


Three Case Studies

from Ethiopia, Syria and Honduras



After the randomized controlled trial (RCT): Implementing Problem Management Plus (PM+) through humanitarian agencies

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During and after emergencies and humanitarian crisis, there are large numbers of people who are impaired for prolonged periods by distress. Grief and acute stress are usually transient psychological reactions to adversity and loss, but extreme stressors may also trigger prolonged states of anxiety and depression. These chronic problems undermine the functioning of individuals and their communities, which can be essential for their survival and is vital for socio-economic recovery. In these periods of crisis, the health systems also tend to be overwhelmed and unable to meet the demand for essential services, and often the existing supportive care systems in the communities have also been damaged.

The World Health Organization (WHO) developed a psychological intervention for low resource settings called Problem Management Plus (PM+) for adults impaired by distress in communities who are exposed to adversity. PM+ was found effective in two randomized controlled trials, (RCTs) funded by Elrha's Research for Health in Humanitarian Crises (R2HC) program and by Grand Challenges Canada. PM+ can improve mental health, functioning, and psychosocial well-being of people in humanitarian settings. It is a scalable, manualized, evidence-based intervention that can be used by both the health and social sector to reduce distress and improve functioning. It has proven to be effective in diminishing depression and anxiety and improving people's functioning and self-selected, culturally relevant outcomes. Some of its very distinct and innovative features include:

- a transdiagnostic intervention, addressing a range of client identified emotions (e.g., depression, anxiety, traumatic stress, general stress) and practical problems
- designed for low-resource settings
- intended for people in communities affected by any adversity (e.g., violence, disasters), not just focusing on a single kind of adversity
- it is empowering as it teaches adult participants to self-manage their distress for sustainable, long-term solutions.

In PM+, clients are seen on an individual, face-to-face basis for five weekly sessions with a lay helper. The length of the sessions is 90 min, to allow adequate time for explanation of a strategy and application to client-identified

problems. Independent practice of strategies between sessions is encouraged and reviewed in subsequent sessions, thus enhancing learning through repetition.¹

Following the PM+ RCTs and the published manual, the World Health Organization (WHO) and Terre des hommes (Tdh) with support from Elrha, launched a capacity-building project to not only train humanitarian organizations to implement PM+ in their organizations but also support them through mentorship beyond the training. The mentorship was provided through continuous group and individual supervision, a community of practice hosted on MHPSS.net and webinars on implementation, adaptation, and sharing models across contexts.

To date, 34 master trainers have gone on to train and supervisor 305 PM+ providers throughout the globe. The first master training took place in Cairo, Egypt in March 2018 and the second master training was held in Istanbul, Turkey in May 2019. Both master training courses consisted of pre-reading, an introduction webinar and eight full training days.

Three case studies were conducted in Ethiopia, Syria, and Honduras with three different humanitarian organizations between April 2019 through July 2019. To evaluate the relevance and appropriateness of PM+, in-depth qualitative interviews were conducted with trainers, supervisors, PM+ helpers, and PM+ clients, to identify barriers and facilitating factors to scale up PM+.

¹ Dawson, Katie & Bryant, Richard & Harper Shehadeh, Melissa & Kuowei Tay, Alvin & Rahman, Atif & Schafer, Alison & van Ommeren, Mark. (2015). Problem Management Plus (PM+): A WHO transdiagnostic psychological intervention for common mental health problems. World psychiatry : official journal of the World Psychiatric Association (WPA). 14. 354-7. 10.1002/wps.20255.

Integrating PM+ into existing mental health and psychosocial support programs

Ethiopia

To serve Eritrean refugees living in northern Ethiopia, PM+ is used as an intervention to support clients that are experiencing extreme distress due to poor living conditions, grief, loss of loved ones, stress, isolation and extreme poverty. The implementing organization is delivering PM+ through their healing centres for clients alongside their signature therapeutic groups. PM+ was adopted by the organization to serve individuals who were not ready to attend group-based sessions, did not meet the criteria for group or needed continued support following the culmination of the group sessions.

The trainer who attended the master training in Cairo trained 27 mental health workers and psychosocial counsellors² for seven days using the PM+ training manual. Before PM+ providers were seeing the clients, the PM+ supervisor conducted bi-weekly supervision sessions using role plays, observation and discussion. One person acted as the client, one role-played the PM+ provider and the third person observed the session using the WHO competency assessment developed to accompany the training manual. The generic PM+ manual was adapted and translated into the local language to ensure the PM+ manual and handouts were in the provider's and client's language and that local idioms of distress were used instead of terms that were not contextualized or culturally relevant.

Nine implementing staff and two clients were interviewed about their experience delivering and receiving PM+. The results from those

interviews were positive with one female PM+ helper reporting, „I believe that PM+ is a valuable intervention and I'm seeing a lot of progress in my client who is attending the PM+ sessions" and „it is very interesting for those who are living in the camp as refugees because most of the refugees living in the camp have low mood, are isolated, sleep all day, cry a lot and don't do activities and that is why PM+ is important to support them to manage their problems and bring them out of their low mood." She continued, „when clients start practicing the techniques they are taught [in PM+] it will help them to break the low mood cycle and get out to engage in activities by solving their problems by themselves and using the calendar which helps them to engage in activities to make them feel grounded and encouraged when they complete a task on the calendar." In using the manual, she reported, „the PM+ sessions are step-by-step and clear and help clients to learn tools and build strategies." The only barrier she reported was the length of the sessions [90 minutes] and how challenging it is to stick to the exact time given for each step in the manual. A psychosocial counsellor providing PM+ reported that as clients share their stories and their troubles through PM+, it helps them to manage their problems; he also mentioned that the PM+ intervention is easier to follow and use because it is manualized.

A mental health worker at the organization stated that moving forward he would like to change the rating scales used to determine if the client meets the inclusion criteria. He suggested, "when rating

functioning, it would be better to use pictorial representations of functioning versus using the WHODAS 2.0³." He continued to say, "when I first taught deep breathing to my client, she was confused and I explained to her that I was also confused when I first learned it, in the end she tried the exercise at home and came back and reported that deep breathing helped her." Thus, another challenge was explaining deep breathing to clients, but this was resolved when he shared his personal difficulties. When he ran the Managing Problems session with a female client he reported, "she knew how to solve problems

A 23-year-old woman who completed all five PM+ sessions said, „I would recommend PM+ to a friend because I would want them to learn the skills that I learned to be able to help them manage their stress." She also reported that her PM+ helper taught her a skill that she can use when she is feeling stressed or worried, called deep breathing. She said, „these skills could help anyone who was feeling stressed, angry, or aggressive because when you take a deep breath in, you feel relaxed." She also reported that sharing her stressors with her PM+ helper supported her. Another older female client even



but had to be reminded that she had those skills." He discussed two additional barriers to delivering PM+ in saying, "I hesitate to terminate the session after the fifth session is complete because some people might need six or seven sessions and it is difficult to determine if five sessions is enough for them." He continued to state, "sometimes it is difficult to stick to the time allocated in the PM+ manual because each session is 90 minutes long."

said that before she received PM+, she did not speak or look at anyone in the camp. She felt ashamed that her husband left and could not bear facing the community. During session two, Managing Problems, her PM+ provider helped her come up with a plan to start saying hello to a few people on the street every day. Even though saying hello is a simple task, she reported that it was extremely powerful since she previously had no contact with others.

² Psychosocial Counsellors are camp residents who are trained and supervised to provide mental health and psychosocial support services in the camp.

³ WHO Disability Assessment Schedule 2.0. The WHODAS 2.0 is a recommended tool to measure functioning. In the PM+ manual it states, "the choice of measure depends on what measure has been locally validated."

Using remote supervision to implement PM+ in hard to reach areas with psychosocial workers in Syria

Syria

Through an initiative led by the Mental Health and Psychosocial Support Technical Working Group, 26 Syrian and Turkish mental health practitioners from multiple humanitarian organizations were trained as PM+ trainers in November of 2018 over the course of nine days. Directly following the training, each trainee took on two practice cases and received remote group supervision for three months. A translator who was trained in PM+ supported the remote supervision calls because the supervisor only spoke English. It was required that each trainer complete two practice cases before training non-specialists on PM+.

Following the supervised practice cases, the 26 individuals went on to train and supervise 120 psychosocial workers (PSW) living in northern Syria who have seen 219 clients to date. Furthermore, in July of 2019, 70 additional PSWs were trained on PM+ and will receive weekly supervision as they see practice cases. Each

training was nine days long, following the WHO PM+ training manual. The key to the program's success was a robust supervision system that included group supervision sessions, on-site observations and a refresher training.

Weekly group supervision sessions were conducted for 90 minutes with seven to eight PSWs per group. This weekly supervision lasted four months, followed by a refresher training based on the supervisor's feedback of the skills and strategies needing to be reviewed. Various supervision techniques were used, with a specific focus on case presentations using a case reflection form that was completed before the supervision session and sent to the supervisor via WhatsApp. Role-plays were also used to support PSWs with challenging cases. Each supervisor completed one observation session per PSW and completed the WHO competency assessment form to assist the PSW with skill development.

To support the eight field supervisors, a master supervisor conducted remote weekly supervision sessions for 120 minutes with four supervisors per group. In a similar manner to the supervision for PSWs, supervisors presented on their supervisees challenges and sought support from their peers. To ensure fidelity to the PM+ protocol, an external supervisor (based outside the region) met with the master supervisor weekly to discuss frequently asked questions and support any technical issues. Using a tiered model of supervision ensures that the PSWs have various levels of support from the outset.

The master supervisor said, „my role was not only to support the supervisors with PM+ but also to make sure to focus on staff-care since my staff are living and working in a war zone.“ He reported that „PM+ is one of the first manualized and structured interventions used in the region“ and „PSWs have reported that they feel as though they have more skills to use in their work because of PM+.“ He also stated, “PM+ gave two things to this region. It gave PSWs a method to support people in the community using an evidence-based approach, and secondly there has also been a gap in structured supervision which has since changed due to the rollout of PM+.” He went on to say that he “appreciated the supervision forms that were used and sent by the supervisors before each session.” The supervision forms allowed him to read through the supervisors' reports and reflection forms and familiarize himself with their caseload before the group supervision session started each week. He was initially sceptical about conducting group supervision remotely and still prefers supervision vis-à-vis; however, he is grateful that remote supervision is available and sees it as the only option in this case because the north of Syria is often inaccessible.

Four PSWs in northern Syria delivering PM+ through protection and primary healthcare centres were interviewed together. One female PSW reported, „some of the barriers we face are that when clients are referred to us, they don't always meet the inclusion criteria for PM+ and ask for different services such as money and economic support.” They stated that this was the only barrier they faced, and overall, they believe that PM+ is very accepted in the community because it covers „real-life situations for them.” A male PSW continued to say, „because it is a simple program, it was accepted quickly and it supports people with common mental health

concerns.” They saw very positive results with PM+, even though they are living in a war zone. Furthermore, another female PSW said, „the supervision sessions were beneficial because we were provided with real feedback.” This was the first time they engaged in consistent supervision because previously a culture of supervision did not exist; it has now been created for PSWs.

Over the course of nine months, the supervisors and PSWs developed a frequently asked questions list with over 50 questions and relevant answers that were reviewed by the core supervision team. This working document will

continue to support PM+ providers and program staff for years to come. Furthermore, the Syria team adapted the generic PM+ manual by asking the PSWs to create drawings that were more appropriate for their settings. Please see the adaption of the Get Going Keep Doing Inactivity Cycle in Figure 1.

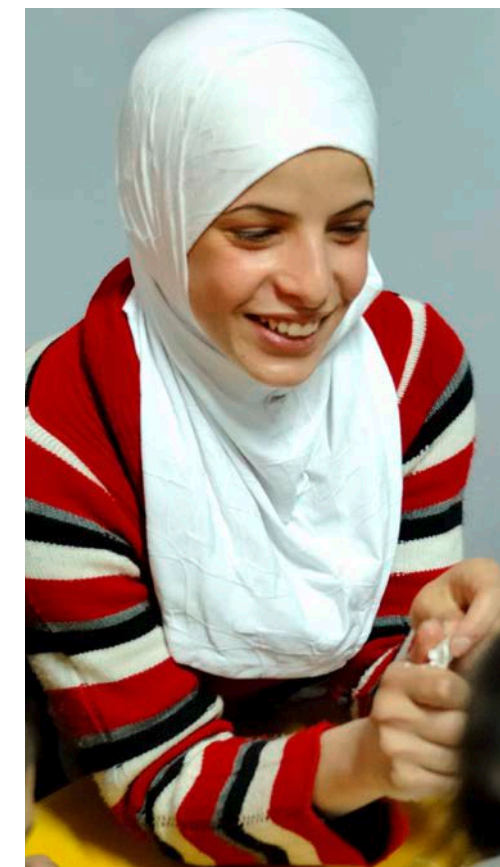


Figure 1 The PM+ inactivity cycle drawn by a trainee in Syria during the PM+ helper training. An example of adaptations made to ensure the manual is culturally and contextually relevant to the population.

Implementing PM+ with a volunteer workforce

Honduras

A mixed training for PM+ helpers and future trainers was conducted in December of 2018. 12 community volunteers and five psychologists participated for six days with two additional days for future trainers. From January 2019 to May 2019 each trainee received 10 hours of remote individual supervision for two practice cases. Starting in April 2019, supervisors started group supervision for community volunteers. In June 2019, the supervisors traveled to Honduras to conduct face-to-face supervision and a refresher training.

As of July 2019, the 12 community volunteers have worked with 32 clients, 20 of which completed the PM+ sessions and 12 of which are still completing the sessions. Ten follow up sessions have been conducted where the PM+ strategies are reviewed with clients, two or three months after completion.

Three interviews were conducted with staff from this implementing organization: one master supervisor, one supervisor, and one community volunteer PM+ provider. When asked about the effectiveness of individual supervision, the master supervisor reported, „once group supervision started, it was more effective than individual supervision, and it took a while for the community volunteers to get comfortable with the supervisors.” She continued, „during the



refresher training and face-to-face supervision, I could tell that they were more comfortable, which makes me think that more face-to-face contact is important.” She stated that in the beginning, „it was difficult to get the project [PM+] started because we couldn’t find resources and the settings in which we were working in already had projects. It was difficult to explain to the implementing partners why supervision was so essential and that the training couldn’t be conducted without supervision.” She also stated, “we had to involve various partners which made it difficult to convince everyone of the importance of PM+.” Now that the first PM+ training has been conducted with partners and community volunteers she reports, „in the future we want to train community volunteers first on basic mental health or work with volunteers who have some experience identifying people with mental health concerns.” She reported that a barrier they faced

when conducting the training was the amount of time that people could be present and away from work. She continued to explain that six days of training was not enough for PM+ helpers, but this was the best they could do. In the future she hopes to have more time since she recognizes how difficult it is to teach the material over the course of only six days.

A female community volunteer who is working as a nurse assistant in Honduras and volunteering to provide PM+ reported, „I use the tools to implement PM+ and find the tool very useful, and it’s a tool that tackles stress and anxiety with very easy to follow guidelines.” When asked if PM+ is a feasible intervention to scale up in her community she reported, „the tool has been useful because when clients come they are stressed and anxious, and in the beginning I did not see how the tool was going to be helpful, but after I saw clients benefit from the tool, I knew it was helpful, specifically the stress management technique.” She reported, „I have seen changes

because it was different from her regular job, but the skills she uses as a nursing assistant helped her to provide PM+ and connect with clients.

The community psychologist delivering remote and face-to-face supervision reported, “I work to train and support medical providers to make referrals to community volunteers delivering PM+, but since it is a new intervention it takes time.” She continued to say, “the intervention [PM+] has been accepted in the community because it teaches people skills to solve their problems, and people usually go to a provider and they try and solve their problems for them.” The master



in my clients. One of them was in a situation of depression and wasn’t bathing. Now she started bathing, which is a small change but significant, and they aren’t as depressed.” The community volunteer also reported one of her clients living in a rural area must walk three hours to reach the place where she receives PM+ even though there is no financial incentive given. This shows dedication from the client and the effectiveness of the intervention. She finished by saying she was nervous to deliver PM+ in the beginning

supervisor requested that she conduct supervised practice cases before working as a supervisor to allow her to truly understand the intervention. She reported that this method helped her to feel comfortable supervising PM+ providers and she hopes that her organization can use it in various locations.

Conclusion

Based on the information gathered from these case studies, it can be concluded that PM+ is both relevant and appropriate for use in various humanitarian settings. One of the most valuable lessons highlighted in each case study was the importance of having a robust supervision system. The rollout of PM+ varied slightly among the three implementing agencies, but to the best of our knowledge it can be concluded that all three models worked effectively. This was due to the strong supervision system along with practicing the intervention before it was fully delivered.

To implement and scale up PM+ requires dedicated staff or volunteers and adequate time to conduct the initial training, followed directly by supervised practice cases. In addition, continuous supervision is required once PM+ providers start seeing clients. This entire process demands dedicated time and needs to be thoughtfully planned out in order to deliver quality services at scale. It is important to note that supervision does not always have to be delivered face-to-face. Evidence from the case studies in Syria and Honduras demonstrates that remote supervision delivered online via Skype with WhatsApp groups for ad hoc messaging is an innovative and viable option in hard to reach humanitarian contexts or contexts.

In both Syria and Honduras, the master supervisor handed over responsibility to the field supervisors once the core competencies were shown, using the WHO competency assessment. It is important to note that in all three case studies, the PM+ trainer was also the initial supervisor. It can be hypothesized that the trainer had a strong sense of the PM+ trainee's strengths and areas that needed to be improved and could tailor the supervision sessions to individual needs in the group.

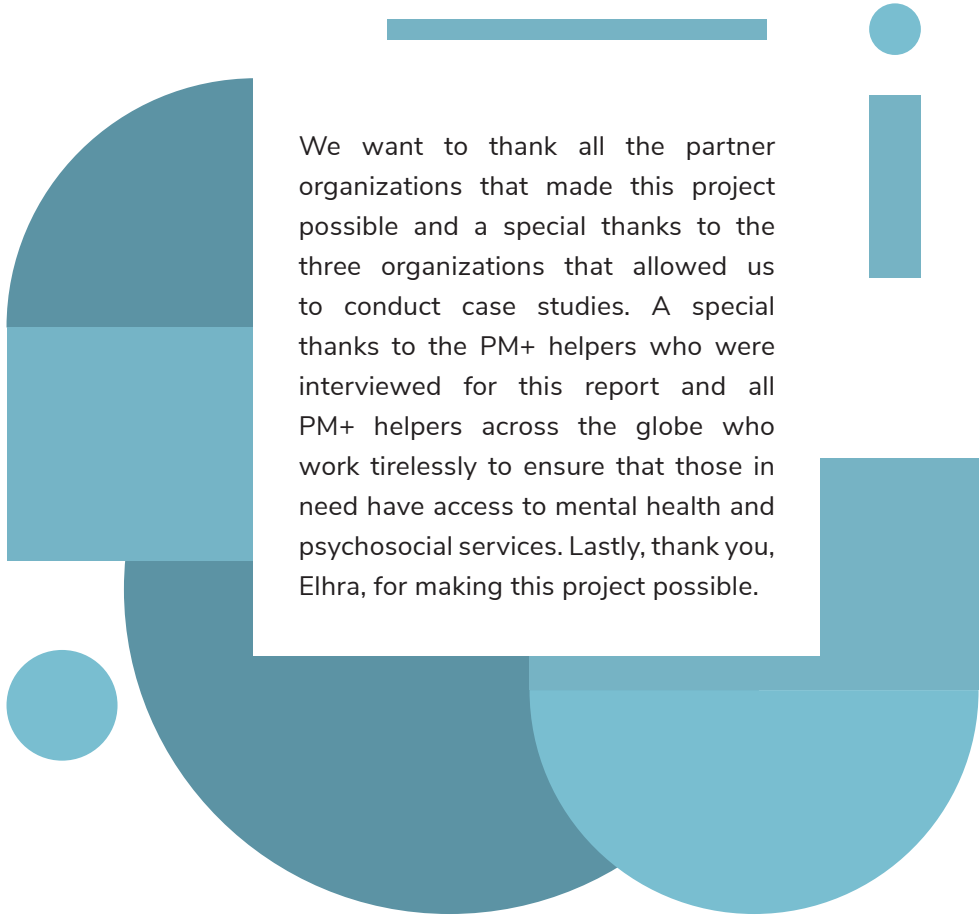
Furthermore, these case studies conveyed that there must be a culture of supervision created for PM+ to be implemented effectively. As evident in Syria, the PSWs were grateful for the supervision they received which has changed the way they work, not only in delivering PM+ but for other interventions. In order to create this culture, supervision should be supportive, encouraging and not punitive. The master supervisor in Syria emphasized that it was really the supervisees who supported one another with challenges and encouraged each other in difficult cases while he was there only to facilitate the conversation through supportive means. The case studies show that to deliver PM+ effectively and at scale, there must be a whole system of people working together to ensure quality services are delivered while keeping fidelity to the PM+ model. In each of the three settings, PM+ was not the only intervention being delivered, but time and intentionality were dedicated to ensuring that PM+ was functional and part of the larger intervention package.

We confirmed through these case studies that adapting and translating the generic manual will always support PM+ implementation. As seen in Figure 1, adapting the manual does not always require hiring a graphic designer; many of the adaptations to the drawings can be made by PM+ providers or community members. Translating the manual to the local language is challenging and requires more resources but is imperative to effective implementation.

Through these case studies, we gathered meaningful examples of the different ways that PM+ can be implemented in various settings with non-specialized providers. We also determined that PM+ is effective following the initial RCTs conducted in Kenya and Pakistan. Even though minor barriers were encountered, the case studies strongly suggest that PM+ is a relevant and appropriate psychological intervention delivered in humanitarian settings.



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