

Building Mental Health and Psychosocial Support Capacity During a Pandemic: The Process of Adapting Problem Management Plus for Remote Training and Implementation During COVID-19 in New York City, Europe and East Africa

Kelly A. McBride¹, Sarah Harrison², Sudeshna Mahata³, Kendall Pfeffer⁴, Francesca Cardamone⁵, Teresa Ngigi⁶, Brandon A. Kohrt⁷, Gloria A. Pedersen⁸, Claire Greene⁹, Darryll Viljoen¹⁰, Orso Muneghina¹¹ & Adam D. Brown¹²

¹MA, International Federation of the Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support, Denmark, ²MA, International Federation of the Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support, Denmark, ³MFA, International Federation of the Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support, Denmark; Department of Psychology, The New School for Social Research, New York, USA, ⁴MA, Department of Psychology, The New School for Social Research, New York, USA, ⁵PsyD, SOS Children's Villages International, Global Hub on Mental Health and Psychosocial Support (GH-MHPSS), Italy, ⁶PhD, SOS Children's Villages International, Global Hub on Mental Health and Psychosocial Support (GH-MHPSS), Italy, ⁷MD, PhD, Director, Division of Global Mental Health, Department of Psychiatry and Behavioral Sciences, George Washington University, Washington, DC, USA, ⁸MSc, Research Associate, Division of Global Mental Health, Department of Psychiatry and Behavioral Sciences, George Washington University, Washington, DC, USA, ⁹PhD, Research Scientist, Program on Forced Migration and Health, Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health, New York, USA, ¹⁰MA, SOS Children's Villages International, Global Hub on Mental Health and Psychosocial Support (GH-MHPSS), Italy, ¹¹MA, SOS Children's Villages International, Global Hub on Mental Health and Psychosocial Support (GH-MHPSS), Italy, ¹²PhD, Director, Trauma and Global Mental Health Lab, Department of Psychology, The New School for Social Research, New York, USA; Department of Psychiatry, New York University School of Medicine, New York, USA

Abstract

On March 11, 2020, COVID-19 was declared a pandemic by the World Health Organization. In response to the sudden rise in COVID-19-related mental health and psychosocial impacts, we embarked on a digital training (e-learning) and remote delivery adaptation for Problem Management Plus Training for Helpers (Remote PM+ Training) based in New York City, four European countries and six African countries. This paper provides an overview of the two Remote PM+ Trainings, including key adaptations and lessons learned across the contexts. Trainings were approximately 75 hours in duration, with a mix of group and individual work, in diverse contexts. Overall, remotely delivered PM+ training and intervention appear appropriate. There were a number of critical lessons learned that contributed to the efficacy of the trainings, such as technological support, digital literacy, preparation and flexibility among the trainers and the trainees. There is also a need for cultural and contextual adaptation towards the delivery of remote training and implementation of PM+. However, the outcomes from these two trainings indicate that PM+ may be adapted for remote (online) training and, if supported with additional studies, could build workforce capacity in contexts in which there is limited in-person access to mental health and psychosocial support services and staff.

Keywords: capacity-building approaches, digital learning, mental health and psychosocial support, Problem Management Plus (PM+), remote adaptation, scalable psychological intervention

Key implications for practice

- If there are barriers to in-person training, Problem Management Plus (PM+) may be delivered remotely (Remote PM+).
- Remote PM+ may be adapted for providing psychosocial support for individuals in high income countries.
- Remote PM+ training appeared relevant for trainees with prior clinical experience.

Address for correspondence: Adam D. Brown, PhD, Department of Psychology, The New School for Social Research, 80 Fifth Avenue, 601, New York, New York 10003, USA.
E-mail: brownad@newschool.edu

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Introduction

On March 11, 2020 the World Health Organization (WHO) declared COVID-19 a global pandemic (WHO, 2020). This classification prompted governments to implement strategies to reduce the spread of infection by limiting the size of gathering, instituting quarantines, promoting physical distancing, as well as mass closures or reductions in the operations of major civic institutions, transportation and private business. Nine months from the initial reports of a pneumonia-like disease, it is estimated that over 33 million people have been diagnosed with COVID-19 and over 900,000 deaths throughout the world (WHO, 2020). COVID-19 remains a major public health threat as efforts to characterise, treat and suppress the virus continue (e.g. Anand et al., 2020).

In May 2020, the United Nations (UN) released a policy brief calling for a whole-of-society approach emphasising inclusion of mental health and psychosocial support (MHPSS) in national response plans and ensuring widespread availability of emergency MHPSS including *scaling up access to remote support* (UN, 2020). The brief was in response to emerging concerns of negative mental health and psychosocial impacts arising from the health and societal consequences of COVID-19. These impacts exacerbate existing stressors and inequalities while generating new social, economic, cultural and political challenges. Extant population-based research is showing high rates of anxiety, depression and general distress in many parts of the world (Ahmed et al., 2020; Brooks et al., 2020; Pierce et al., 2020; Rossi et al., 2020; Torales et al., 2020; Twenge & Joiner, 2020; Xiong et al., 2020) coupled with the disruptions or closure in the provision of MHPSS due to travel restrictions and the distancing measures put in place to protect the health and social welfare workforce.

The ubiquity of smart phones in most settings makes it possible to operationalise the UN's call to scale up remote MHPSS services. Remote delivery forms of MHPSS may serve as an important mechanism to facilitate access to care (e.g. Campbell et al., 2020; Carlbring et al., 2018; Fortney et al., 2015). Well before COVID-19, studies have indicated that remotely delivered psychotherapy can be effective in certain contexts (Hubley et al., 2016; Shore, 2013; Yellowlees et al., 2008), especially if the interventions are adapted and protocols are put in place to assess suitability and risk (The American Psychiatric Association and The American Telehealth Association, 2018). Reviews of video-based therapy have shown promising results in the treatment of anxiety (Berryhill et al., 2019a), depression (Berryhill et al., 2019b; Lungu et al., 2020), posttraumatic stress disorder (Morland et al., 2020), substance use disorder (Lin et al., 2019) and psychosis (Sharp et al., 2011). Although video conferencing software may be the preferred mode of delivery in contexts with the technological capacity, data also indicate that therapy can be effectively delivered through telephone and email (Hilty et al., 2013; Langarizadeh et al., 2017; Mohr et al., 2012).

More recently, remote forms of MHPSS have been developed and tested for contexts in which there are limited

resources, lack of humanitarian access and considerable gaps in service provision. Models that build on increased supervision and task-sharing between professions are gaining traction. For example, WHO has developed self-guided or remotely assisted, guided forms of MHPSS that can be delivered and supported by community members trained in the intervention. For example, the intervention Self-Help Plus (Epping-Jordan et al., 2016), consisting of pre-recorded, self-help information delivered in a group format, was found to be effective in reducing a range of mental health issues among South Sudanese refugees in Uganda (Tol et al., 2018). Similarly, WHO is developing digitally delivered self-help intervention therapy called Step-by-Step (SbS; Carswell et al., 2018). Preliminary data show that SbS *may be* effective in reducing depression and anxiety symptoms and is now being adapted and tested in a variety of contexts including Jordan (Burchert et al., 2019), Lebanon (Harper Shehadeh et al., 2020), Switzerland (Heim et al., 2020; Shala et al., 2020) and China (Sit et al., 2020). In a recent review (Naslund et al., 2019) of the potential for digital technologies to aid in the capacity building of mental health interventions in low-resourced contexts, it was emphasised that more research is needed to better understand how digital technologies may be added to existing interventions and modes of care or as a new form of intervention or system of delivery. There is some evidence that the integration of mobile technologies into interventions in postconflict settings, for example, may facilitate the delivery of mental health support in task-sharing and community-based models. For instance, text messages have been incorporated into the Friendship Bench in Zimbabwe (Chibanda et al., 2015) in which lay health workers receive text messages throughout the intervention. Moreover, in postconflict rural areas of Pakistan, the Technology-assisted Cascade Training and Supervision (Zafar et al., 2016) employs a tablet-based approach to guide the Thinking Healthy Programme. The digital tools include animated *avatars* who narrate the session. Despite these promising approaches, there is an urgent need to understand how to integrate digital tools into MHPSS, especially in contexts and cultural settings in which individuals are at high risk for mental health concerns, such as postconflict settings.

Despite the existence of promising remote and digitally mediated interventions, there is a need to test such interventions in response to COVID-19 (Wright & Caudill, 2020). One intervention that could be adapted for remote delivery is Problem Management Plus (PM+). PM+ is a scalable, transdiagnostic psychological intervention developed by the WHO for adults experiencing symptoms of common mental health problems (WHO, 2018). PM+ is designed to be delivered by trained helpers under the supervision of a mental health professional. Individual and group-delivered formats of in-person PM+ have been shown to be effective in several randomised controlled trials (Bryant et al., 2017; de Graaff et al., 2020; Rahman et al., 2016, 2019). It is comprised of four evidence-based techniques: (a) problem solving, (b) stress management, (c) behavioural activation and (d) accessing social support. It is recommended as part of the WHO Mental Health Gap

Action Programme for communities affected by adversity, particularly at the community and primary health care level (Dawson et al., 2015).

Methods

Adapting, Training and Delivering PM+ in New York City, Europe and East Africa During COVID-19

Towards the end of March 2019, as rates of COVID-19 were near their peak in New York City (NYC) and throughout Italy, clinical psychologists from the New School for Social Research (NSSR) in NYC (ADB) and SOS Children's Villages International (SOS CVI) in Italy (OM) contacted the International Federation of the Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support (IFRC PS Centre) for support with adapting and training individuals in a remote version of PM+ for their staff in the USA, Greece, Sweden, Italy, Nigeria, Belgium, Ethiopia, Uganda, Rwanda, South Africa, Burundi, Somalia and Somaliland. Weekly logistical planning discussions took place over Skype between the three organisations during the first week of April 2020. Questions, concerns and needs were considered during the initial planning stages of this work in consultation with WHO (see Table 1). Due to the limited time to adapt the training materials prior to the start of the remote training and implementation of the intervention, full adaptation work in line with existing theory-based frameworks (Applied Mental Health Group, 2013; Barrera & Castro, 2006; Heim & Kohrt, 2019; Perera et al., 2020) was not possible. However, elements of these frameworks, such as the use of qualitative interviews with trainees and recipients of the intervention, were conducted to help inform future work.

By May 2020, it was agreed that the IFRC PS Centre would conduct two trainings: one with the NSSR (led by KAM) referred to as Cohort 1, and a second with SOS CV (led by SH), referred to as Cohort 2.

Selection of Trainees. Cohort 1 was originally intended to be comprised of staff and volunteers who are currently working within social service agencies in NYC. However, due to concerns regarding licensure requirements to implement psychological interventions in New York and the high rates of COVID-19 throughout the city at the time, students beginning their first or second year of the clinical psychology doctoral programme ($N=8$) at the NSSR were selected as trainees because they are already supervised by

licensed professionals within the state. In addition to these eight trainees, participants who were pre-identified to become supervisors of the Cohort 2 also took part in the training ($N=2$).

Similar procedures and criteria to the ones used for Cohort 1 were followed to identify and select 16 trainees from SOS CVI. The SOS Global Hub on Mental Health and Psychosocial Support (GH-MHPSS) helped in guiding national associations (NA) to select the appropriate candidates based on a series of considerations, including: (a) potential need in the context, (b) pathways for referrals to specialised care, (c) some degree of previous experience and proven skills in the helping relationship and/or MHPSS interventions, (d) English language proficiency, (e) a stable internet connection and (f) availability to participate.

Surveying Trainees. Prior to the training for Cohort 1, a brief open-ended survey was developed and emailed to each of the trainees to give them an opportunity to share their thoughts, interests and concerns about the training. In this survey, trainees were asked about their motivation, expectations and styles of learning (see Table 2). Following the survey, participants were sent an informational welcome letter and video, as well as a copy of the manual¹.

Several adaptations were brought over from the training of Cohort 1 for the SOS surveying of trainees. A pre-training meeting was held 1 week before the start, with all participants, the trainer and technology and design facilitator. The meeting provided the opportunity to clarify the expectations and objectives of the training and address logistical and technical matters including timing of the training given that trainees/trainers were working across four time zones spanning 7 hours; the optimal balance between synchronous and asynchronous work; which technological platforms to be used and means of communication. Participants were also encouraged to look at the Ensuring Quality in Psychological Support (EQUIP) interface to learn more about digital learning approaches (<https://whoequipremote.org/en-gb>).

Pre-Training Assessment of Trainees. Prior to training, individuals in both cohorts were asked to complete a brief assessment with a remote version of Enhancing Assessment of Common Therapeutic factors (ENACT). ENACT was developed for face-to-face delivery of care and piloted in Nepal and has since been used extensively in mental health research in several countries (Kohrt et al., 2018; Pedersen et al., 2021). Given the need to train individuals in

Table 1: Preliminary Clarifications for Remote PM+ Training of Helpers

1.	What potential MHPSS gap will remote PM+ fill?
2.	How will the training take place (asynchronous vs. synchronous)?
3.	Who will be the trainees/helpers receiving the training?
4.	Do the trainees/helpers have experience in MHPSS?
5.	What contextual barriers to remote training may exist (privacy)?
6.	What times of day are most suitable for training?
7.	What is the level of fluency with technology and technology capacity (e.g. Wi-Fi, video conferencing)?
8.	How will supervision take place if the training takes place?
9.	Will trainees be able to deliver PM+ in accordance with local accreditation and legal bodies?

remote interventions and also develop and validate tools to assess competencies, a remote version of ENACT is being piloted within the context of Remote PM+ training for both the cohorts. In the remote ENACT role plays, the actor explains the purpose of the role play followed by a brief remote mock session (approximately 10 minutes). The role play is video recorded and then observed by trained raters who complete ENACT scoring. As part of the new development work on a remote version of ENACT, qualitative interviews were carried out with the trainers and trainees. For the Cohort 1, ENACT-Remote will also be administered at the end of the test cases, including qualitative interviews with the trainees and clients. After PM+ training, the ENACT-Remote competency role play assessments were repeated. Competency role plays focusing on PM+ skills were also conducted by the actor-rater teams after the training. The ENACT and PM+ competency role play assessments for Cohort 2 replicated that of Cohort 1.

Training Duration, Cohort Size and Trainer Support. For Cohort 1, the training was conducted over 9 days and approximately 75 hours. Originally, trainees were going to spend about half of the time working synchronously on Zoom (Figure 1) and half working asynchronously on their own time. However, by day 4 of the training, the trainees

indicated that they felt the synchronous time was more conducive for learning, and it was difficult to manage their independent work. At that point, the training was adapted for more synchronous work. This adaptation was an important change as it provided more time for “live” role plays, engagement, time to learn from other trainees and to receive live feedback.

In addition to trainees ($N = 10$) and the trainer, there was a fulltime technology and design facilitator (SM) who assisted with breakout sessions, cueing videos and trouble-shooting technological issues. Three individuals involved in various aspects of the research and organising also observed the training.

The size and duration for Cohort 2 was similar to Cohort 1. SOS CVI staff ($N = 16$) were screened by the SOS CV GH-MHPSS and were invited to be participants in the training. Two of the selected colleagues from Ethiopia were unable to join the training due to a national level internet blackout lasting the entirety of the training. The two SOS staff members who took part in Cohort 1 training attended the training as observers to build their skills as PM+ supervisors. The training lasted 10 days, with 5 hours of synchronous work and 2–3 hours of asynchronous work per day, totalling approximately 75 hours.

Table 2: Expectation Survey for Remote PM+ Trainees

1. What is your motivation for taking the PM+ helpers training?
2. How do you expect to use PM+ in your work?
3. How do you best learn?
4. How do you best cope with stress?
5. Please tell me a bit about your background (where you are from, education background, where you are currently at in your studies, previous experience with mental health and psychosocial support).
6. Do you have any concerns about this training?
7. Do you have any concerns about this training?

Figure 1: Illustration of Remote PM+ Trainer and Participants Working Together on Zoom



Technological Platforms. In an effort to make the training as similar to experiential and participatory approaches utilised in the in-person PM+ training and to consider multiple learning modalities and learning styles, a number of online platforms were used to engage and promote participation and interaction among the trainees (see Table 3).

Apart from Ethiopia, there were relatively few electricity and internet connectivity problems. When power and Wi-Fi connection issues did occur for Cohort 2, the participants had backup computer batteries and Wi-Fi phone hotspots to reduce disruptions, or they switched to doing role plays by WhatsApp (using their phone's internet connection) or via a standard telephone. Whereas all the trainees from Cohort 1 and a number from Cohort 2 participated from home, others from Somalia, Rwanda and Burundi took part in the training from their work offices.

Practice Role Plays and Demonstrations. Throughout the course of both trainings, there were two forms of role play, "live observation" and "recorded practice". Live observation took place in Zoom breakout rooms, in which the trainees were placed in dyads and asked to practise full sessions and strategies together. The trainer visited each breakout room to observe the trainees. Throughout the live observations, the trainer kept the microphone muted and camera off to avoid interrupting the session. Feedback was given by the trainer if there was time during the session or through a Google Doc feedback form. Trainees had the opportunity to "time out" and ask questions in real time during the live observation sessions.

Trainees were also asked to practise their skills through asynchronous "recorded practice". The trainees would practise with another trainee or a volunteer friend or family member. The sessions were recorded and uploaded to Google Drive folders for the trainer to review and provide feedback. In addition to role plays, demonstration videos were created by the IFRC PS Centre that included sessions and strategies being done by PM+ trainers (as helpers) and volunteers. This provided an additional learning modality to enhance integration of materials.

Providing Feedback. Providing feedback is believed to be a central component of trainee learning. In the case of remote learning, consistent and timely feedback may help trainees to adapt and incorporate critical information and

techniques prior to learning new strategies. Throughout the training, participants received feedback through a password protected folder in Google Drive. This folder was shared only with the trainer, the tech facilitator and the trainee and was used by the trainer to provide feedback to trainees after observing each strategy and session. Trainees also received feedback from the trainer within their online submission forms that were sent to the trainer after completion of each day. The trainer would then respond and provide comments throughout this document, reproducing a conversation or dialogue with the trainee. In addition, each trainee had a role play feedback form, in which the trainer provided feedback on observed strategy and session role plays.

Implementation of Practice Cases. Among the 10 individuals trained in Cohort 1, eight began their supervised practice cases (six NSSR, two SOS). For those implementing in NYC, clients were referred through the university psychotherapy training clinic at NSSR. Individuals referred to receive PM+ were either seeking treatment and on a waiting list or had previously completed treatment at the clinic and were recontacted to see if they would be interested in receiving additional skill-focused support. At time of submission, 11 clients have received five sessions of Remote PM+ in addition to pre- and post-sessions conducted for remote assessments and another two clients have begun the programme. As the collection of pilot clinical outcome data is still ongoing, these findings will be published subsequently. However, preliminary process data are promising, as only one client has not completed all five sessions and anecdotal feedback from clients to the helpers has been positive.

With regards to Cohort 2, at time of submission, of the 14 trainees, 13 of the trainees began their supervised practice cases. The individuals referred to receive PM+ were either seeking services for the first time or were former SOS beneficiaries. Participants who are receiving PM+ sessions are either part of ongoing SOS family strengthening or alternative care programmes, or were referred from family, colleagues and local social services, as well as the SOS website. At time of submission, four clients have received five sessions of Remote PM+ with pre- and post-sessions conducted for remote assessments and one client has received five sessions of face-to-face PM+ with pre- and post-sessions conducted in person. Nineteen clients have

Table 3: Technology Platforms Employed for Remote PM + Training

Zoom	Used daily for online plenary and breakout sessions, both for activities and role plays. Participants were also able to use Zoom to record offline role play and teaching demonstrations.
Mural	Mural attempts to recreate the use of a whiteboard. Used for participatory exercises and training guide throughout online and offline training.
Google Drive	Used to store training materials including daily training slides, submission forms and supplementary materials. Each trainee had a private folder that was shared between themselves and the trainer. Within that form, they submitted daily submission forms as well as role play videos. The trainer could then provide feedback on their daily submission forms, as well as on a role play feedback form.
YouTube	Video recordings of most Sessions and Strategies can be viewed by participants when provided with direct links.
WhatsApp	Used by the trainer and the technology facilitator to coordinate transitions and cue technology. It was learned that it would have been helpful to have a similar informal communication channel set up with participants of the training as well, as it is difficult to broadcast to participants while they are in breakout rooms or doing activities during Mural.

started to receive Remote PM+ and one additional client has been scheduled for the pre-assessment.

Supervision. For Cohort 1, supervision by the trainer (KAM) began when the trainees started seeing clients and has continued on a regular basis, initially weekly, and as confidence increased, tapered off to twice a month. Supervision takes place in group format on Zoom and individual sessions have been held when necessary. Group sessions last approximately 90 minutes and include a check-in, case presentations by trainees (two to three per session) and feedback facilitated by the supervisor but provided by the group of trainees. Self-care check-ins and in-depth discussion around caring for yourself as a helper have been integrated into supervision.

The trainer suggested that the Cohort 1 trainees hold peer supervision sessions between formal group supervision sessions. The group has adopted this practice and meets regularly. Supervision forms (editable Google Forms) requesting specific information about the case that the helper is working with and any feedback they hope to receive are submitted 24 hours prior to each session. The supervisor uses this to identify who should present cases, common difficulties the group is experiencing and as an indicator of how the helper is navigating the PM+ sessions.

Supervision for Cohort 2 is provided by a trainer (SH). Due to the size of Cohort 2, two supervision groups have been formed. One group ($N=5$) is comprised of European SOS CV NAs and the other comprised African SOS CV NAs ($N=9$). Supervision sessions began in mid-September and run twice a month, with each group receiving three sessions in total with the trainer, with the two facilitators trained with Cohort 1 serving as co-supervisors. The first two supervision sessions were led by the trainer, with the third supervision session being led by Cohort 1 co-supervisors under the overall observation of the trainer. The co-supervisors will then lead supervision sessions until the trainees have completed their practice cases. This model is to allow for the transfer of skills and responsibility to SOS through an apprenticeship model which was conceptualised prior to the beginning of the training of Cohort 1 and allows for stronger integration of PM+ into NAs.

Contextual adaptations to handouts and how to recruit potential clients from SOS CV have played a key role in supervision sessions, in addition to topics reflected in Cohort 1 supervision. Trainees working within the same NAs (e.g. Somalia, Somaliland, Italy and Rwanda) also provided peer supervision to each other. Cohort 2 follows the same process of filling out supervision forms prior to the start of each session.

Supervisees from Cohort 1 were briefly interviewed by an external partner about their experiences with remote supervision. The findings of these interviews suggest that remote supervision played a key role in their training and development as PM+ helpers. A key factor that was indicated was that small supervision sizes ($N=6$) were preferred in order to facilitate group cohesion and to allow for fuller participation. The supervisor (KAM) affirmed that the possibility to conduct remote supervision allowed for

continued growth and development throughout the entire Remote PM+ training process, and that it was possible to form a supervisory alliance remotely. Time needed to facilitate sessions was not perceived as more than if they were to be done face-to-face, as an understanding of the platform and supervision forms was already established prior to the start of supervision, and preparation work such as reviewing notes and supervision forms would have been the same as if face-to-face.

Results

Lessons Learned²

Remote PM+ Training may be Feasible. Overall, the trainers were successful in delivering the training to the trainees. The majority of participants completed the training and were competently prepared to deliver the PM+ intervention. Although the follow-up ENACT data from the two cohorts are still being collected, based on the trainers' observations, the participants in both cohorts showed consistent engagement with the materials and demonstrated core competencies in PM+ such as delivering assessments, learning basic helping skills, determining inclusion or exclusion criteria from PM+ and meaningful participation in supervision.

Remote PM+ Training can be Immersive and Participatory. Although some aspects of the traditional PM+ trainings are didactic, the trainings are designed to be immersive and participatory. Despite what could have been potential barriers, we found that remote delivery of PM+ training still managed to promote participation. The trainer, the technology facilitator and the trainees developed a strong relationship throughout the training. Although there was some reticence and lack of engagement during the first and second day of training for Cohort 1, by the third day almost all of the of the trainees were engaging consistently and there seemed to be a strong sense of trust and mutual appreciation for everyone's role and effort in the project. This trust appeared to strengthen due in part to the trainer's willingness and ability to remain flexible and adaptive to meet the logistical and contextual needs of the trainees. The trainer and the trainees meet consistently and appear to have established a strong supervision alliance. Moreover, the trainees in Cohort 1 have self-initiated a remote peer supervision group as well, which further suggests the ability for the online training to foster cohesion among the group.

Remote PM+ Training Increased Diverse Participation. The remote nature of the training made it possible for a more diverse group of participants to come together. Both cohorts consisted of participants from Africa, Europe and USA which allowed for a richer, more dynamic learning environment, as trainees could share varying life and professional experiences and ideas. In addition, we believe these preliminary outcomes could increase greater diversity (cultural, economic, geographic) in training, as it may allow participation among those who would otherwise not be able to receive the training due to barriers associated with in-person training (e.g. travel time, restrictions

because of conflict, cross-border work, ability to be away from household responsibilities and costs).

New Learnings on Technology and Training. Through the use of technical and design support, the trainings were immersive and incorporated considerable discussion, feedback and real-time role plays. Learning how to use new technology platforms was a challenge for both cohorts, but the focused orientation and experiential learning process enabled it to be well integrated into the training. A number of websites and online platforms were used to help support the adaptation of the PM+ Training of Helpers to remote delivery (see Table 3; Figure 2). The trainees became increasingly fluent with their use over the course of the training. Importantly, success with these platforms was made possible with a full-time technology support person. It would have been impossible for one trainer to lead the training and facilitate the online platforms.

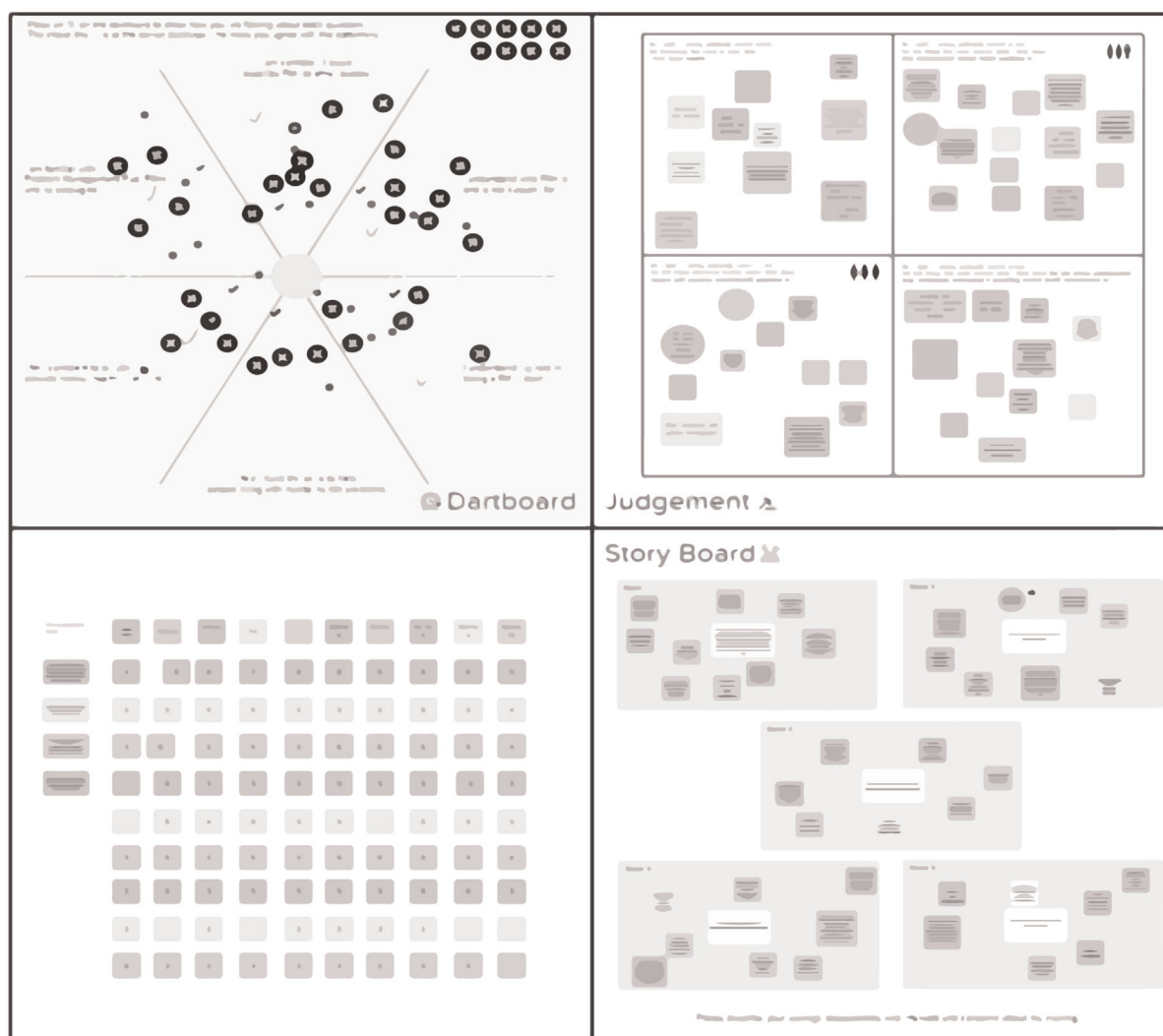
Remote PM+ Training Appeared Relevant for Trainees with Prior Clinical Experience. The majority of studies of task-sharing have focused on the training of non-specialists and individuals with no prior clinical training. Although

trainees in Cohort 1 were not senior clinicians, the majority had some prior clinical experience. There was some concern before the training among the coordinators about whether the participants' clinical experience might make it harder for them to engage in learning basic helping skills and adhering to the manualised intervention. While there was evidence of this at the outset of training for Cohort 1 (e.g. participants expressing that they already knew these approaches), the participants increasingly expressed that the PM+ framing was helpful, and the majority demonstrated the ability to follow the protocol throughout training. This continued to hold true during the implementation of strategies with their practice cases. Although these findings suggest that the individuals with some clinical experience can be trained remotely, we do not believe that this is limited to remote training. Future work would benefit from exploring the potential roles for individuals with some prior clinician experience in the training and implementation of MHPSS, including in-person PM+ contexts.

Remote PM+ has Relevance for High Income Contexts. Despite numerous forms of MHPSS available in places like NYC, gaps and barriers to mental healthcare still exist, and

Figure 2: Sample of the Digital Tool "MURAL" Used in the Training

Activity 2 Pre-assessment Activity



in the context of COVID-19 it is unclear the extent to which physical distancing may impede access to support. Although clinical data from the trial cases are still being collected, those individuals who have been receiving the PM+ intervention remotely appear to find it relevant, as all but one out of 12 individuals have completed the full intervention. Anecdotal feedback from the clients to the helpers has been very positive (e.g. they have stated that the intervention has been helpful for addressing the current challenges they are experiencing). Of course, clinical data from larger numbers of clients must be evaluated prior to determining whether Remote PM+ training will lead to the effective implementation of PM+, whether it is delivered in-person or remotely.

Lack of Time for Adaptation. Due to the urgency to provide remote MHPSS support in response to COVID-19, the trainer and technology and design facilitator worked very quickly to adapt the traditional PM+ materials to an online version. Although the IFRC PS Centre created a series of role play videos and training scenarios, given time constraints, it was difficult for these videos to fit the cultural and contextual experiences of those being trained, particularly for Cohort 2. Future adaptations would benefit from a longer period of formative work to help contextualise the content and visuals used throughout the training.

Bandwidth (Digital and Mental). Overall, the delivery of the training via the internet for the two contexts was carried out with relatively minor interruptions. However, as was expected, there were moments throughout both trainings in which individuals had trouble connecting to a reliable internet source. Perhaps even more challenging was the scheduling and “Zoom fatigue” expressed by a number of the participants. Some of the trainees reported challenges with the stamina needed to be online for such long periods of time. It was more difficult than expected for trainees to block out time to carry out the asynchronous work, which led to a greater emphasis on synchronous learning. One way to mitigate this is to ensure that expectations are clearly set prior to the start of training to ensure that participants are able to fully clear their schedules. This was an important lesson that was carried over to Cohort 2. At this point, it is difficult to make specific recommendations, as future research is needed to determine whether consecutive training or distributing the training over time would help to reduce fatigue. How the training is delivered with regard to timing will likely differ by context and would benefit from pre-training adaptation work.

Focus on Live Practice and Feedback. It was initially assumed that participants would prefer dividing up the training between synchronous and asynchronous work, but ultimately the participants expressed greater interest in synchronous learning, especially for role playing and feedback. Participants were originally going to record their role plays and submit them via Google Drive for the trainer to observe and provide feedback. The trainees found this process very time consuming after completing several hours of online learning. In addition, the trainer found it nearly impossible to view videos and provide meaningful feedback prior to the start of the next training day.

Incorporating the role plays into the online training led to higher levels of engagement and reduced trainer workload between training sessions.

Discussion

In the face of global public health challenges caused by COVID-19, there has been a rapid mobilisation of online strategies to provide access to healthcare. Given the likelihood of both new onset and the exacerbation of mental health issues associated with COVID-19, there is a need to identify strategies that can be scaled up to reduce distress and offer the potential for remote delivery. Although very preliminary, findings from these two pilot cohorts suggest that remote delivery of PM+ Training of Helpers is appropriate, especially if certain considerations and forms of support are put in place throughout the training. Additionally, although we are still awaiting the findings from the clinical outcome data, there have been high levels of engagement from the clients and anecdotal feedback suggests that the majority of clients find PM+ both relevant and beneficial.

Three essential lessons learned were *preparation, flexibility* and *technical support*. In terms of preparation, online learning requires not only making sure one has sufficient time set aside to participate in the training, but also that time is spent preparing trainees to create, when possible, conducive physical and virtual environments for engaging in the learning. Future trainers could benefit from carrying out pre-training assessments of the participants digital literacy, technology and Wi-Fi speed. It is helpful for the organisers to gauge the participants’ ability to find a space or technology (e.g. headphones, virtual backgrounds) that provides some privacy and to work with participants in setting up workspaces for learning. It is important to include trainees early in discussion about the format of the training. Studies of online learning have found that there is greater engagement in learning when such preparations are carried out in advance (Czerkowski & Lyman, 2016). Future work would benefit from integrating such guidance directly into the PM+ training materials. Cohort 1 had a relatively reliable internet connection, high technology literacy and privacy, which was not always the case for Cohort 2. This will differ considerably by regional context, and additional research will help support digital learning in diverse contexts.

Flexibility of the trainer and trainees was critical for training success. Materials were adapted in real time and the trainer had to solve problems quickly to adjust activities with little to no warning. Cohort 1 trainees expressed various degrees of reluctance, frustration and concern about the concept of PM+, as well as the length and format towards the beginning of the training. There was a pivotal moment in which the trainer provided extra time at the beginning of the following morning’s session to better understand the experiences of the participants and encouraged them to share their concerns. The discussion prompted the trainer to share personal experiences with PM+ (both as a former trainee and now trainer). Since the trainer and participants already had some clinical training

prior to learning PM+, the trainer was able to articulate how she found the learning of basic helping skills useful. It was during this discussion that it became clear that the group favoured synchronous learning and subsequent sessions were adapted to better suit their learning preferences. Participants were grateful for these discussions and the training adaptations, which promoted a sense of cohesion and goodwill among the group. Had she responded to their concerns with less flexibility, it is unlikely that the training would have been so successful. If time and resources allow, it would be ideal for trainees to go through the PM+ intervention as clients first to experience the treatment first hand. Although the brief nature (only five sessions) makes this possible under some circumstances, in most instances there would not be the human resources available (e.g. enough helpers to cover 10 people for five sessions).

Given these promising preliminary findings, we believe that there is a solid rationale for the additional study of Remote PM+ Trainings and implementation. An important step for future work will be the inclusion of theory-based cultural frameworks, such as the Design, Implementation, Monitoring, and Evaluation (DIME) methodology, the Ecological Validity Model and the Cultural Sensitivity approach (Applied Mental Health Group, 2013; Barrera & Castro, 2006; Heim et al., 2019; Perera et al., 2020) in the adaptation of Remote PM+ for training and implementation for diverse contexts and cultures. This may be especially important in postconflict regions given many of the challenges in scaling up and delivering MHPSS in such contexts. Importantly, it must be noted that these findings thus far do not provide significant evidence regarding cultural adaptation of Remote PM+, including in the context of postconflict settings (UNICEF, 2018). A number of considerations will have to be taken into account in postconflict settings, including varying levels in digital connectivity, fluency and literacy with digital tools as well as economic barriers that may limit access and sustainability with such tools. That being said, digital adaptations with interventions such as Remote PM+ could aid in reducing barriers to care and the scaling up of interventions in postconflict settings through the streamlining of communication and data collection, providing tools for tracking and monitoring recipients of interventions and through the enrichment of training and supervision.

Therefore, although it is currently too soon to suggest that Remote PM+ trainings and delivery will be effective within the contexts in which they were piloted or others, it is encouraging to see how PM+ could be rapidly and digitally adapted to overcome the physical barriers and challenging operational programme constraints imposed by COVID-19.

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Conflicts of interest

There are no conflicts of interest.

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¹A more detailed account of the training for Cohort 1 can be found in Remote PM+ Training of Helpers: Training & Lessons Learned Report. (2020). IFRC Reference Centre for Psychosocial Support, Copenhagen. <https://pscentre.org/?resource=10695>

²For a summary of Lessons Learned please see: McBride, K. (2020). Remote PM+ Training of Helpers: Training & Lessons Learned Report. IFRC Reference Centre for Psychosocial Support, Copenhagen. <https://pscentre.org/?resource=10695>