interviews with providers in high-income countries and LMICs who were delivering remote services during the COVID-19 pandemic;[54] iterative adaptation and piloting of ENACT-Remote in New York City, Europe, and East Africa[55]	Modifications were made to ten of the 15 ENACT competencies to create the ENACT-Remote adaptation

EQUIP=Ensuring Quality in Psychosocial and Mental Health Care. LMICs=low-income and middle-income countries. ENACT=Enhancing Assessment of Common Therapeutic factors. PM+=Problem Management Plus.

Table 2: **Literature reviews and associated activities informing development of EQUIP resources**

relevance, feasibility, and acceptability in low-resource settings. Interpersonal psychotherapy,[61] Problem Management Plus (PM+),[62] and Early Adolescent Skills for Emotions (EASE)[51] have options for group-delivery formats. Therefore, we also identified and extracted common competencies needed for facilitating groups. This led to a draft version of the Group Facilitation Competency Assessment Tool (GroupACT), which was reviewed by experts from LMICs who had experience in group-based interventions delivered by non-specialists.[63]

In addition, competencies were identified for treatment classes (eg, behavioural activation, cognitive techniques, interpersonal techniques, motivational enhancement) that were used in multiple interventions delivered by non-specialists.[60] Draft versions of the treatment class tools were developed (appendix pp 3–4). Competency assessment tools for specific interventions were developed for PM+[64] and the Thinking Healthy Program[52] because they are widely used, open-access interventions distributed by WHO (appendix p 4).

For services focused on children and adolescents, a tool was created to assess psychological support, education, and protection skills. This development was done through a literature review of existing tools, followed by free listing exercises (ie, a rapid qualitative technique in which participants generate lists of items related to domains of interest, such as important skills for psychosocial support) with groups of children, parents, and helpers in a centre for asylum seekers in the Netherlands and community programmes in Gaza.[55] Validation and operationalisation workshops were conducted with children and their parents in Gaza and Colombia. These activities culminated in development of the Working Together with Children Assessment of Competencies Tool (WeACT), which has 13 observable behavioural competencies for psychological support of children and adolescents (appendix p 3).[55]

ENACT, WeACT, GroupACT, and treatment class-based competency assessments were sent to global mental health practitioners and stakeholders to collect feedback on the content, format, and implementation feasibility of the tools. For example, experts reviewing interpersonal competencies suggested that the term "sick role" had insufficient cross-cultural relevance. Therefore, use of the phrase "explains sick role" was revised to "explains depression (or other relevant cultural concepts of distress) in association with interpersonal problems". For non-verbal communication, reviewers reported the term "open body posture" was unclear for translation. The item was adapted to "maintains open posture (body toward client)". Competency items were modified, removed, or added based on this feedback.

In 2020, the COVID-19 pandemic prompted a shift to remote-based services.[53] A rapid review identified competencies for synchronous remote delivery (eg, phone and video calls) of psychological and other mental health services.[54] Qualitative interviews with providers in LMICs and high-income countries informed the adaptation of competencies for remote delivery.[65] These efforts culminated in the ENACT-Remote tool for telehealth interventions (appendix p 3).[54] Similar adaptations were made for remote use of WeACT and GroupACT.

Phase three: adaption of materials based on experiences in diverse global settings

Adapting competency tools

Organisations that had expertise in mental health research and implementing services were selected through a competitive application process to become part of the EQUIP consortium. The consortium included organisations in Ethiopia, Kenya, Jordan, Lebanon, Peru, Uganda, and Zambia. From July, 2019, until December, 2020, consortium partners adapted the competency tools and role play materials.

Each partner translated the competency tools into languages that would be used locally (eg, Arabic, Spanish, Tigrinya). A modified version of the transcultural translation monitoring form[66] was used to document comprehensibility, acceptability, relevance, technical equivalence, and completeness. The teams reached consensus wording, for example "appropriate for the setting and helper" for behaviours such as body language (eg, eye contact, posture, and physical contact). Similarly, the descriptions of potentially harmful behaviours were written to be interpretable in local contexts (eg, inappropriate physical contact, uses culturally and age-inappropriate language and terms, lectures client with religious or legal reasons against self-harm). This interpretability enabled trainers and other raters to judge behaviours according to what would be acceptable in their cultural contexts accounting for the gender, age, religion, and other characteristics of the helper and the person being helped. Digital versions of the competency assessment tools in the different languages were added to the EQUIP platform.

Adapting role plays

Key prompts, one for each competency, were developed to efficiently elicit behaviours during role plays. For example, rather than a detailed vignette related to self-harm and suicidality, a person acting as a client could give a prompt of: "sometimes I go to sleep at night and wish that I wouldn't wake up in the morning", to prompt a helper to screen for self-harm and suicide risk. The prompts are flexible and adaptable so that organisations can use language typical of people seeking services in their settings. Items with behaviours that could not feasibly be assessed through prompting in role plays were dropped from the assessment tools. The item "demonstrates collaboration with caregivers" was dropped from WeACT during feasibility testing because it required a role play with both child and adult actors, and competencies for engaging with parents or other caregivers were already addressed through ENACT. Sample role plays, prompts, and guidance on adaptation are available on the EQUIP platform. Trainers commented that role play materials are easily adapted across cultural contexts (appendix p 5).

Facilitating inter-rater agreement for real-world implementation

For scalable use outside of research studies, competencies needed to have good inter-rater agreement without requiring extensive training and psychometric testing in every new setting. Initial inter-rater agreement on competencies was modest to good across EQUIP partners (appendix p 6). Non-verbal communication, exploration of feelings, confidentiality, verbal communication, empathy, eliciting feedback, involvement of promotion of hope, and assessment of self-harm had more than 66% agreement. Those learning to rate emphasised the benefit of practising rating together before use of the competency assessments in real-world training (appendix p 6).

Acceptable agreement for ENACT items could be reached with practice using demonstration videos. Most partners created brief role play videos (2–3 min per competency) showing a mix of helpful and unhelpful behaviours in local languages. In Zambia, use of demonstration videos led to good inter-rater agreement on all items: intraclass correlation coefficients ranged from 0·71 to 0·89.[67] The EQUIP PM+ tool had an intraclass correlation coefficient of 0·73.[64] Brief role play videos for practising rating are included in the resources section of the EQUIP platform.

Format and structure of the EQUIP competency

Panel 2: **Experiences from pilot testing Ensuring Quality in Psychosocial and Mental Health Care (EQUIP) resources for training non-specialist helpers to deliver psychological interventions**

Ethiopia, Problem Management Plus (PM+)

In Ethiopia, PM+ training was conducted for refugee facilitators working for the non-governmental organisation (NGO) Center for Victims of Torture.[64,70] The PM+ training of facilitators lasted 5 hours per day for 2 weeks, with directly observed supervision for the first client receiving PM+. 24 facilitators had data available for Enhancing Assessment of Common Therapeutic Factors (ENACT) assessments pre-training, post-training, and post-supervision (appendix pp 9–12). With the ENACT tool, facilitators were scored as displaying unhelpful or potentially harmful behaviours (level one) on an average of 4·06 competencies at pre-training, which dropped to 0·04 competencies at an unhelpful or potentially harmful level post-supervision (appendix pp 9–12). Non-specialist helpers were assessed as having basic or advanced skills (level three or four) on an average of 1·48 competencies before training compared with 10·54 competencies after supervision (appendix pp 9–12). These results supported face validity of the tool to track changes in competency over time.

"For the trainer, it's very good to know whether the trainee understands the idea of the training. You can evaluate them, and it can help you to understand what they are experiencing in the training. If they show you a good example of the skill and they show progress, then you have a sense of your capacity as a trainer." (Trainer, Ethiopia)

Kenya, trauma-focused cognitive behavioural therapy (TF-CBT)

In Kenya, 2-week training in psychotherapy derived from TF-CBT for adolescents was conducted for community health workers through the Nairobi Metropolitan Mental Health Unit.[33] The TF-CBT intervention had been simplified for delivery during the COVID-19 pandemic. After the training was over, the supervisors reviewed trainees' post-training ENACT scores, and they focused online supervision sessions on the competencies that trainees had performed poorly in post-training. 16 trainees had ENACT data available for pre-training, post-training, and post-supervision (appendix pp 9–12). From pre-training to post-training, the number of level one behaviours identified did not improve. However, there was a drop in level one behaviours from 1·53 to 0·80 per trainee from post-training to post-supervision. Similarly, the number of trainees showing competencies at level three or four showed a modest increase from pre-training to post-training, but a notable increase to 3·83 helpful competencies per trainee after the competency-based supervision (appendix pp 9–12). Qualitative feedback suggested competency assessments and associated skill-refresher activities improved supervision.

"Yes, it was useful because we got to know where they are, and we got to know the areas in which they needed improvement. Initially, they were very focused on the TF-CBT skills because those were freshly learned, but they weren't doing the other [foundational helping] skills, so [EQUIP] helped to know where to focus on during the supervision before delivery." (Trainer, Kenya)

Lebanon, Early Adolescent Skills for Emotions (EASE)

In Lebanon, the NGO War Child conducted proof-of-concept testing to compare competency outcomes of standard EASE training approaches (training-as-usual) versus time-matched competency-based EASE training.[34] For the EASE intervention training, 12 trainees were randomly assigned to training-as-usual and 12 to competency-based training. In both groups, pre-training and post-training competency assessments were completed with standardised role plays. Working Together with Children Assessment of Competencies Tool (WeACT), ENACT, and Group Facilitation Competency Assessment Tool (GroupACT) competencies were assessed. In the training-as-usual group, the trainers were masked to the competency assessment results. In the EQUIP competency-based training group, the trainers had access to the pre-training competency assessment results and information from in-training competency assessments.[71] Trainers in the EQUIP group could use competency-assessment results to adapt the training and focus on areas for improvement. During the competency-based training, the trainer also used the tools informally to provide trainees with competency-based feedback. Competency-based training led to trainees showing 17% greater competency in the WeACT skills for supporting children and adolescents and 18% greater competency on the GroupACT for group facilitation skills than the training-as-usual group.[34] Due to the COVID-19 pandemic, implementation was halted and doing an additional competency assessment during supervision was not feasible. Trainers also reported that their skills improved using the EQUIP-based approaches.

"I feel like my skills have evolved a lot, so on a personal level it was very fruitful for me. I learned a lot. Not only did I learn a lot of concepts and theories, and things to apply, but I learned a lot of skills, and I learned a lot of things about myself." (Trainer, Lebanon)

Peru, Thinking Healthy Program (THP)

In Peru, the NGO Socios En Salud conducted THP training, with training-as-usual[52] compared with EQUIP competency-based training for community health workers. In the training-as-usual group, for 17 community health workers who had ENACT data available before training, post-training, and post-supervision, the number of level one behaviours identified decreased from 2·00 before training to 1·71 post-supervision. In the EQUIP

(Continues on next page)

(Panel 2 continued from previous page)

competency-based training group, for which data on 14 community health workers was available at all three time points, level one behaviours reduced from 2·66 before training to 1·22 post-supervision. Level three or four helpful behaviours in the training-as-usual group went from 0·40 before training to 0·41 post-supervision and in the EQUIP competency-based training group 0·57 before training to 0·81 post-supervision (appendix pp 9–12). Due to the COVID-19 pandemic, supervision and all services were disrupted in Peru between the period of post-training and post-supervision. Trainers, supervisors, and programme staff provided positive feedback about the use of role plays in training.

"It seems to me an important point because in role-playing games they will also make the person realize what things they are failing at and what things they are doing well, and after the role plays they are given feedback." (Trainer, Peru)

Uganda, group interpersonal therapy (Group-IPT)

In Uganda, the NGO HealthRight conducted two iterations of training for community health workers using Group IPT. One group used EQUIP with literate experienced community health workers who were affiliated with large government health centres. The second group used the EQUIP resource with low literacy community health workers working in remote areas. The same trainers were used in both groups. ENACT data at pre-training, post-training, and post-supervision were available for 25 community health workers (appendix pp 9–12). Across both groups, competencies assessed as level one decreased by 1·56 from pre-training to post-supervision, and competencies assessed at level three or four increased by 3·21 at the time of supervision. Although the trainers and supervisors reviewed the competency results, they did not use structured competency-based feedback or share the results with trainees, as was done in Lebanon and Peru.

"According to the role plays that we did, I would be able to see that there can be difference from the first role plays before they began the trainings and the last ones after the trainings. The thing that I could clearly see in those ENACT competencies is that they are able to work on some non-verbal things, which they clearly displayed compared to the first time when they did not know anything." (Trainer, Uganda)

Zambia, common elements treatment approach (CETA)

In Zambia, the Centre for Infectious Disease Research conducted a 3-day refresher course for a telephone-based adaptation for components of CETA.[67,72] The EQUIP tools were solely used for evaluation and the trainers did not review the competency assessment results to modify their training. Among 18 trainees who had ENACT data available at all time points (appendix pp 9–12), level one behaviours reduced from 1·30 pre-training to 0·33 post-supervision. Level three or four helpful behaviours increased from 3·61 pre-training to 4·11 post-training.

assessment tools

To improve objectivity and speed when rating competencies, partners proposed to change the format of the previous ENACT tool by adding checkboxes for specific helpful and unhelpful behaviours that constitute a competency, rather than only listing examples of behaviours for each competency level. In this way, demonstrated behaviours (harmful, basic helpful, and advanced helpful) can be tracked for each competency (appendix p 7). The first category refers to potentially harmful or unhelpful behaviours (eg, forcing a client to disclose information against their will or discussing confidential information of another client); these are behaviours that would potentially exacerbate psychological distress for clients. The second category is basic helping behaviours, which all helpers would be expected to show across contexts and types of interventions (eg, a helper introducing themselves and explaining their role and asking a client about their view on the cause of the problem for which they are seeking help). The third category includes behaviours that are more advanced and might not be relevant for all helping interactions with clients (eg, exploring potential reasons for hesitance to share emotions, developing a safety plan with a client, addressing differences in a client's view of the problem *vs* family members' views of the problem).

The behaviours shown by a helper across the three categories are used to determine which competency level is selected. Level one refers to any potentially harmful or unhelpful behaviours; level two refers to displaying no harmful behaviours, but not displaying all basic helping behaviours for a competency; level three refers to displaying all basic helping behaviours and no harmful behaviours; and level four refers to displaying all basic helping behaviours, at least one advanced helping behaviour, and no harmful behaviours. Each site conducted cognitive interviewing to confirm that trainers understood the four level rating strategy.

When the previous ENACT tool, which only included levels and not behaviour checkboxes, was compared with the ENACT tool using the behavioural attribute checkboxes, the behavioural attribute checkboxes had better model fit for predicting clinical behaviours related to suicide risk screening among primary care providers.[68] Trainers and trainees expressed that the checkboxes led to more focus on what specific behaviours to avoid or improve, rather than solely relying on a numerical score, which does not have detailed information on behaviours demonstrated. Both harmful behaviours and helpful behaviours can be captured for the same competency, which the trainers and supervisors reported to be more realistic,

because trainees typically display a mix of potentially harmful, basic, and sometimes advanced behaviours (appendix p 7). Trainers and supervisors reported that giving feedback about potentially harmful behaviour was more acceptable when paired with showing the behaviours done well for a competency.[69]

Phase four: piloting EQUIP resources when training non-specialists to deliver psychological interventions

To evaluate if EQUIP tools capture change over time, manualised intervention training programmes (eg, PM+, group interpersonal psychotherapy, EASE) were conducted in six countries (panel 2 and appendix pp 8–12). Competencies were assessed before training, immediately after training, and after supervision if feasible. Initially, an additional comparison between EQUIP competency-based training and standard training was planned for each country.[73] However, because of COVID-19-related disruptions, only partners in Lebanon and Peru evaluated differences in training approaches. Alongside the competency data collection, a qualitative study was conducted in all countries to evaluate competency-based strategies and feedback.[69]

Modifications to the EQUIP platform based on piloting

Results from the pilot studies informed the development of additional data visual representation tools on the EQUIP platform to support competency-based feedback (appendix p 13).[69] Trainers and supervisors can immediately get visual representations showing an individual's performance during a single assessment period or visual representations of an individual's improvement over time with multiple assessments. Summary visual representations for groups of trainees are also available. Trainers and supervisors valued the group visual representations to easily identify which competencies were most frequently being done harmfully and which trainees had the greatest number of unhelpful or potentially harmful behaviours (appendix p 13).

E-learning courses were created to prepare any trainers, faculty, and others to use the platform and competency-based strategies (appendix p 14). Trainers and supervisors do not need to have a background in competency-based techniques before using EQUIP because these courses introduce the concepts and processes. The courses addressed concerns that were raised during the piloting phase.[33,64,67,71] For example, guidance was needed on how to explain and implement role plays with trainees. In Ethiopia and Uganda, some trainees became distressed because they thought the role plays were a pass or fail test, as opposed to the intended purpose, which was quality improvement.[64] Also, based on the pilot experiences, a course was added on providing competency-based feedback [69]

Phase five: dissemination of EQUIP resources and ongoing monitoring of use and implementation

Public launch and global training

On March 31, 2022, EQUIP was officially launched for public use through a webinar. Two global training courses on EQUIP were held in 2023 for 74 participants representing 48 organisations. Participants included programme directors, mental health trainers, and experts in child protection, gender-based violence, education, and nutrition. The 4-day training courses prepared attendees to use EQUIP in their organisations. To support the integration of EQUIP into pre-service clinical training, online training sessions of 12·5 h spread over 5 days were conducted for 21 faculty from universities in 11 LMICs. A 4-day training session was held with Makerere University's Department of Psychology in Uganda to integrate competency-based methods in practicums and internships.[35,36]

In the 2 years after the public launch of EQUIP in March, 2022, EQUIP's digital platform had 3212 registrations and had been used in 794 training programmes in 36 countries with 3760 trainees, resulting in 10 001 competency assessments and 9810 identified unhelpful or potentially harmful behaviours (appendix pp 15–16; data are not available for usage of paper versions). The top users of the EQUIP platform, as defined by the number of competency-assessments conducted, have been NGOs responsible for training government health workers in India, Nepal, Peru, and Uganda, as well as humanitarian organisations conducting training globally for child and adolescent mental health and psychosocial services. Panel 3 provides examples of how organisations are using EQUIP resources.

Integration into WHO and UNICEF manuals and guidelines

Since launch, EQUIP has been further adapted and expanded to promote widespread use. Competency assessment tools are being translated, with ENACT available in 14 languages. EQUIP has been recommended in interagency protection and education manuals and guidelines, including the Inter-Agency Standing Committee mental health and psychosocial support (MHPSS) Minimum Service Package[28] and UNICEF's Global Multisectoral Operational Framework for MHPSS of Children and Families Across Settings.[74] Forthcoming WHO training manuals for commonly used psychological interventions will include advice on how EQUIP tools can be used throughout training and supervision. To support integration of mental health into primary care, there is a forthcoming competency assessment tool for the WHO Mental Health Gap Action Program-Intervention Guide.[75] These experiences have shown that it is possible to use a subset of the core competencies tailored to the needs of particular interventions and settings. In addition, a modular, EQUIP competency-based training package in

***Panel 3*: Use of Ensuring Quality in Psychosocial and Mental Health Care (EQUIP) in training and supervision for mental health services**

Psychiatric Disability Organization (PDO) Kenya

PDO Kenya is a community-based mental health organisation in Nakuru, Kenya, led by mental health service users. PDO Kenya chose to incorporate EQUIP with the goal of enhancing the quality of mental health service delivery, expanding access to services, and promoting increased participation of people with lived experience of mental health conditions. PDO Kenya Champions, who are young people aged 18–30 years who have lived experience of mental health conditions, provide peer support to one another and assist peers on their recovery journeys. In April, 2022, PDO Kenya started using EQUIP to improve assessment of the youth Champions' counselling skills. After using EQUIP competency assessments, PDO Kenya identified gaps in the Champions' skills. They adapted training courses and supervision and were able to measure improvement over time in the Champions' abilities to deliver low-cost psychological interventions with greater quality. The Champions reported that they noticed immediate and ongoing improvement in their skills through the use of the role plays and receiving feedback. They also noted the skill improvement benefited diverse clients in various circumstances in their communities. PDO Kenya leadership report that EQUIP is an essential part of their programming by fostering positive project outcomes.

"We did not perceive [competency assessment] as additional work or time-consuming. We will certainly continue to use EQUIP. The most significant difference we observed compared to previous training was that we now have firsthand knowledge of whether our trainees possess the competencies we want them to acquire." (Programme staff, PDO Kenya)

International Organization for Migration (IOM) Nigeria

The IOM Nigeria initiated mental health and psychosocial support (MHPSS) services programming in 2014 in response to the abduction of Chibok girls in northeast Nigeria. In Maiduguri, Nigeria, 54 IOM staff, including psychiatric nurses, social workers, and community health workers, underwent competency-based training with EQUIP competency assessments. EQUIP was used to strengthen the MHPSS workforce by categorising skill levels for specialised and non-specialised services. To reduce the risk of harm at a community level, EQUIP was used to assess and enhance the competencies of mobile teams. IOM Nigeria implemented separate competency-based training sessions for specialist and non-specialist providers. The training process began with short role plays to assess participants' baseline skills. Throughout the training, the use of EQUIP role plays and competency assessments supported continuous and personalised feedback to trainees. This approach enabled trainees to receive regular guidance tailored to their individual needs with a specific focus on areas requiring improvement. Upon training completion, role plays and assessments were conducted to evaluate the competencies of participants. For trainers, the use of role plays and feedback empowered them to provide tailored training and address learning gaps. Trainees reported having a clear understanding of the essential competencies required to deliver high-quality services. Supervisors now tailor their sessions to the identified learning needs and gaps.

"EQUIP strengthens existing tools and resources that IOM uses for service delivery to meet the specific needs, concerns, and challenges of the populations we serve." (Programme staff, IOM Nigeria)

The International Federation of the Red Cross and Red Crescent (IFRC) Reference Centre for Psychosocial Support, Syria

The IFRC Reference Centre for Psychosocial Support works under the framework of the IFRC to support all national societies in promoting and enabling the mental health and psychosocial wellbeing of affected populations, staff, and volunteers. IFRC, in collaboration with the Syrian Arab Red Crescent, used EQUIP to select and support peer supervisors. Initially, 17 case managers in Syria were trained on Problem Management Plus (PM+). The training concluded with role plays to evaluate foundational helping skills using the EQUIP platform. After the training, supervisors integrated the EQUIP platform to enable capacity building through online sessions. The case managers received a total of 180 online supervision sessions over several months. After the online supervisions, a 3-day PM+ refresher training was delivered to the case managers. Seven trainees were then selected based on their competency assessment results to serve as supervisors for the future PM+ cohorts. The trainees who became supervisors shared that giving feedback was challenging and can sometimes be sensitive. However, EQUIP made giving feedback more objective, feel less subjective, and established more comfort for discussions. They said the EQUIP tools were helpful to facilitate a peer supervision system that was characterised by personalised feedback delivered with empathy.

"EQUIP is a constructive tool that has fostered team collaboration and helped trainees [learn] how to provide feedback in a caring way." (PM+ trainer, IFRC Psychosocial Reference Center, Syria)

foundational helping skills has been created to promote safe and effective support in mental health and other sectors (eg, in education, child protection, law enforcement, reproductive health services).[76]

Outreach with organisations is ongoing, including monitoring of platform use, follow-up surveys with implementers, and in-person and remote training on EQUIP. Implementers requested refining EQUIP to ensure that competency tools could be feasibly scaled

up, which led to the simplification of prompts tied to competencies and the provision of instruction on how peer trainees can conduct role plays. In pilot studies, use of EQUIP role plays conducted by peers was advantageous because it allowed trainees to reflect on the experience of helpful and unhelpful behaviours from the perspective of clients.[76] This finding suggests that peer role plays are feasible and promote empathy for clients' experiences of helpful and unhelpful behaviours.

Future directions

Although the current tool can be used to identify harm, further research is needed to identify the minimum skill needed for each competency. Going forward, EQUIP has the potential to use data on the platform to benchmark the minimum competency needed to produce effective results related to client outcomes.[34,77] Moreover, data on the platform can also be used to observe the relation among competencies, which would be helpful to select a minimum set of competencies. The platform data can identify which unhelpful or potentially harmful behaviours are most frequently observed and which competencies are the most difficult to improve. Training and supervision guidance could better address these more difficult skills.

Other research opportunities include use of EQUIP data to elucidate mechanisms of action in mental health interventions. For example, how competencies in common factors contribute to outcomes compared with treatment-specific competencies, and how competencies related to common factors influence attendance and treatment engagement.[56] Additionally, pre-training competency assessments could be used to select people likely to reach safe competency after training; a preliminary study suggests that pre-training non-verbal competencies predict post-supervision competence in other foundational helping skills.[78] Other emerging areas are use of EQUIP for professional self-development and self-evaluation.

For successful scaling and sustained use of competency-based training, establishing the cost–benefit ratio of the additional time and resources required is also important. An incremental cost analysis comparing standard PM+ training versus EQUIP-based training of PM+ found that EQUIP required an additional 70% investment in cost and time for the PM+ training of trainers (50 h *vs* 85 h), but there were no subsequent additional time requirements to integrate EQUIP into the PM+ training of helpers.[79] Further studies will need to evaluate costs across different contexts and interventions.

With growing use of EQUIP, it will be important to monitor whether competency-based trainings are conducted with an approach of teaching to the test, as this reduces concepts such as empathy to mechanical displays of a few specific behaviours. In medical education, preparation for standardised role plays has been criticised for oversimplifying empathy to a checklist rather than fostering genuine support of patients.[80] Therefore, the Foundational Helping Skills training includes a module about cultivating helping attitudes.[76] Research with ENACT has shown that training interactions with people with lived experience of mental health conditions can foster empathy and other helping skills.[48,81,82]

Another area for future development is engagement with people with lived experience to refine existing tools and develop new tools. A limitation in the initial development of EQUIP was inadequate formal engagement of people with lived experience. However, a forthcoming initiative with the Global Mental Health Peer Network will focus on developing assessments that can be completed by people with lived experience and used for advocacy for quality improvement in health systems.

Conclusion

Based on expert consultation, literature reviews, and feasibility testing, the EQUIP initiative has a range of competency assessment tools for use in mental health and psychosocial training in diverse contexts. Pilot testing showed how the tools measure change over time, with initial evidence that competency-based training has a greater effect than standard trainings on improving skills among non-specialists. EQUIP has evolved from an initial focus on humanitarian settings to wider use and integration for any mental health service delivery by non-specialists and specialists. The high number of registered users and assessments completed on the platform suggest that EQUIP is being applied to improve training and services. Ultimately, EQUIP is intended to provide competency assessment tools and resources that can evolve to remain current with best practices in training to achieve the vision of a safe and effective mental health-care workforce around the world.

The EQUIP Consortium

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