

# A Cambodian-Norwegian Competence Building Program in Child Mental Health: A Qualitative Focus-Group Study

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## Research article

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# Abstract

## Background

The prevalence of mental health and neurodevelopmental disorders in young people is high in low- and middle-income countries, such as Cambodia, as risk factors in the perinatal period, malnutrition, infections and adverse childhood experiences can be abundant due to poverty and/or conflict. Collaboration between institutions from high-income countries and institutions in resource-poor settings for professional development can improve service providers' knowledge and skills, which is key to bridging the gap between service needs and the ability to meet those needs.

## Methods

A Norwegian team comprised of a pediatrician, a child and adolescent psychiatrist and a child psychologist implemented a participatory program for competence building at Centre for Child and Adolescent Mental Health in Cambodia (Caritas-CCAMH) two weeks per year over a 14-year period. Herein, we explore some aspects of this Cambodian-Norwegian collaboration from the perspective of the Caritas-CCAMH staff with a qualitative approach using thematic analysis of the transcripts from a focus-group interview with 11 staff members at the end of the 14-year period.

## Results

The multidisciplinary team at Caritas-CCAMH described the learning process with the Norwegian team as a "meeting between experts" characterized by collaboration in planning and implementation, which enhanced the contextual relevance of the project. Mixing theory and practice in clinical case discussions with a bio-psycho-social perspective was perceived as the cornerstone of the pedagogical process. Learning by observation and supervision from the Norwegian team led to mastering skills and enhancing self-confidence and job satisfaction. A pedagogical strategy that involved constant reflection back and forth enabled the customization of the content and method of knowledge exchange despite the difference in socio-economic conditions and learning styles that were unfamiliar to the mental health professionals from high-income countries.

## Conclusions

Building knowledge and skills within a dialogic partnership over a significant period of time contributed to learning across cultures. This model of continuity, low-investment and low-intensity collaborative capacity building may enrich the child and adolescent mental health settings in high-, low- and middle-income countries. Furthermore, the model appears feasible for Western professionals who collaborate with institutions for child and adolescent mental health in low- and middle-income countries.

## Background

Acknowledging the burden of mental health problems in low- and middle-income countries (LMIC), World Health Organization (WHO) has developed the Mental Health Action Plan 2013–2020 (1) to expand services for those with mental health disorders in low-resource settings. A subdomain of specific importance is the mental health of children and adolescents (2). The fact that 50% of mental health disorders commence by the age of 14 years and 75% by the age of 24 years, underscores the reason that investing in the mental health of children and adolescents is a global priority (3). Though strategies for the promotion, prevention and treatment of mental health issues among children and young people are well documented (4, 5, 6), the gap between the service needs and the availability of services remains wide due to inter alia funding constraints, misplaced priorities and a lack of human resources (7).

Strengthening the provision of mental health services to young people in LMIC can be reached through multiple tracks. Juengsiragulwit (8) refers to the following, taken from WHO-AIMS (9): policy and legislative frameworks, mental health specialist services, mental health in primary health care, human resources, public education and links with other sectors, monitoring, and research. According to the WHO Mental Health Gap Action Programme (mhGAP) (10), mental health, neurological and substance use disorders rely heavily on health personnel resources rather than on technology and equipment. Therefore, enhancing human resources, including adequate and appropriate training, is necessary for scaling up health interventions for young people with mental health problems. The mhGAP goal is “to get the right workers with the right skills in the right place doing the right things” (10, p18).

There are many projects worldwide with documented evidence concerning the enhancement of human resources and capacity building in LMICs, targeting health professions in specialist health care (11) and primary health care (12, 13, 14). “Scaling up,” “task-shifting” and “dissemination” are central concepts, meaning to provide mental health care for young people through transference of competence from specialist-trained personnel to primary health-care workers. Some of these projects are partnerships between mental health professions from developed and developing countries (8, 15, 16).

The current article explores the experiences from a capacity-building program over 14 years at Centre for Child and Adolescent Mental Health in Cambodia (Caritas-CCAMH), performed by mental health and paediatric personnel from Norway. To the best of our knowledge, there are few reports of capacity-building programs seen from the local staff members’ point of view. The aim of this research project was therefore to qualitatively explore a Cambodian-Norwegian program in capacity building at Caritas-CCAMH from the perspective of the Cambodian staff.

## **The setting: The Cambodian-Norwegian capacity building program**

The Cambodian health system collapsed during the Khmer Rouge era, and the two decades of internecine war made the situation worse because trained personnel were unavailable to provide quality services (17). Cambodia is a LMIC, post-conflict country with an emerging economy in Southeast Asia. The

estimated population is 15.6 million, and approximately 85% of the Cambodian population lives in rural communities. The few mental health facilities that exist are located in urban centers.

## **Caritas-CCAMH**

Being the pioneering service for children with mental health problems in Cambodia, Caritas-CCAMH at Chey Chumneas Hospital, Takhmau, Kandal Province, Phnom Penh, is a public-private partnership between Ministry of Health Royal Government of Cambodia and Caritas Cambodia (18).

Since 1995, the Caritas-CCAMH team has provided clinical services for children and adolescents with mental health and neurodevelopmental disorders (MNDD). The main problem presentations among patients include developmental problems (mainly autism and intellectual delay, 60%), neuropsychiatric problems (mainly epilepsy and tic disorders, 20–25%), and psychological problems (mainly psychosis and anxiety disorders, 10–20%). Currently, the staff at Caritas-CCAMH performs around 5,000 consultations per year at their main clinic and remote service centers. Until 2000, providing clinical service was the main focus, whereas currently additional emphasis is given to human resource development, capacity building, outreach services to remote provinces, research and documentation in accordance with Fricchone et al. (15).

The Caritas-CCAMH team is multidisciplinary. The team comprises 16 mental health workers, most of them have credentials in education, but their training in child and adolescent MNDD is short and basic. To overcome this challenge, the Caritas-CCAMH team has established collaboration with institutions in Egypt, India, Norway, Singapore, Sweden, Thailand and the United Kingdom. The Caritas-CCAMH staff can access training in some of these institutions, and professionals from these institutions visit Cambodia.

## **The Norwegian team (NT)**

The NT, comprised of the same pediatrician and child and adolescent psychiatrist from 2005–2018, supplemented by child psychologist from 2013–2018, have had yearly two-week stays at Caritas-CCAMH. The NT's expertise covers both somatic medicine and mental health. In a LMIC like Cambodia, the physical impact of inter alia poverty, abuse, birth complications and sequelae connected to infectious diseases on mental health is substantial. Teaching health personnel about young people's mental health in this context requires competence in both somatic and mental health. The primary aim of the program has been capacity building in the multidisciplinary team working at Caritas-CCAMH. A second aim has been to document staff experiences from the program as a model for health-care professionals who do or aim to do similar work at child and adolescent mental health care sites in other LMICs.

Each year, the NT presented summaries from meetings with the Caritas-CCAMH staff at the end of their stay to obtain their verbal evaluation and suggestions for the next year's program. Workshop participants also gave structured evaluations of the workshops. In addition, every year the NT presented a written

evaluation to the sponsors of the program (listed under “Funding”). This material provides the basis for the section “Program: Topics, planning and implementations” below.

## **The program: Planning, topics and implementation**

During the capacity-building program, the lessons and workshops were developed in negotiations between the NT and Caritas-CCAMH staff. The topics and schedules were discussed via e-mail beforehand and settled in meetings on the first days of the visit at Caritas-CCAMH. The schedule was regularly changed according to progress of the training program during the two weeks. Over the years, the management group at Caritas-CCAMH took more responsibility not only for the practical organization of the workshops, but they have also increasingly contributed during the workshops. The topics proposed were usually based on the evaluation of the previous year’s sessions and a desire for further development of specific topics, but also on the actual clinical situation at Caritas-CCAMH, new patient groups and the developmental plans for Caritas-CCAMH. Repetition of material from previous years often preceded implementation of new issues.

The NT has taken part in the clinical work at Caritas-CCAMH and at their satellite clinics in villages and remote sites. As part of the program, the NT followed consultations and discussed specific cases with the staff.

For the content and development of the topics in the program, see Table 1. There has been a gradual shift from normal motor, cognitive and emotional development over neurodevelopmental problems to mental health disorders, treatment and interventions. Epilepsy, pharmacological treatment, and mental sequelae of the general risk factors towards health and wellbeing of children in Cambodia were persistent topics, as were understanding and skills in assessments and interventions concerning abuse, neglect, malnutrition, children affected by HIV/AIDS, and cerebral infections (e.g., tuberculosis and malaria). Other topics addressed in the past have been newborn screening and group interventions for anxiety, psychosomatic complaints and interventions for siblings and parents of children with disabilities.

Table 1  
Topics and teaching approaches, 2005–2018

Year	Topics *	Teaching approach
2005	<b>Basic understanding</b>	Lessons
2006–	Development (motor, cognitive, emotional)/developmental delay (ID, autism, specific developmental delays)	+
2007		Case discussions
2008	Assessment (bio-psycho-social approach)	+
2009	+	Role play
2010 -	Relevant disorders for CCAMH (PTSD, dissociation, abuse, neglect, autism, epilepsy, behavior problems, psychosis, anxiety, Tourette syndrome, medical causes for mental disorders, HIV, cerebral tuberculosis, and malaria)	+
2014		Demonstration with real clients (baby-mother dyads)
2015 -		+
2016	<b>Interventions</b>	+
2017	Behavior problems, ADHD	Video and one-way-window to demonstrate role play or real situations
	+	
	CBT approach (depression, anxiety, PTSD)	+
	Family counselling	
	+	Guidance on real consultations via one-way window or video
	<b>Relevant theoretical topics</b>	
	Nutrition/malnutrition	
	Orphaned vulnerable child	
	Resilience	
	Psychopharmacology	
	+	
	<b>Skills</b>	
	Newborn observation and screening, education of new mothers	
	Relaxation techniques	
	Communication with children (play- and drawing-based interventions, narratives)	
	+	
	CBT workshop, behavior management, group interventions	

\*The different topics and teaching approaches were repeated from year to year, marked with “+”, while new topics and approaches were added

Year	Topics *	Teaching approach
	+	
	Therapeutic alliance	
*The different topics and teaching approaches were repeated from year to year, marked with “+”, while new topics and approaches were added		

Usually, the teaching sessions took place before and after the clinical appointments, but did, at times, take the entire day. The NT created handouts from the theory sections, which were mainly translated to Khmer. The participants often brought with them the handouts from earlier years to the lessons and used them as basis for building in new knowledge. For the first six to eight years, the education was an opportunity for the entire staff, and the aim was to build on their common knowledge base concerning understanding in and assessments of mental health problems in young people. Later, the different professional groups also had separate teaching sessions according to their clinical tasks, and personnel from collaborating organizations, such as NGOs, were invited in.

In addition to lectures, the teaching was comprised of case discussions, practical training using role-play, small group discussions, use of one-way mirror observations of live cases, and reviews of videos of clinical consultations and groups. Case presentations were a central element. The second year, members of the staff took over this task and prepared case presentations according to the planned topics. The cases were examined using structured models (19, 20) to raise awareness that mental health problems of young people must be assessed from a bio-psycho-social perspective (21). In addition, awareness of individual resilience (22) was repeatedly addressed.

Insert Table 1 here

## Reflexivity

It may be challenging to be part of a competence building program in a multidisciplinary team in an unfamiliar culture and different socio-economic context. To overcome some of these challenges, the NT emphasized collaboration and used relevant cases to illustrate the topics with thorough case discussions and evaluations of both oral and structured feedback from the participants. These strategies are in accordance with reflective practice education (23, 24). Therefore, concepts of *reflection-in-action* and *reflective practice* (24, 25) have been normative for planning and implementation of the program. Schön (25) claimed that mastering the complex relation between theory and practice is based on the capacity to reflect in action and relates to one’s conduct while undertaking the task. This allows both teacher and learner to modify what (s)he is doing while doing it. Mann et al. (24) argued that facilitating reflection, as described above, may assist learners in connecting and integrating new learning into existing knowledge and skills. The learners may need feedback on both the content and the process of their reflections.

## Material And Method

With reflexivity as a frame of reference for developing the capacity-building program, the content and aims of the program changed and developed throughout the 14-year period. Furthermore, the program was not initially planned as a research project. For these reasons, we could not perform a reliable evaluation based on pre-post testing (26). To examine the process, we chose a qualitative research approach with focus-group interviews (27) as the data collecting method to gain insight from the staffs' point of view.

## Data collection and participants

We conducted focus-group interview with 11 Caritas-CCAMH staff members who had taken part in the program for at least two years. The participants worked together on a daily basis and knew each other well. We wanted to recruit all members, but for practical reasons the final sample comprised 11 staff members. The sample comprised three nurses (two women), two psychologists (both women), one special educator (woman), one social worker (woman), one speech therapist (woman), one occupation therapist (man), one art therapist (man), and one program administrator (woman). They had been employed at Caritas-CCAMH for two to 20 years (mean ten years). Caritas-CCAMH have a rather stable personnel group. However, we also included two members who had been employed for only two-three years to get their impressions as novices. We distinguish quotes from novice and senior staff in the results section. The interview was audio taped and transcribed verbatim. Two of the authors administered the interview. PP was the moderator and BJ the secretary. The main questions were about the participants' overall impressions of the clinical program, the influences of the program both personally as clinicians and in Caritas-CCAMH, what topics had been valuable, what had not been valuable and their suggestions for further training (see Appendix).

All participants took part in the interview. However, there were differences in their levels of involvement. Most often, they exchanged reflections on the questions raised, but sometimes only gave short answers. This was especially pronounced towards the end of the interview where the issues were their evaluation of the importance of the specific topics during the program and their desires for the future.

## Analysis

The results are based on a thematic analysis (28) of the text from the transcription of the focus-group interview, translated into English. The analysis began by all authors reading the transcripts and exchanging immediate impressions and thoughts. Then, JB and MH read it thoroughly and identified subordinate interpretations/sub-themes. MH integrated them into four overarching themes forming the result section of the present article (see Table 2). The concepts of reflection on action and reflective practice (25) were theoretical support (29) during the analysis. During this process we continually went back to the written material from the development of the project to seek validation for our interpretations of the transcripts.

Table 2

The analytic process from thorough reading of the full text to the identification of sub-themes and the search for overarching themes

Sub-themes	Overarching themes/results
Exchange Partnership Continuity Multidisciplinarity	Participatory learning
New knowledge Integration of theory and practice Skills as most important Cases as starting point The 4-foot model Cognitive behavioural therapy Training skills Lack of follow up	Integration of theory and practice
Learning in situ Newborn screening Modelling NT's* friendly attitude	Learning in clinical situations
Building self-confidence by mastering skills Relief from unrealistic expectations Job satisfaction Confidence from clients and partners	Self-confidence and job satisfaction
Topics in past and future Improve English	Not enough elaborated material to bring into the results
*Norwegian team	

Insert Table 2 here

## Results

The engagement in the discussions was not so much on specific questions on topics as on how this program had changed them as professionals, their clinical practice and Caritas-CCAMH. Although one of the participants said, “changes are difficult to explain”, we obtained rich material and found four overarching perspectives during the analysis: participatory learning process, integration of theory and practice with an emphasis on skills, learning in real clinical situations and building self-confidence and job satisfaction.

### **“All topics were relevant because we chose them”—participatory learning process**

Participants described having partnerships or collaborations with different experts from abroad. The experts provided them with new knowledge that had been adapted to the Cambodian context so as to be useful for the staff. Then, the experts had to learn from the staff at Caritas-CCAMH and a mutual learning process was going on. One senior staff member said:

I think experts from abroad learn from other developing countries like us. And we get new experiences that the experts can use in their countries as well. They adapt them to fit with our country.

Another senior participant added:

They [the NT] shared experiences with us, and we had some points to share with them. For example, we helped with cases and those cases were difficult, so they shared with us how to help.

The participants experienced an exchange of knowledge enhanced over time. They emphasized the importance of the discussions of topics for the program beforehand and during the stay. This was the background for statements that all the topics have been relevant for Caritas-CCAMH; that is, the topics were chosen in collaboration with the NT. As one participant said, “Usually, before taking any topics, they asked us to choose and always asked for ideas from our team.”

The Caritas-CCAMH team is multidisciplinary comprised of professionals with various backgrounds concerning knowledge and experiences. The participants stated that essentially the multidisciplinary nature of the NT (i.e., a pediatrician, a child and adolescent psychiatrist and a child psychologist) was an advantage when selecting issues for the teaching blocks to fit the needs of the staff. They reflected that for instance children with autism and intellectual disability may also have emotional problems. However, when the training did not match the everyday work and if there was too much information, it could be difficult for them to follow when they could not apply the knowledge to their own practice.

The participants described the program as a “meeting between experts”. The NT members were experts on different aspects of children’s mental health while the staff members were experts on the Cambodian context; children’s health risks, the availability of resources, etc. Participants emphasized their active participation in developing the teaching block and the flexibility of the program, both before and during the NT’s stay. This required an ability of the NT to modify the teaching process while they were actually doing it, that is, to reflect in action.

## **“Theory applied with cases and skills is crucial”—integration of theory and practice**

The participants characterized their existing knowledge about young people’s MNDD as superficial and said that their education was not “deep enough” and that they to a small extent, had learned the skills needed to manage children’s mental health problems before they started working at CCAMH. They all agreed on the need for new knowledge and that the learning was most effective when the teaching combined theory and practice. To facilitate that, they emphasized the value of applying theory in the analysis of cases from the daily clinic. One senior male participant said:

We brought our own cases for the discussion. We took part in analyzing and assessing the case with them to come up with a plan for how to change the child’s behaviour.. . Therefore, this is different from class teaching.

A novice added:

Theory combined with practice makes us learn faster. .. And without practice, theory never becomes skill.

Participants summarized that knowing how to analyse a case is the first step to applying a skill, and frequently repeated that learning skills was an important aspect of the teaching. A senior staff member reflected:

So, they told that “if we have knowledge, we need skills.” For example, if children threw things, how should we handle this? If we did not have skills, we did not know how to help children. Therefore, we have to have skills to succeed in our work. Some people are good at talking, but not doing. To help children, you should have knowledge and skills.

However, skills can be difficult to learn within the frame of the one/two-week’s courses the NT provided and the participants asked the team to stay longer, which to some extent, can be compensated with repetition over years. Participants recalled, as an example, a workshop on cognitive behaviour therapy (CBT). After three days, the session had to start over from the beginning; the concepts were unfamiliar and the skills were complex. The training in the CBT approach was repeated in later workshops and different situations. For some of the participants, that meant they had got a basic understanding and said it had been useful for them to apply this thinking in their daily practice.

An example of the interactive learning with repetition is a senior female therapist rendering from a workshop on management of children’s behaviour problems:

The teacher made a table and asked us to fill [it] in. .. and then she showed us the proper places. We noted that we put things in the wrong places. Then we knew the right places after the mistake. Later we practiced with clients. At first things did not go smoothly. But after practicing again and again, we felt confident in helping clients and asking questions.

To be able to practice the new skills in clinical work, participants said the training was necessary. Some participants mentioned that some staff lacked commitment and they went on as usual, for example, by continuing their routine without changing to a broader bio-psycho-social-inspired assessment. Participants reflected that maybe a structure for following up the new knowledge was missing.

Participants gave examples of how useful cases from their daily clinic were for them to connect the new knowledge to their everyday clinical work. The learning process shifted between theory and practice with frequent repetitions in the actual session, but also the topics and skills could be an issue in later sessions. They expressed high appreciation for the opportunities for feedback and reflections both on the content and the process.

### **“It opened my eyes widely”—learning in real clinical situations**

Many said they had vivid remembrances of clinical demonstrations, for instance, the pediatrician training them in newborn baby screening. They described how the pediatrician screened newborns in hospital, and then supervised staff at health centres. This awareness in observation was transferred to other situations, for instance, to observe children at all ages when they come to consultations—to assess their appearance, hygiene, drooling, nutritional status, etc. They also mentioned that from the abovementioned demonstrations they learned to pay attention to the parents as well. A senior nurse said:

I learned how to communicate with mothers, for example, when we did newborn screening at health centres; we always asked the mothers “how are you?” Before, I was not aware of this.. . This is what I learned: when the young patients come, do not forget to talk with the parents.

Some elaborated further on this and recalled from other sessions that the therapist has to reach a consensus with the parents on the nature of the problem, how to understand it and what to do about it. They remembered the repetition of the concept of “therapeutic alliance.” After observing the NT’s consultations and having had their supervision on real consultations on video or through the one-way mirror, they said they felt more comfortable starting a consultation. One senior male nurse said, “They have offered us skills on how to sit with clients, how to listen to clients and how to ask [questions]. Those are skills that we do in practice with clients, not [just] theory.”

Participants explained that they had learned these skills, to a large extent, unconsciously, regardless of their professional background, just by being present. The NT’s attitude facilitated their learning; as one novice staff member said, “I want to say about communication.. . for example, she listened to us, asked us questions.”

The NT team was characterized as polite and friendly, almost like friends. Some added that maybe because of this closeness, the NT too often said “yes.” Sometimes the staff actually needed frank feedback, even if it was negative, to learn. A staff member been at CCAMH for six years said “They do not need to please us”.

They remembered this learning in clinical situations as pegs for memory, as one said: “I still remember this as if it was the last lesson.” However, most of the cases for discussion were prepared from the files, and demonstrations were done through role-play. Many stated that they missed learning in real situations.

Regardless of background knowledge and profession, all the participants mentioned observing the NT in consultations and clinical procedures or having gotten supervision in clinical situations. They evaluated this learning highly and talked about transferring knowledge and skills from one situation to another. This modeling and acquiring of tacit knowledge seemed to have been facilitated by what was experienced as the NTs friendly attitude.

### **“The changes are not only for clients, but ourselves as well”—self-confidence and job satisfaction**

This capacity-building program, in their perception, changed their thinking, feelings and behaviour. Concerning thinking, they mentioned empathy for the client and knowing how to analyse them. Concerning feelings, they said they had gained confidence in and enjoyment of their work. As a senior nurse said:

Like others have said, we get knowledge without [conscious] awareness, for example, skills in communication. We have improved a lot now. We have confidence in working with clients. If we had not, we would feel unease, cold hands, cold feet and sweating.

Concerning behaviour, they gained the skills to do their work. Acquiring skills and self-confidence were closely related. They said that when they had skills and knew what to do, they felt self-confident, which made the work more effective. However, there would be cases that were out of their reach and could not be alleviated. One senior therapist recalled once she had presented a case that never improved, she felt bad as a therapist:

She said there must be one or some who are not [getting] better, despite [our] efforts. Therefore, there is no need to feel bad [about this case].. . So after I met her, I felt relieved.. . I never blame myself anymore.

Circumstances outside the therapy room that the therapist could not influence, might have had a negative impact. For that participant, acknowledgement of her helplessness in these situations changed her attitude when seeing clients.

The challenges for professionals in the field of children’s MHDD problems in LMICs are tremendous, and the staff said that they could sometimes feel “anxious, sweating and fearful.” Mastering clinical skills and acknowledging the limits of their mandate supported the participants’ self-confidence. The learning strategy inspired by reflective practice seems to have assisted the participants in integrating the affective aspects of the therapist role.

## **Discussion**

The current analysis of a Cambodian-Norwegian continuing professional development (CPD) program showed that the knowledge and skills exchange held in the framework of dialogic partnership, particularly over significant period of time, contributes to learning across cultures. The results have several implications for how a cross-cultural CPD programs can be enhanced. For example, some participants mentioned that they would have preferred that the NT came more frequently and for longer stays. This indicated that the current two-week framework for exchanging competence is perceived as suboptimal concerning learning therapeutic methods and interventions targeting specific mental health diagnostics. The time span each year may be too short despite the repetition over years. Continuous development of mental health service tasks may require another kind of continuity and intensity than our project can offer.

However, despite these practical limitations, it is important to consider the opportunities the current framework provides according to the participants. Over the years, the topics of teaching intentionally moved from normal development towards developmental delay and bio-psycho-social problems. This knowledge base, combined with clinical cases and the teachers' demonstrations and active participation in the daily clinical work, provided a platform for the staff to adapt basic relational attitudes, build self-confidence and enhance job-satisfaction. Kokota et al. (30) recently examined a two-day training program on mental health topics for primary health professions in Malawi. They found that scores in knowledge and confidence in identifying mental disorders were significantly higher immediately after the training and six months thereafter. The participants' attitude towards mental illness and mentally ill was not changed when scored by instruments that measure benevolence, authoritarianism and primary health ideology. Possibly, the strength of our program is its long duration and stability that seems necessary to build competence in therapeutic skills like empathy and therapeutic alliances.

The concepts of *reflection in action* and *reflective practice* (24, 25) guided the development of the program and provided a conceptual background for the analyses. We found that these concepts were helpful in promoting the changes the participants describe "in thoughts, feelings and behaviour" and "in ourselves and in Caritas-CCAMH." Participants provided examples of collaborative planning, frequent feedback and repetition upon the participants request, all requiring that the teachers have the ability to modify the teaching process while performing it. They highly evaluated the facilitation of reflection both on the content and the process in the integration of theory and practice. The extensive use of actual cases from the clinic and the NT's participation in the clinic and demonstration of clinical procedures seemed to have promoted this. Naidu and Kumagai (31) have commented on exporting the concept of reflective practice for a global medical education audience. They claim that globalization of medical education demands critical reflection on the reflection itself. They urge educators to "aspire to turn exportation of educational theory into a truly bidirectional, collaborative exchange in which culturally conscious views of reflective practice contribute to humanistic, equitable patient care." In the actual project, we have put emphasis on collaborative learning, and the participants used the word "partnership." It is probably impossible to eliminate the cultural "white spots" or taken-for-given perspectives in Western clinicians' performances (32), but we would argue that we have paid critical attention towards our practice. We have learned that reflective practice combined with critical reflection on practice have

secured the relevance of the project, as is supported by the present evaluation from the staff. Our conclusions are in accordance with the recommendations for “Value-driven Training Innovation” in global mental health from the Society for the Study of Psychiatry and Culture (33).

The participants overall gave a positive description of the NT, describing them “almost like friends”. This may have been influenced by the bias that the leader of Caritas-CCAMH was present. One participant expressed the view that she missed frank feedback, even if it was negative, to learn better. Maybe this tells about a cultural difference in communication between Scandinavia and South-East Asia. The NT team’s reflective stance by listening, exploring and discussing a topic, was interpreted as friendly and pleasing in a cultural context where the communication could be direct and unilateral.

Caritas-CCAMH is a clinic for child mental health care with a multidisciplinary team of doctors, psychologists, nurses, special pedagogue, social worker, occupational therapist and art therapist. The staff appreciated the program because it rendered them “new knowledge”. Caritas-CCAMH needed staff with a basic common knowledge in MNDD in young people, and the different professions needed knowledge adapted to their specific tasks. There is a balance to find when the teaching focuses on the whole group of staff or is given to selected groups. In collaboration with the staff in planning and implementation, it seems we have reached this balance reasonably well, but some of the participants said that the lessons were hard to follow when the topics did not match their daily work.

## Strengths and Limitations

To our knowledge, few studies have brought forward the staff’s experiences from CPD projects mediated by Western experts to a team in child and adolescent mental health in LMIC. Our participants emphasized the importance of learning by participation, integration of theory and practice and modeling, which have got little attention in the literature regarding capacity building in a global context.

The empirical data to this project is from one focus group only. We wanted to include as many as possible of the staff, and 11 of the staff were available in addition to those two who administered the interview. We might have divided this group into two, and possibly got some more aspects and deeper understanding (27). However, CCAMH is a busy clinic, and it turned out to be difficult to get enough participants to run two groups. Despite this limitation, we got rich, varied and valid descriptions, and we are aware that there are more aspects that our project did not catch.

The current analysis has several possible biases. The first is that the documents following the development of the project were recorded by the NT from their perspective except for the participants’ structured evaluation after each session. The second is that the leader of the psychology team at Caritas-CCAMH (PP) headed the focus-group discussion and the manager (BJ) was present, but did not take part in the discussion. The participants may have been reluctant to bring negative experiences to the attention of the leaders and their colleagues (34), and the overall positive accounts from the program may be a result of this. In this context, we could only, to a small extent, expect to get negative comments about the program, although the participants also reported some challenges and sort-comings. We could not get the

complete picture, but we evaluated what the staff said and analysed it with this bias in mind. We therefore determine the results to be new and valid, although not complete.

The program started 14 years ago. Some of the participants had not followed the project from the beginning, and in the interview, they mainly referred to topics from recent years regarding learning skills, interventions and therapeutic alliance. As one participant said, "Change is difficult to explain". The background material reveals a gradual development of the program as a result of the feedback process together with the staff (see Table 1). There has been a process from more general topics relevant for all staff to more specialized topics and practices, and a gradual development to more involvement of the staff concerning organization and participation in the lessons and practice. The participants to a small extent refer to this process; however, we think this is a basis for their present evaluation.

## Conclusions

Our results bring forward attitudes and perspectives developed over the years. We believe this can be a valuable contribution to the different interventions developed, performed and evaluated to enhance the mental health of children and adolescents in LMICs (12, 13, 14, 16). We give a case that illustrates the main opportunities of a CPD characterized by collaboration, short intervals of training, long duration and a stable team of experts from abroad. The most salient points are:

- Foreign experts' reflexive attitude of collaboration in planning and implementation and continuous changing of the program according to feedback from the staff is crucial.
- Teaching should represent an integration of theoretical presentations and practical training from a bio-psycho-social perspective.
- Presentations and analyses of cases from the clinic are a useful way to secure relevance and explore cultural differences between the contexts of teachers and staff.
- Live observations and/or videos enhance learning of clinical skills and attitudes, modeling, team discussions and reflections.
- It could be valuable, when it is possible, to plan measures to facilitate the practice of the new knowledge once the experts have left.
- The two-week framework is suboptimal for learning therapeutic methods and interventions targeting specific mental health diagnosis.

To conclude, the model described herein of low investment and low intensity may be feasible for Western professionals with the ambition to support institutions for child and adolescent mental health in LMICs over years.

## Abbreviations

Caritas-CCAMH Caritas Center for Child and Adolescent Mental Health

CBT Cognitive behaviour therapy

CPD Continuing professional development

LMIC Low- and middle-income country

MNDD Mental health and neurodevelopmental disorders

NT Norwegian team

WHO-AIMS Assessment Instrument for Mental Health Systems

WHO mhGAP World Health Organization Mental Health Gap Action Program

## **Declarations**

### **Ethical approval and consent to participate:**

Participants were provided with information on the study. Written informed consent to participation and publication was obtained from participants. They were free to withdraw from the study any time without any consequences for their work situation. All data are anonymized and stored securely.

### **Consent for Publication**

The participants have signed a consent for publication of the results in an international scientific journal.

### **Availability of data and material**

The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

### **Competing interest**

The authors declare that they have no competing interests.

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## Authors' contributions

PP and BJ performed the interview. All authors read the transcripts and had a preliminary exchange of reflections. JB and MH read the transcripts thoroughly. MH did the analysis and did the write-up. All authors commented on drafts and approved the final version.

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