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**Airbel Impact Lab**  
Research & Innovation at the IRC



# Understanding COVID-Inspired Shifts to Remote Systems of Care

Perspectives on the Provision of Remote Mental Health and Psychosocial  
Support Services in the Middle East



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# Summary

COVID-19 and the subsequent lockdowns led to disruptions in service delivery across the world. For mental health, the World Health Organization (WHO) estimates that 93 per cent of services were halted worldwide. This disruption precipitated a rapid shift to using phone and internet modalities for delivering services, enabling continued and/or expanded access to mental health and psychosocial support (MHPSS) interventions for clients. “Not only has it illustrated that remote services were possible, but that they likely play an important role in the future of MHPSS across the Middle East and the entire world.” To maximise this opportunity, it is necessary to take a step back and assess where we are now to create a new path forward for effective remote mental health services.

This paper looks at the remote delivery of MHPSS services across the Middle East. It synthesises an evidence review, interviews from practitioners across the region complemented by interviews with clients from Jordan. Research results suggest that the impact and quality of remote MHPSS services depend on certain variables including context, client characteristics, practitioner characteristics, client needs, and therapeutic techniques. Currently, **remote services work particularly well for the treatment of mild cases and short-term counselling or therapy**. They are more impactful for **individual sessions** compared to group sessions. Moreover, clients with **higher digital literacy and the possibility to have sessions in a private environment** benefit more.

The following key recommendations centre practitioner’s perspectives and what they need to deliver the best remote care possible. They will form the basis for short-term and long-term efforts to strengthen MHPSS across the Middle East.



1.

**Develop evidence-based, hybrid models of care with complementarity between in-person and remote services to improve quality, accessibility, and scale of services through a robust research agenda.**

These models should be centred on what works for clients and practitioners, and should be specific to the needs, culture, and opportunities in the region. They will need to go beyond a focus on new ways of accessing services to look more deeply at the therapeutic techniques themselves. This includes adapting existing approaches and developing new approaches more effectively, while taking full advantage of technology.

2.

**Design an integrated approach to practitioner training, supervision, and well-being.**

This process and materials should be co-created with practitioners, and should be engaging, fun, easy to incorporate into daily activities, and facilitate peer-to-peer learning.

3.

**Protect the well-being of staff by investing more time and resources in supervision and staff care.**

In some cases, it may require structural shifts in the organisation to ensure that staff are not overburdened by their work.

# 1. Introduction

COVID-19 has severely disrupted the provision of mental health and psychosocial support (MHPSS) services. A World Health Organization (WHO) survey (WHO, 2020) showed that the pandemic has disrupted critical mental health services in 93 per cent of countries worldwide.<sup>1</sup> Concurrently, the pandemic and containment measures have triggered mental health conditions such as bereavement, fear, and anxiety, or exacerbated pre-existing ones. To ensure a continuum of care, many MHPSS service providers swiftly adapted to remote service delivery through psychiatrists, psychologists, psychotherapists, health, and social workers. Although not new, the use of technology to overcome service delivery disruptions has soared due to COVID-19.

In this paper, we define remote MHPSS services as therapeutic interventions delivered using phones or internet devices. Prior to COVID-19, most remote MHPSS-related services in Iraq, Jordan, Lebanon, Syria, and Turkey consisted of referral hotlines provided by governmental, non-governmental or private institutions. To a more limited extent, remote therapy sessions have also been present in the Middle East, particularly in areas that are impossible to reach otherwise, such as in areas of conflict in Syria. Across the Middle East, the adaptations catalysed by COVID-19 have been swift and impressive. However, because they emerged quickly and organically, in many cases they happened without previous training of practitioners on the specific aspects of remote settings; without integrating evidence on what works for remote delivery of MHPSS services; and without positioning services strategically within the broader landscape of services. This new situation poses challenges to MHPSS professionals and raises questions on what the future of remote service delivery will look like in the Middle East.

While the pandemic has underlined the necessity for remote counselling, these needs existed before. The Middle East has witnessed decades of armed conflict and millions of people have been displaced. This has not only had detrimental effects on the psychosocial well-being of people on the move, but it has also increased pre-existing gaps in (mental) health care systems in the hosting countries. For populations affected by violent conflict and displacement, access to MHPSS services is often severely restricted and remote

<sup>1</sup> ► The survey covered 130 countries.

counselling sometimes is the only mode of delivery available. Conversely, in more stable environments the costs of transportation and scheduling conflicts prohibit more vulnerable communities from accessing care. COVID-19 has exacerbated the dire health and economic situation of refugees, internally displaced persons (IDP), and host communities and further increased the need for MHPSS services. While online- and telephone-based services have been developed and implemented successfully for many years, the shift to remote delivery was initially perceived as a temporary adjustment to ensure continuity of care during lockdowns and movement restrictions. It is recognised that these services are promising and necessary; and they are increasingly being considered a key feature when ensuring a broad range of service coverage in MHPSS.

At the heart of these services are those delivering them: practitioners who have rapidly pivoted to remote delivery face numerous challenges, including having appropriate models of care, the right clinical and technical skills to deliver care using technology, and a supportive environment to operate in. The challenges they experience in delivering care will affect the development and scale-up of high-quality, affordable, and sustainable services. Addressing these challenges requires a long-term view, including strategically targeted investments to advance both research and practice. To build on the movement towards remote services spurred on by COVID-19, it is therefore essential to better understand where such investments could have the largest impact, based on the experiences of those currently providing and receiving care.

To address this need, this study was launched to learn about the experiences of clients using MHPSS services and service providers – practitioners, programme managers, supervisors, and researchers. The purpose was first and foremost to understand the current state of remote delivery of MHPSS services from the perspective of practitioners; to understand what is currently working well and what the key barriers are; and to develop a vision for the future of MHPSS service delivery in the Middle East.



## 2. Aim and Study Design

This study is targeted at practitioners, implementing organisations, policymakers, and donors working in MHPSS in the Middle East. The countries included in this study were Syria and those bordering Syria, namely Jordan, Lebanon, Turkey, and Iraq. In addition to actors providing services in these countries, three experts on remote services based in Germany and the United States shared their perspectives.

Implemented between January and April 2021, the aims of the study were to:

- ▶ **Capture the perspective of front-line practitioners and strategy-level staff across the region on their experience with remote MHPSS services before and during COVID-19.**
- ▶ **Based on these perspectives, develop recommendations to strengthen remote MHPSS services.**

While acknowledging there is a wide range of remote MHPSS services, the study looked at **focused non-specialised support and specialised services**, including individual or group counselling, psychotherapy and psychiatric consultations, and case management, corresponding to level three and four of the intervention pyramid established by the Inter-Agency Standing Committee (IASC, 2007).

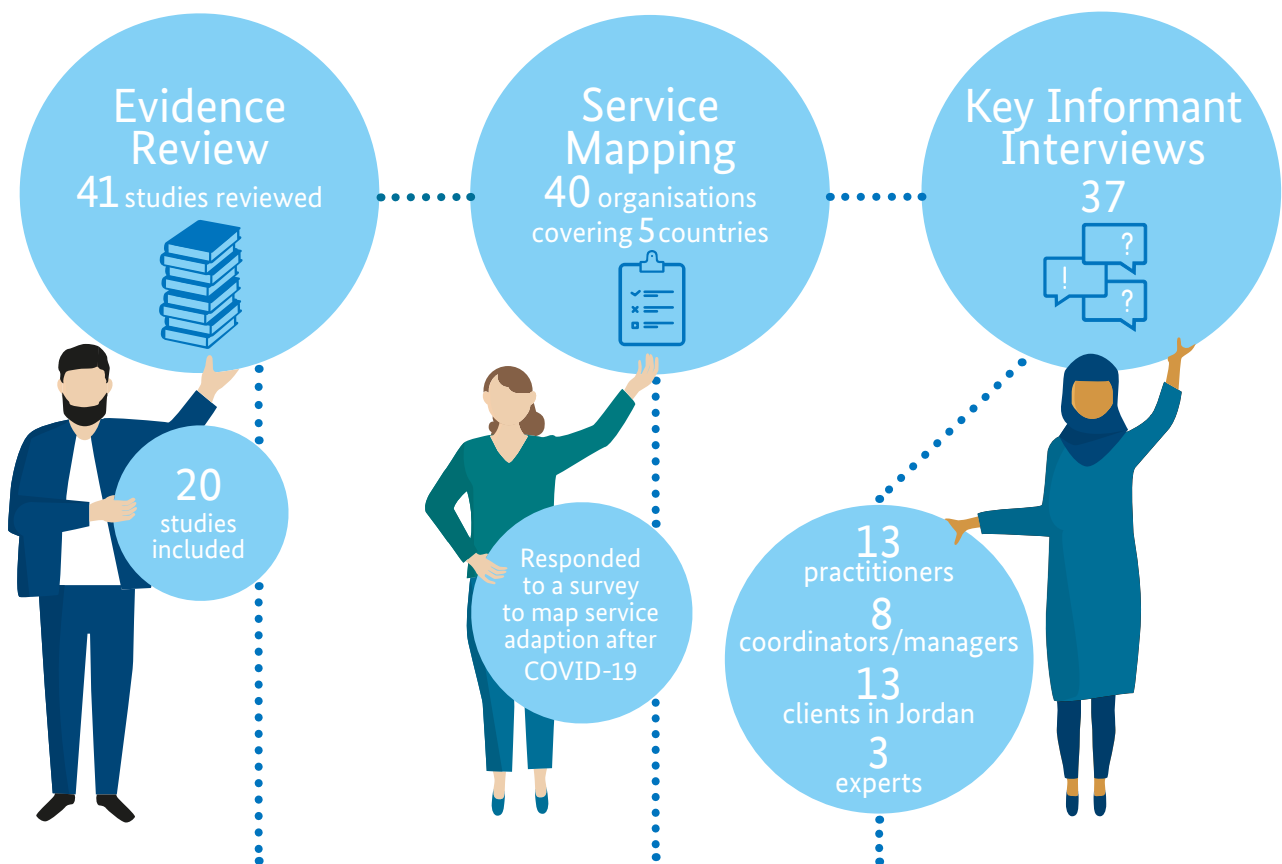
First and foremost, the study centres practitioners' experiences carrying out these services. Qualifications for working in the field of MHPSS vary greatly between the different countries in the Middle East. Therefore, practitioners are broadly defined in this study as non-specialist healthcare workers such as generalist medical practitioners, nurses and community mental healthcare workers<sup>2</sup>, as well as specialist mental healthcare workers such as psychiatrists, psychiatric nurses, and psychologists working in the framework of humanitarian assistance and development cooperation. Additionally, the study includes the perspective of programme managers and global MHPSS experts, who work in humanitarian and development organisations with a focus on programme design, strategy, and monitoring.

Furthermore, this was complemented by a small number of interviews with clients who had accessed remote services as well as programme managers and global MHPSS experts. This paper uses the word "client" to refer to those accessing mental health services. This was used instead of "patient" as patient implies a previously issued diagnosis which is not a pre-condition for accessing services on level three of the IASC pyramid.

<sup>2</sup> ▶ A community mental health worker is a member of the community who has been trained to provide mental health support, education, and care coordination within the community.

It is important to note that **this is a qualitative study** and that **convenience sampling** was used to identify participants for the primary data collection. While a balanced representation between countries was sought, this study does not statistically represent the availability or functionality of remote MHPSS services in the covered countries; rather, it sheds light on the perspectives and experiences of a varied group of practitioners, coordinators, and clients.

This report is based on a synthesis of the following inputs:



Deep dive into the study findings during a workshop with **20** practitioners

Ideation workshop with **24** MHPSS specialists

### 3. Making a Case for Remote MHPSS in the Middle East: An Evidence Review

Results from an evidence review of studies that looked at services prior to the onset of COVID-19 suggest that clients in the region, including Syrian refugees, perceive remote mental health as positive and welcome the prospect of using mobile technology to monitor and bolster their mental health (Ashfaq et al., 2020, p. 11).

In the study by Ashfaq and colleagues, which was reviewed and included in the results, the following opportunities were identified:

- ▶ **Lifesaving.** With the severe disruptions to in-person services, remote service delivery has often become the only possible way of getting help. Despite the challenges, practitioners and clients acknowledged that these services are essential and, for some critical needs, lifesaving.
- ▶ **Greater anonymity.** Personal and social stigma prevails with seeking MHPSS services, and remote modalities can help circumvent this. The possibility that remote services offer for anonymity can be particularly relevant for individuals from stigmatised groups such as lesbian, gay, bisexual, transgender, queer, and intersex + (LGBTQI+) people, who may prefer to maintain their anonymity.
- ▶ **More cost effective for clients.** The possibility of accessing services anywhere is time and cost saving. For those living in congested cities or remote areas, this can be a determinant factor. Practitioners also highlighted the cost effectiveness of remote services for organisations, which can have practitioners work under more flexible modalities and across different geographical locations.
- ▶ **Bridge resource gaps.** In contexts where there is a limited number of mental health professionals, remote services allow clients to be connected with practitioners elsewhere. This is the case in Syria, where the availability of mental health specialists is dire.
- ▶ **Increase access.** Expand reach to individuals who may otherwise not access these services. This may include: parents of young children, people with disabilities, elderly people with limited mobility, adolescents who depend on parents/caregivers for transportation.
- ▶ **Complement in-person services.** Remote MHPSS services can also help manage more effectively the workload of in-person services, especially with remote case management.

While the case is clear, there are significant challenges, which vary according to country characteristics, client needs, client characteristics, and practitioner characteristics. These variables are described in more detail in section 3.2. In this paper, we focus on challenges prioritised by practitioners including information/research gaps, practitioner training, supervision, and practitioner well-being.

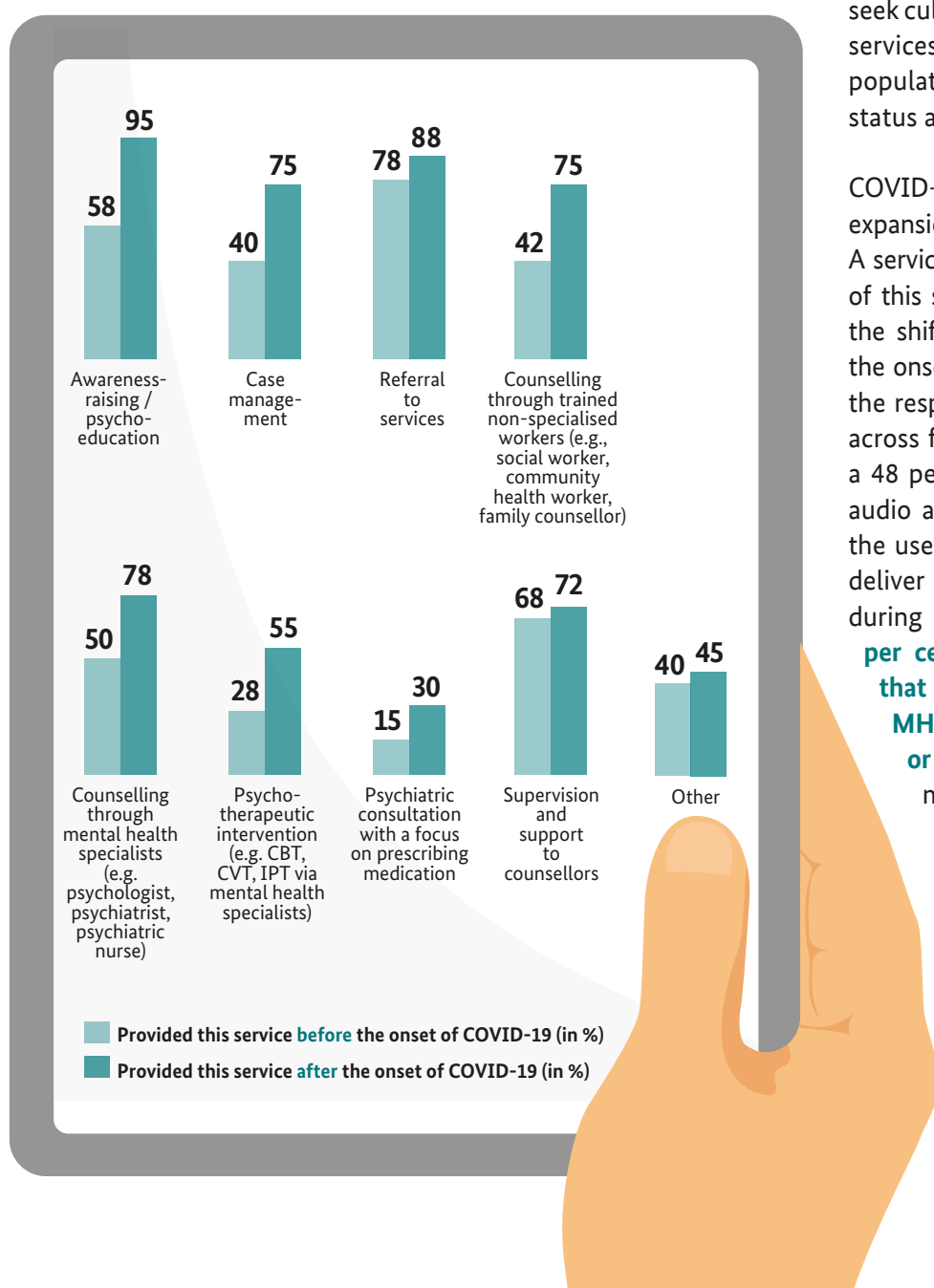
## 4. Current Landscape of Remote MHPSS Services in the Middle East

### 4.1 Availability of MHPSS Services Before and After the Onset of COVID-19

The literature review showed that, albeit limited, **a range of remote MHPSS services were available in the Middle East prior to the COVID-19 pandemic.** Most of these services consisted of mental health hotlines, phone-based and messaging services. A few private and non-governmental organisations (NGOs) offered more structured therapeutic interventions. Among the four countries of this study, remote service delivery has been used in Syria prior to COVID-19, where in-person services have been severely constricted by the conflict. In Lebanon, the interest for and update of remote services have been partly driven by the number

of Lebanese living abroad who may seek culturally and language-relevant services. However, this is typically a population of higher socioeconomic status and level of education.

COVID-19 has been a catalyst for the expansion of remote MHPSS services. A service mapping conducted as part of this study examined the extent of the shift to remote modalities since the onset of COVID-19. According to the responses from 40 organisations across five countries, there has been a 48 per cent increase in the use of audio and a 79 per cent increase in the use of audio/ video as means to deliver MHPSS services before and during COVID-19. In addition, **73 per cent of respondents reported that they would continue remote MHPSS services either partially or fully.** The availability of remote services prior to COVID-19 and the readiness to transition to this modality after the pandemic varies by countries and is contingent upon a range of cultural, financial, legal, and infrastructural factors.



## 4.2 Types of Remote MHPSS Services

Remote MHPSS services range from audio or audio/video-based counselling to app- or text-based services. Audio and audio/video services essentially replicate in-person counselling remotely, where a practitioner engages directly with an individual or (in the case of group therapy) a group. App- or text-based services are largely automated, with a client being either self-guided or sent automated prompts related to their therapeutic needs (see the examples described below). Finally, some services combine self-guided and/or automated elements with support from a practitioner.

Broadly speaking, the practitioners that participated in this study as interviewees relied primarily on audio-only or audio/video, both pre- and post-COVID-19-onset. Research conducted in other contexts suggests that video-based services can be as effective as in-person services (Hungerbuehler, 2016); however, there is a dearth of evidence from the Middle Eastern context.

Conversely, automated or self-guided services relying on messaging, emails, and mobile applications have been considerably rarer. However, the limited number of high-quality research on remote services in the Middle East is largely focused on these types of services:

- ▶ **Asynchronous CBT for PTSD:** In a study by Knaevelsrud et al. (2015) in Arab countries with a focus on Iraq, participants were given a web-based cognitive behavioural therapy (CBT) two times a week. In the intervention, participants wrote about their experience for forty-five minutes and received detailed responses from a trained caregiver. A significant reduction was found in Post-Traumatic Stress Disorder (PTSD) symptoms and the improvement was sustained in a three-month follow-up.
- ▶ **Text-message based care for veterans:** In an Iran-based randomised controlled trial (RCT), Darvish et al. (2019) attempted to improve quality of life (QoL) and reduce PTSD symptoms through a text message intervention where participants received daily messages for six months on self-care. Significant improvement was found in both PTSD symptom reduction and QoL relative to the control group.
- ▶ **WhatsApp-based smoking cessation:** In a Turkey-based RCT, Durmaz et al. (2019) sent 60 WhatsApp messages over several months to participants ‘about having a plan of action and preventing relapse, which were developed through expert panels.’ The intervention significantly reduced the abstinence rate amongst participants relative to the control group.
- ▶ **Social cognitive theoryt intervention for depression:** In an RCT in Iran, Moeini et al. (2019) developed a web-based course to treat mild-to-moderate depression amongst young women with seven modules (e.g., positive psychology, problem-solving, and relaxation). Depression symptoms significantly improved in participants in the intervention group, but these improvements were not sustained over a 24 week follow-up.

Because our interviewees were almost exclusively using audio or audio/video interventions, the recommendations are also largely related to this type of service, with the exception of the research recommendations.

### 4.3 Case Studies of Different Types of Services Before and After the Onset of COVID-19

Some examples of remote MHPSS services **developed or operating before COVID-19** include:

- ▶ **Step-by-step (Khoutweh Khoutweh)** in Lebanon is an e-mental health intervention designed by WHO in collaboration with the National Mental Health Programme (NMHP) and partners, and is currently being managed by the NMHP and hosted by Embrace. This electronic self-help, story-based intervention is a five-week programme that focuses on depression with behavioural activation as the central therapeutic component. The intervention includes psychoeducation, stress management techniques, and positive self-talk. Users can choose from a number of characters that guide them in the exploration of their own experiences and struggles. The self-help component is accompanied by a weekly, 15-minute remote guidance through phone or message with an e-helper (trained non-specialist). E-helpers are volunteers who receive a five-day training on the programme and are supervised on a weekly basis by a clinical supervisor. The intervention is free of charge and confidential as users are able to generate the username of their choice. First developed in 2016, the intervention went through a RCT in 2019-2020 and has been launched in March 2021.
- ▶ **The International Psychosocial Organisation (IPSO) and INTERSOS have partnered to** offer integrated case management and online psychosocial counselling to Syrian refugees and vulnerable Jordanians since 2018. Clients are assessed, provided psychological first aid and then briefed on available MHPSS services – including INTERSOS’s in-house psychologist and IPSO’s remote services. INTERSOS can also provide cash for protection, and clients are safely referred to other organisations for other needs related to livelihood, legal representation, medical services, etc. If clients choose IPSO remote services, they are connected to IPSO for specialised services which run up to an average of six sessions. The Arabic-speaking counsellors are based in Germany and connect with clients via a secure video chat. INTERSOS case managers conduct follow-up meetings/sessions with the client after each IPSO session to schedule the next session, provide support for any technical issues related to the IPSO platform, or for any other concerns. The service is open to clients aged 16 and above. IPSO’s platform was originally developed to provide psychosocial services in Afghanistan and then expanded to offer services to refugees in Germany. To date, the platform has over 40 counsellors working in more than 15 countries and offering services in 20+ languages.
- ▶ **The IRC has conducted remote training in Syria** in order to increase the number of trained community mental health practitioners inside Syria. For many years, the IRC’s mental health work in Syria has been largely remote due to the unavailability of trained mental health professionals in the regions IRC works in. In the past, this has included remote psychiatry services. More recently, in Northwest and Northeast Syria, the IRC and WHO provided remote Program Management Plus (PM+) training for IRC partners’ frontline staff in women’s protection centres and in health clinics. The training was complemented by a three month-long remote supervision. The team found that PM+ training was easy to deliver remotely because of its structure. Similarly, the supervision was also very structured and was implemented through group sessions via Skype. Each session included five people and lasted about one hour. Overall, this mechanism for training was deemed to be very feasible in complex situations like north-eastern or north-western Syria.

Some examples of remote MHPSS services that started operating **during COVID-19** include:

- ▶ **The Centre for Victims of Torture (CVT) in Jordan** provides mental health, physical therapy, and case management services to refugees living in Jordan who have experienced highly traumatic events. Prior to COVID-19, services were exclusively provided in-person. During the first lockdowns in March 2020, CVT decided to transition to tele-mental health to ensure continuity of services for its existing clients. Initially, only phone-based, individual sessions were provided between March and June 2020, when some lockdown restrictions eased. While transitioning to remote services, CVT staff developed a number of guidelines and standard operating procedures (SOPs) to help practitioners in the process, acknowledging that the provision of remote services during subsequent lockdowns was easier as practitioners became more experienced: the lockdown in March 2020 was more difficult than subsequent lockdowns. Moving forward, the organisation aims to continue the development and adaptation of its services to remote modalities. It is currently looking into the technology and infrastructure that can best support their type of work as well as the ways in which their services, namely group therapy, can best be adapted to online platforms.
- ▶ **The Social, Educational, and Economic Development (SEED) Foundation in Kurdistan Iraq**, provides a range of MHPSS services, including individual, group, and family psychotherapy, counselling and case management with a focus on gender-based violence. All services were provided in-person before COVID-19, mainly at their centre but also through home visits. With COVID-19, these in-person services were quickly adapted to phone-based services. Considering the socioeconomic situation of most clients, who may struggle to afford data required for video, this was the only feasible option. Existing clients were provided with weekly sessions, and WhatsApp-based groups were also formed for a range of psychosocial support services. At the outset, only existing clients were provided remote services, and the uptake of new clients took place several months after the first lockdowns. Once the initial lockdown was lifted, some in-person sessions resumed for very high-risk clients, with appropriate COVID-19 preventative measures in place. Key challenges for the transition to remote services were the lack of safe spaces for clients to take confidential phone calls and challenges associated with treating trauma remotely.



## 5. Factors Influencing Success of Remote Service Delivery

The success of remote service delivery is influenced by various factors pertaining to country context, therapeutic technique, as well as client and practitioner characteristics.

The success factors as well as barriers identified through the evidence review largely resonated with those identified by clients, practitioners, and experts through the KIIs and workshops. While many of these barriers existed prior to the onset of COVID-19, they were magnified by the transition to remote MHPSS service delivery during the COVID-19 pandemic (Ashfaq et al., 2020; El Hayek et al., 2020; Jefee-Bahloul, 2014).

### 5.1 Country Context and National Healthcare Systems

Particularities of each country influence the feasibility and uptake of remote MHPSS services. **The history of remote services in the country influences practitioner and client readiness**, even if they themselves have not engaged in remote services before. Practitioners in some countries have a stronger history of remote services than others. Due to the conflict and lack of trained practitioners inside the country, organisations have been providing remote services and remote training in Syria for a number of years. In Lebanon, which has a large diaspora, the remote service ecosystem advanced due to members of the diaspora seeking a practitioner in their home country.

The **government's commitment to and role in the MHPSS ecosystem** makes a significant difference in the coordination of services across diverse sectors. For example, through the Ministry of Health, the government can play a strong role in setting quality standards for services and training, as well as in coordinating remote services like national hotlines with referrals to public or private MHPSS services or services provided by NGO's. Practitioners also noted the government's role in data protection, including national laws



The Lebanese NGO Embrace works on mental health awareness and suicide prevention and is an example of collaborative work with governmental entities. In 2017, Embrace launched the National Lifeline (1564) the first emotional support and suicide prevention helpline in Lebanon in collaboration with the NMHP under the Ministry of Public Health. The National Lifeline is a specialised telephone service that provides emotional support, suicide risk assessment and referrals to community mental health services.

A team of over 130 highly trained volunteers operates this service. The National Lifeline is a key component of an evidence-based framework for preventing and monitoring suicide. This framework is one of the strategic objectives of the Ministry of Public Health in Lebanon that is aiming to build a sustainable system for mental health.



or regulations to data protection and confidentiality standards. In some countries, clients worry about government surveillance of digital communications, which can influence clients' comfort with discussing their mental health issues in a digital setting.

**The availability and robustness of healthcare systems** can make a difference in the success of remote MHPSS services. While these services can bridge local mental health gaps, they also require to be part of existing health systems, especially for cases that may need hospitalisation.

**IT infrastructure is essentially a pre-requisite for reliable access to remote services.** In Jordan and Turkey, electricity and internet are almost universally available, while this is more of a challenge in Iraq and Syria, particularly in areas affected by conflict and remote areas. Similarly, in Lebanon, the frequent power and Internet cuts will influence how remote services can be provided.

## 5.2 Tailoring Therapeutic Technique to Client Needs

Practitioners felt that remote delivery of services worked better for some client needs than for others. It is important to emphasise again that, because the switch to remote services happened so swiftly, most practitioners essentially replicated what they do in-person using digital delivery modalities. There was no scope to substantially adapt interventions to the digital context or to explore synergies between in-person and remote services. That being said, practitioners' perspective on where remote services are currently not effective is certainly instructive to understand where more investment in learning is needed.

Overall, practitioners felt remote services were **most appropriate for the treatment of low to mild cases**, including moderate anxiety and depression. While they noted that they were able to offer emergency stabilisation for cases in acute need (such as suicidality or self-harm), they felt that remote services were **insufficient for the long-term needs of clients facing severe mental health issues**, e.g. psychosis and longer-term management of suicidality.

Conversely, practitioners observed that **acceptance of remote services was interconnected with clients' level of suffering**, with those in acute need bound to seek help regardless of the mode of delivery. Acceptance and continuity of remote services were perceived by practitioners as driven by clients' commitment and motivation rather than by the medium.

Some therapeutic techniques were cited as less appropriate than others for remote modalities. Many practitioners noted that **interactive techniques are difficult to apply remotely**. This particularly impacts their ability to cater to children's needs, who typically require parental support both to use the technology and to engage in therapeutic exercises. This may affect the child's ability to express themselves. Practitioners also highlighted their difficulty in modelling, a method used in some CBT-based interventions in which the practitioner models certain behaviours for imitation by the client. **Short-term interventions and psychological first aid were thought to be relatively easy and effective to deliver remotely.**

Both practitioners and clients noted that remote services felt **less appropriate for group sessions compared to individual ones**. Part of the effectiveness of group sessions, such as psychoeducation and awareness, is to enable the development of social networks and peer support among populations in distress. This function is diminished in remote services as currently practiced.

### 5.3 Client Characteristics and Associated Barriers

In addition to client needs, clients' **demographic characteristics, socioeconomic status, and living conditions** are diverse and may act as both barriers and enablers for accessing remote MHPSS services. As much as remote delivery could expand access to some populations, this modality could systematically exclude some segments of the population. Currently, the dynamics of this exclusion and inclusion are not totally clear, but practitioners mentioned several elements.

Most clients who swiftly shifted to remote services during COVID-19 experienced an initial scepticism. However, both practitioners and clients noted that this progressively faded as it became evident that a prompt return to in-person services was not feasible, and as people adjusted to the technology and new medium. This was true across client profiles. Indeed, some clients noted advantages to remote delivery such as greater flexibility and anonymity. It also had a significant impact on the amount of time and money spent on accessing services, specifically on transportation. Practitioners also noted that some age groups, **in particular adolescents**, tend to prefer remote modalities as it gives them greater independence from their caregivers, and it mimics their day-to-day behaviour of using technology as their primary communication tool with friends. It was also observed that remote delivery helped mitigate gender-related barriers by expanding **access to women practitioners**.

However, clients face significant material or capacity barriers to effectively access remote services.

What do you like about meeting your counsellor via video app?

And what doesn't work so well?

I am grateful that I could access and continue with therapy sessions despite lockdown restrictions and the ongoing pandemic. The sessions were very helpful for me as things have started to become difficult again. Doing them online also saved time that I would have spent travelling to the NGO centre which is a bit far from my neighbourhood.



I do not have a stable enough internet connection to have an uninterrupted session. I also think I communicate better with my therapist when we meet in person and I seriously worry about the privacy risks of having sensitive conversations over the internet.

This is Ibrahim.  
He uses remote therapy services.  
He lives with his mother and younger sisters.

Note: For full persona and more examples, see Annex Two.

First and foremost is the **access to technology**, both devices and connectivity, which can preclude clients from accessing services altogether or limit the type of services that can be used. For instance, lack of smartphones or laptops and/or unstable internet connections limit the use of video-based services. In such cases, phone-based services remain the only option. When devices are available but shared among family members, the client may have limited access to the device, making the scheduling and attendance of sessions challenging. It was noted that this barrier may be most significant for vulnerable women and children.

Similarly, **limited or lacking digital literacy** prevents clients from accessing remote services. During group sessions, practitioners reported that varying levels of digital literacy disrupt the flow of the session and interaction. Some clients also cannot use technologies that require some level of literacy (reading and writing), i.e., emails, text-based services, and mobile applications. Practitioners stressed the importance of using technology and platforms that are readily accessible and, ideally, already familiar to clients. WhatsApp was particularly cited as easy to use for clients and practitioners.

Clients' living situation significantly influences their ability to engage with remote services. This is largely related to a **lack of privacy**. Clients may not have a private area in their home from which they can take the call; or their family members may interrupt the call frequently. Clients mentioned it can be difficult to explicitly express themselves for fear of being heard by family members in the same household. Lack of privacy also affects clients' ability to stick to a schedule. For practitioners, the limited control in ensuring a safe and private space for a client was problematic and can become a potential source of harm. For instance, clients who experienced gender-based violence (GBV) may be living with the perpetrator and have few opportunities to access a safe and private space. Some practitioners also mentioned that seeing the client's home environment gave them additional insight into their clients' circumstances.

Finally, some clients **lack basic tools** (e.g. pens and pencils) that may be needed for activities. In some cases, practitioners mentioned they developed and delivered a toolkit containing basic material for clients to

Dr. Yara is a psychiatrist who is from Jordan and is based in the US. Since COVID-19, Dr. Yara's practice in the US has largely shifted to remote delivery. However, even before the pandemic Dr. Yara provided remote services to clients in the Middle East. She also runs psychoeducation campaigns on social media targeted at Middle Eastern users. She uses Instagram and Facebook, and sometimes works in collaboration with local hospitals. Dr. Yara has realised that because she provides specialised services, she often serves as a critical lifeline to clients who would otherwise not have access to the type of care that she provides. Clients find her either through referrals from doctors in Jordan or through her online presence. She learned that connecting her services to primary health care facilities in Jordan has been instrumental to her work.

She can order any necessary lab work or provide prescriptions in collaboration with the local doctors. This ensures holistic care. Dr. Yara noted that for some clients who have significant trust issues, the remote format simply does not work.

ensure access to required materials. That is less possible in some contexts, for example Syria, where practitioners are, in some instances, located outside the country.

## 5.4 Practitioner Characteristics and Associated Barriers

Practitioners range from psychiatrists to community-based mental health workers. In many ways, in the context of COVID-19, practitioner barriers mimicked many of the clients' barriers, in particular those practitioners who are on the lower end of the socioeconomic strata.

Some practitioners also **lack appropriate devices**. While most practitioners have smartphones, they also cited headphones and noisecancelling devices as essential for them to provide an appropriate therapeutic environment. Many practitioners also struggled with their **digital literacy**. Grappling with the technology was a source of stress for practitioners, and it was also noted in our interviews with clients as being disruptive to their care.

Practitioners' **ability to adapt to different client situations in remote settings** was in part dependent on their level of prior experience and training. Considering the multifactorial barriers that affect remote MHPSS service delivery, there is a need for flexibility and adaptability, with no single approach that can be universally adopted. Most practitioners did not feel they were adequately prepared to adapt their therapeutic techniques or communication skills to a digital format.

Finally, the loss of non-verbal cues negatively affected communication and rapport building for practitioners who speak with a different accent or dialect than their clients. Conversely, practitioners who were from the community reported that they were able to quickly build rapport with an impressive network across their community.



This is Adam. He is a case manager. He graduated with a BA in Psychology in 2019 and immediately started his current job. He had been working for less than one year when COVID-19 pandemic hit.

## 6. Recommendations Towards Adaptable and Effective Remote MHPSS Services

The use of technology represented a new way of accessing services, but in most cases, practitioners simply sought to replicate what they had been doing previously to the new modality. While practitioners and programme managers expressed cautious optimism that they could learn-on-the-job and adapt to the new modality, they also emphasised that they felt there was a variable level of efficacy. Overall, they were left constantly wondering if they were approaching things in the right way, and underlined a need for more evidence-based approaches. Context-specific research should be done both to understand how to better adapt existing services, and potentially develop new approaches which maximise what is possible with these specific modalities. These approaches need to be flexible, so that practitioners can adapt to different country circumstances, client needs, and client circumstances.

However, this shift requires training and capacity building that comprehensively supports the shift to remote delivery; supervision and staff care procedures that can facilitate a supportive working environment for practitioners, and a dedicated research agenda.

### 6.1 A Different Approach to Training and Capacity Building

An important number of resources – guidelines, SOPs, technical notes and others – have been developed by service providers. From our interviews with practitioners, it is clear that **existing resources do not meet the current needs of practitioners**. This is due to two main reasons. First, the distribution of these materials is typically through one-off training or stand-alone guides. This is not the best way for practitioners to learn the materials. Second, there are significant gaps in what information and protocols are provided through these materials, in terms of what is needed in a day-to-day way for practitioners to feel confident in their ability to deliver services. This may be exacerbated by the fact that during the COVID-19 crisis, these resources have rarely been developed in a participatory manner, and thus may miss the mark in incorporating practitioners' concerns.

#### Delivering on-the-job-training and capacity building

Overall, the main message from practitioners was that one-off training is not adequate, and that **training materials should be embedded within supervisory practices or broader engagement around capacity building**.

Many practitioners noted they were given guidelines to follow. They also noted that these guidelines frequently changed, and those changes were not always reflective of what would work best for clients. They were therefore perceived as disruptive. Guidelines also do not support managing cases very well. There is also a need for a more 'qualitative'/trouble shooting approach. This pertains to what information is included (e.g. "in this scenario, what would you do?"), and how it is delivered (e.g. more ongoing, interactive, and tailored support).

Finally, the conversations with practitioners illuminated that it was impossible to separate technical capacity needs from feelings of isolation, loneliness, and anxiety that were experienced by practitioners as they shifted to remote service delivery. This was especially the case for practitioners who had joined their organisations during COVID-19. There might be an opportunity to imbed training or capacity building exercises within a more social, interactive approach that targets both training and social needs of practitioners.

### **Gaps in existing materials**

Practitioners need support in adapting their existing knowledge and skillset for this new environment, as well as developing new skills that are specific to remote delivery.

**Practitioners need continuous training and support in the interventions they are delivering remotely.** COVID-19 has exacerbated some mental health conditions as well as triggered new challenges for clients, for example, feelings of isolation, anxiety, and fear related to the disease or prevention measures. Practitioners may require specific training geared towards addressing these circumstances and their related mental health consequences. As noted in section 3.2.2, practitioners felt they needed new approaches for some client needs (e.g. clients experiencing trauma), and there was not adequate instruction for dealing with more severe mental health issues. Practitioners also did not feel they knew how to adapt their therapeutic techniques for different client scenarios, e.g. if a client breaks down on the phone or video call.

**Practitioners need support in adapting to maintain a therapeutic relationship and environment.** Practitioners noted that their communication style is critical to developing a trusted rapport with clients and that it is easier in an in-person environment. Some clients reported feeling heard but not listened to, and that perceived distractions from service providers affected their ability to express themselves. For practitioners, the absence of non-verbal cues, which typically help assess clients' reactions and emotions, affected their ability to connect and diagnose. This was noted as particularly challenging for less experienced practitioners, and for practitioners who speak with a different accent or dialect than their clients. Practitioners may need to rely more on voice tone than non-verbal cues. For some, this represents an opportunity to develop and strengthen cognitive empathy in a new way; however, practitioners felt they needed some support on how to adapt their communication style for this purpose.

**Practitioners need support in maintaining a therapeutic environment.** Practitioners did not know how to troubleshoot or guide clients who might be connecting in environments that are not conducive to a therapeutic intervention, e.g. finding a private place to chat. They also did not feel confident to troubleshoot or maintain a therapeutic environment in the context of technical challenges. Technical challenges were cited as very disruptive and frustrating for both the client and the practitioner.

**Some practitioners need further digital skills.** In addition to maintaining the therapeutic environment in the context of technical challenges, practitioners sometimes had trouble in actually using the technology. They did not feel confident in overcoming their own challenges, and they did not feel they could support the client in troubleshooting technical issues the client might be facing.

### Recommendations for a different approach to training and capacity development

- ▶ Co-develop training and capacity-building programmes and materials with practitioners to ensure they are grounded in real-world experiences.
- ▶ Be guided by clients' input on needs and experiences with remote services.
- ▶ Base materials on proven methods of adult learning.
- ▶ Employ entertaining, interactive, and participatory formats, such as role-playing or games.
- ▶ Design materials that are accessible for daily use.
- ▶ Facilitate both long-term professional development and continuous on-the-job learning.
- ▶ Embed capacity development in a network of peer support, where colleagues are incentivised to contextualise and discuss materials with each other.
- ▶ Connect to existing supervisory support.
- ▶ Base programmes on standards signed off by the national government.

## 6.2 Supervision

Inadequate clinical supervision can affect the quality of services as well as the well-being of practitioners. Without qualitatively high, structured, and regular supervision, there is an increased risk of burnout, compassion fatigue, and other symptoms experienced by practitioners. With the COVID-19 pandemic, not only has clinical supervision had to adapt to remote modalities, practitioners also expressed a **need for increased support as they were affected by feelings of isolation and insecurity in their skills in providing services remotely.**

Many supervisors mentioned they enjoyed remote supervision, as it allowed them to expand their geographical reach and facilitate experience sharing across their supervisory network. However, supervisees preferred in-person supervision, noting they felt that they lost the connection to the supervisor.

Many of the challenges faced in remote supervision are similar to those faced in remote delivery of MHPSS services, including challenges in accessing technology or connectivity, as well as the loss of non-verbal communication. Some of the benefits are also the same, **including expanding access to supervision to practitioners in remote areas, and the convenience and flexibility of scheduling.** Some supervisors noted that this could support practitioners in understanding the client experience of receiving remote services.

Practitioners and clinical supervisors noted that remote supervision often takes more time. For practitioners, **supervision can create the feeling of being an additional burden to already tight schedules,** as supervision often takes place after a full day of providing remote services. For supervisors, their role is often combined with many other tasks, including direct provision of services, reporting, and project/ programme management. This can be overwhelming for supervisors.



## Recommendations to maximise the impact of supervision

- ▶ Ensure structured and regular supervision that is scheduled during the workday, whether in person or remotely.
- ▶ Encourage supervisors to have a broader geographical reach, and catalyse relevant experience-sharing across the practitioner network.
- ▶ Develop the capacity of supervisors to provide remote supervisions, including ensuring they are well-equipped to support practitioners in solving the clinical challenges as well as the variety of challenges associated with remote service delivery.
- ▶ Strengthen the quality of supervision by investing in developing the relationship between supervisor and supervisee.
- ▶ Strengthen opportunities to connect supervision to practitioner capacity building and well-being.

### 6.3 Staff Care and Well-being

Many mental health practitioners highlighted a sense of satisfaction and purpose regarding their experience during COVID-19 since they were able to see the impact they were having. This helps with motivation; however, the new set of challenges has also brought stress for mental health professionals. Prior research in Western contexts indicates that while practitioners aim to help clients achieve well-being, tend to focus less on their own well-being as doing so might feel selfish to them (Posluns & Gall, 2020). The evidence review showed that **practitioners' well-being has not been well studied or understood outside of a Western context.**

While it's true that mental health practitioners were motivated by the obvious impact they were having, they also faced a triple burden. First, practitioners face similar COVID-19 related stressors as clients, including fear of the virus, social isolation, or uncertainty about job security and finances. Second, practitioners reported increased workload, often accompanied by inadequate resources including staffing gaps. This surging workload took place in the context of working from home, which blurred boundaries between work and home. Many practitioners reported that the greater demand also generated feelings of helplessness, and a feeling of never being out of work. This contributed to difficulties in establishing boundaries between work and home. Finally, practitioners who had limited or no experience with remote MHPSS services reported feelings of stress, burnout, and uncertainty associated with the rapid shift to new ways of working, without adequate training and support.

These descriptions have the hallmark of burnout. Addressing these issues is not only important for the staff—it is also incredibly important for the effectiveness of client-facing work. For example, one of the symptoms of burnout is a decrease in work performance. Another symptom is to become cynical, defined as 'increased mental distance' from work (WHO, 2019). As one practitioner noted, "having an empathetic view when tired is difficult." To be effective providers of care, staff need to be mentally well.

Overall, practitioners did not feel that their organisations were adequately responding to this triple burden. In most organisations, staff well-being was reported to be ad-hoc, and usually the responsibility of a single department or individual, e.g. human resources or a staff counsellor. Staff care was considered to be an afterthought, rather than a core component of the job.



## What Helps for Self-care

Organisations should be cognisant of how the way the structures of their organisation influence staff well-being. In our interviews practitioners also emphasised the importance of self-care. Overall, COVID-19 was perceived as an opportunity for practitioners and organisations to recognise the importance of self-care. In theory, working from home could also provide more opportunities for self-care, if time previously spent on transportation was re-directed towards self-care activities such as exercising, resting, or developing new hobbies. However, practitioners did not feel that that was happening.

Practitioners currently rely on both informal and formal social support. For informal support, friends, family members, and peers are critical, while professional support (e.g. counselling) was also considered important. Practitioners mentioned the importance of sharing their experience and learning about the experience of others, through both formal and informal channels. Practitioners can and do seek their own support. However, organisations would be doing a disservice to their staff if they did not also create an environment where staff is encouraged and empowered to engage in self-care practices. Organisations should actively educate and support staff, as well as ensuring their staff has the time and (when necessary) resources to engage in such practices.

## 6.4 Expanding Evidence and Strengthening the Link Between Researchers and Practitioners

**There is not enough information or evidence for practitioners to effectively plan for or adjust their approach to the different variables influencing success.** In one systematic review, Ashfaq et al. (2020) highlighted concerns regarding the lack of literature around the development of remote interventions. The review argued that interventions may not be as effective if not tailored to the delivery platform and if they do not consider the cultural constructs of distress. This sentiment was echoed throughout the interviews and workshops of this study. Practitioners noted significant information gaps related to remote MHPSS services in the Middle East. This included both regular needs assessments and evidence on what interventions work best for different therapeutic needs and in a Middle Eastern context.

Practitioners expressed hope for significant investment in understanding the needs and opportunities specific to the region. This includes understanding more about:

- ▶ **The client perspective on remote delivery**, including privacy and confidentiality issues, which is touched upon in this study, but requires more in-depth research.
- ▶ **Changes in the clinical needs across the region** as a result of the pandemic.
- ▶ **Both barriers to accessing digital services, and opportunities that might be available** and are not currently being taken advantage of (for example, providing private spaces for video calls at nearby community centres).
- ▶ **How these barriers differ across different sub-sections of the population**, in order to develop stronger strategies to reach those who are not being reached through the current digital delivery modalities.

Practitioners highlighted that therapeutic techniques, in particular those that rely on activities or interaction, need to change for a remote delivery format in order to avoid being, as one practitioner stated, ‘just talking’. Research is required to develop evidence-based interventions from the region with the purpose of moving remote delivery as an expansion of existing mechanisms towards actually **strengthening the quality of MHPSS**

**services** being delivered remotely. Practitioners felt the most significant gaps in the quality of remote care were related to severe cases. While most high-quality research focuses on single interventions, practitioners were interested in **how individual interventions could fit into a larger eco-system of support**, for example, hybrid synchronous and asynchronous models, or hybrid on-line/off-line models.

Finally, practitioners expressed a need for stronger toolkits for regular monitoring and evaluation of programmes, including understanding any additional and/or different indicators to measure in the context of remote delivery, and/or different data collection practices specific to remote service delivery.

### **Recommendations on strengthening the link between researchers and practitioners**

Doing great research is not enough! For research to have an impact on practice, it needs to be responsive to practitioner and client/patient needs, and to be used and informed by practitioners.

- ▶ Develop evidence-based therapeutic approaches that are adaptable to different contexts, and leverage both online and offline opportunities where relevant (hybrid models).
- ▶ Prioritise research questions that emerge from the field.
- ▶ Translate research findings and make them easily accessible.
- ▶ Ensure that research findings are integrated into the structures of service delivery.
- ▶ Create opportunities for researchers to work with service providers, for example to gain experience as both researchers and practitioners.
- ▶ Increase cooperation and dialogue among researchers and practitioners, for example, holding joint workshops, creating purpose-driven communities of practice, etc.

# Conclusion

**COVID-19 triggered the rapid expansion of remote MHPSS services in the Middle East, where most countries had limited experience with this form of service delivery.** As the pandemic evolves and vaccination campaigns are accelerating, possibilities for a partial return to in-person services are emerging. However, remote MHPSS services have demonstrated to be a promising opportunity for bridging the substantial mental health service gaps that currently exist. If done well, MHPSS remote services can provide high-quality care while more easily accessible for clients who may be currently excluded from accessing such services, for example, because of transportation costs, the lack of locally available practitioners, scheduling difficulties, or social stigma preventing clients from physically seeking out a centre.

The interviews showed that critical factors influencing the success and quality of remote services are context, client, practitioner characteristics, as well as client needs and corresponding therapeutic techniques. For instance, context variables, such as a long-standing history of remote MHPSS services and an integration of remote services into the national health care systems and plans seem to facilitate the implementation of services. Client characteristics, including their age, gender, and socioeconomic status, further influence the client's access to and comfort with remote services. Some women may, for example find it easier to access remote than in-person MHPSS services as they do not have to leave their home and hence do not have to organise childcare. Digital literacy, adaptability to online settings, and other practitioner characteristics also shape the course of the intervention.

There is no single actor responsible for strengthening remote MHPSS services. Organisations, governments, funders, and researchers all have a role in advancing the field. In order to maximise the potential, our work suggests focusing on the following three areas:

- 1 Develop evidence-based, hybrid models of care with complementarity between in-person and remote services to improve quality, accessibility, and scale of services through a robust research agenda.** At their core, these services should be developed around the clients' perspective on MHPSS services, including their care needs and preferences on how to best access care. To achieve scaled impact, these models will need to be flexible in order to adapt to specific needs, cultures, and opportunities across the region.

**2 Design an integrated approach to practitioner training, supervision, and well-being.** This process and materials should be co-created with practitioners, and should be engaging, fun, and easy to incorporate into daily activities. In addition, capacity development approaches should encourage ongoing peer-to-peer interactions and support systems.

**3 Protect the well-being of staff by investing more time and resources in supervision and staff care.** For too long, supervision and practitioner well-being have been considered minor add-ons to programme activities. They should be much more systematically integrated into programme planning. In most cases, this will include dedicated budgets for supervision and well-being as a regular part of funding proposals. It may also require organisations to critically examine their organisational structures and job expectations to assess how the work environment contributes to staff well-being.

While this study highlights many examples and offers a good overview of factors influencing the provision of remote MHPSS services, further research is needed to better understand the dynamics of therapeutic interventions that rely on digital tools. Future studies may look more systematically into techniques being used specifically in online settings or shed light on elements of the client-practitioner-relationship/therapeutic alliance from different perspectives. They may also focus on approaches to overcome existing barriers of a lack of privacy considering socioeconomic aspects and gender dynamics or propose ways to better support staff in their challenging work as online counsellors. Moreover, an interesting research question for future remote MHPSS service delivery is how to design hybrid models of care to ultimately leverage the strengths of both online and in-person settings for a comprehensive approach to care.

The future of these services will likely look very different from what emerged as a response to the COVID-19 pandemic. They will also likely look very different from prior models. Funders, policymakers, programme strategists, and practitioners all contribute to creating this future.

# List of Abbreviations

|              |                                               |
|--------------|-----------------------------------------------|
| <b>CBT</b>   | Cognitive Behavioural Therapy                 |
| <b>CVT</b>   | Centre for Victims of Torture                 |
| <b>IASC</b>  | Inter-Agency Standing Committee               |
| <b>IPSO</b>  | International Psychosocial Organisation       |
| <b>IDP</b>   | Internally Displaced Person(s)                |
| <b>IRC</b>   | International Rescue Committee                |
| <b>MHPSS</b> | Mental Health and Psychosocial Support        |
| <b>NGO</b>   | Non-Governmental Organisation                 |
| <b>NMHP</b>  | National Mental Health Programme (Lebanon)    |
| <b>PM+</b>   | Problem Management Plus                       |
| <b>PTSD</b>  | Post Traumatic Stress Disorder                |
| <b>QoL</b>   | Quality of Life                               |
| <b>RCT</b>   | Randomised Controlled Trial                   |
| <b>SEED</b>  | Social, Educational, and Economic Development |
| <b>WHO</b>   | World Health Organization                     |

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# Annex One

## Recommendation from Practitioners on How to Get Started with Remote MHPSS Services

### 1. What Organisations Can Do To Ensure Meaningful MHPSS Remote Services

- ▶ Work with relevant coordination bodies to ensure a good network of referrals to other service providers including across specialised and non-specialised healthcare providers as well as to physical healthcare and other protection services.
- ▶ Invest in developing practitioners' digital literacy, including the ability to troubleshoot technical issues that they or their clients might be facing.
- ▶ Ensure practitioners have access to more than one technology platform in case of service disruptions, for instance switching to a standard telephone when there are Internet connectivity problems. This will mitigate disruptions to therapeutic sessions.
- ▶ Ensure that supervision is provided in practitioners' native language to ensure smooth communication. While this might be preferred in any scenario, it is particularly important in contexts of remote supervision where the loss of non-verbal cues makes oral communication the only mode of communication.
- ▶ Ensure safe and systematic documentation of cases. While working remotely and in organisations where there was previously limited use of information management tools, the sharing and tracking of information became a challenge. It may be useful for organisations to think about the most appropriate information management tools and monitoring systems, and to train practitioners accordingly in their use.
- ▶ Emphasise the importance of and institutionalise the support for self-care and supervision, as work/life boundaries can get blurred when practitioners are working from home.

### 2. What Practitioners Can Do To Ensure Meaningful and Confidential MHPSS Remote Services

#### Before getting started...

- ▶ Use headphones, which can reduce background noise and ensure client privacy.
- ▶ Ensure you are in a space without distractions or interruptions.

#### Make sure clients can easily access your service...

- ▶ Be willing to switch between platforms (e.g. Zoom vs. WhatsApp) based on clients' needs and preferences. Clients may have difficulty accessing or engaging with some platforms.
- ▶ For low-income or vulnerable clients, consider providing internet credit, SIM cards, or spaces where access to devices in a private setting can be ensured.



- ▶ Where the therapeutic approach might require equipment, like pencils, notebooks, or crayons (for children), consider delivering “toolkits” with all required materials to peoples’ homes.

### **Getting started with a client using remote services for the first time...**

- ▶ Develop a clear digital on-boarding and consenting process, including:
  - Agree on frequency of sessions and best time for sessions to be held. It is important for practitioners to remain flexible throughout the process as clients may need to reschedule a session, especially if they have limited access to devices and private spaces at home.
  - Conduct a thorough assessment of clients’ technological literacy and limitations, and walk them through any technology required to use the service. It may be useful for the first session to focus on testing the platform to ensure the client is comfortable and ready to engage remotely.
  - Be explicit about the benefits and limitations of remote services, in order to make sure that the client understands and is comfortable with them.
  - Discuss client rights regarding privacy, and outline measures taken to safely manage sensitive data and ensure confidentiality.

### **During the session...**

- ▶ Use simple, short sentences to mitigate the effects caused by loss of non-verbal cues.
- ▶ Be mindful of whether the client is able to concentrate throughout the whole session (which can be difficult in a remote setting) and be open to adapting accordingly, e.g. by making sessions shorter.
- ▶ Collect regular feedback from clients on how the service is progressing for them.

### **Keep in mind...**

- ▶ Do not take too many clients.
- ▶ Make sure to leave time between consecutive sessions, in case, for example, a session runs slightly longer or technical issues occur.
- ▶ It can be hard to maintain boundaries with clients when you are engaging remotely. It is important to delineate and communicate your availability to clients and provide them with contact information in case of emergencies, e.g. a hotline or helpline.

## Annex Two

# Remote MHPSS Client and Practitioner Personas

To help illustrate some of the common resources and challenges both clients and practitioners face, personas were developed based on the input from remote MHPSS service users in Jordan, as well as practitioners and management staff working in the Middle East. This might help to illustrate some of the common challenges and resources both clients and practitioners face.



Ibrahim  
Client: Remote Therapy  
Service



Wala'a  
Client: Remote Counseling  
Service



Abdul  
Client: Remote Group  
Support Sessions



Seyma  
Practitioner: Psychologist



Adam  
Practitioner: Case Manager



Reem:  
Practitioner: MHPSS Officer  
and Supervisor



## This is Ibrahim. He lives with his mother and two younger sisters.

He was only 19 years old when his father passed away and the responsibility to provide for his family became his burden to bear. He tries to work very hard but barely manages to meet his family's needs. His mother was the first person to notice the change in his behaviour and had asked him to go for help at an NGO, especially when he started to lose his temper quite often.

He has been going to therapy since 2018. Initially, he used to go to counselling once a week, but gradually the frequency of the sessions tapered down. The experience of going through the lockdown in 2020 was quite difficult for him and he decided to resume his therapy sessions on a regular basis.

### **Remote MHPSS Service Accessed:**

Remote therapy sessions were accessed using the Zoom App. He did the therapy sessions using his own tablet, usually from his friend's house that is vacant during the day. He also gets slightly better mobile data connection from this place.

### **Things Working Well:**

He is very grateful that he was able to access and continue with therapy sessions despite lockdown restrictions and the ongoing pandemic. The ses-

sions were very helpful for him as things had started to become difficult again. Doing them online also saved time that he would have spent travelling to the NGO centre which is a bit far from his neighbourhood.

### **Challenges:**

He had never used the Zoom App before, it took him some time to get used to it. Doing sessions using video calls felt odd to him. One of the biggest challenges he faced was that he did not have a stable enough internet connection on his phone to have an uninterrupted session. He feels that he communicates better with his therapist when he meets in person. He also worries about the potential privacy risks of having sensitive conversations over the phone or internet. Doing the sessions online felt like getting instructions and he often thought that the therapist was not listening to him.

” Doing it over a phone call felt like getting instructions rather than a therapy session. I didn't find the attention I wanted because I didn't feel that [my therapist] was listening to me or being fully interactive.”



## This is Wala'a. She lives with her husband, his parents, and her three children.

Ever since they left their hometown in Syria, her husband keeps taking all his anger and frustration out on Wala'a. She silently faces it all. She is very close to her sister and talks with her on a daily basis.

In April 2020, with the lockdown in place, fights with her husband increased (fortunately, it never became violent) and there was no one to help her with her situation. She was facing insomnia, experienced sadness, and often felt like giving up. Finally, with the support from her sister, she decided to call an NGO workers, whom she had come in contact with back in 2019. In turn, she was referred to a counsellor.

### **Remote MHPSS Service Accessed:**

Remote Case Management is organised through calls using WhatsApp or phone calls. They try to turn the video on, but due to network issues, it is not always possible. She uses her own phone for these calls. She tries to take the calls from her room when her husband is not around, but she always has her infant children with her.

### **Things Working Well:**

Confidentiality is a concern for her. Therefore, participating in these sessions from (the comfort of) her own room gives her a sense of security. She feels

that no one else will know about it. She wouldn't have opted for such a service if she had to physically go to a centre.

She was also able to select a female practitioner, which was important to her. She is learning from the counsellor about how to manage situations when her husband is angry at her. The challenges she faces at home still persist, but she feels better equipped to activate her support system and protect herself.

### **Challenges:**

There were days when she ended up skipping the scheduled sessions because of her husband and others being at home. During the sessions, Wala'a often felt she was not understanding everything being told to her because her counsellor proceeded to use English terminology. They also spoke in different dialects, making communication hard for both of them.

”I hope these services stay online because I have children and I need to stay home with them, but I still want to learn more about these topics. These sessions have helped in reducing the stress I was going through.“



## This is Abdul. He left his country six years ago, along with his family.

He had to leave his country abruptly without any preparation or plan due to some political issues he faced. He has struggled to find a constant source of livelihood ever since, especially because mobility is an issue for him. He has a disability in his right leg.

Abdul barely manages to keep his children at school. He and his family face racism all the time. Things significantly worsened for him in 2019. His financial problems were further exacerbated by his wife's prolonged sickness that resulted in huge medical bills. Abdul had suicidal thoughts but his religious beliefs acted as a protective factor. Since then, he has been attending Group Support Sessions at a CBO near him. Ever since the COVID-19 pandemic started, these sessions are being organised remotely.

### Remote MHPSS Service Accessed:

Remote Group Sessions were organised using the Zoom App. He uses the phone that is shared between him and the other members in the house. There is never a quiet room available for him. He has to attend the sessions with other people around him in the house.

### Things Working Well:

Doing sessions online rather than from the CBO centre helps him a lot, especially because of his disability. He saves about 40 mins by not having to travel to the centre and also ends up saving 7JD (\$10)

per session by not having to pay for transport to the centre and back. He is also glad that the sessions have continued and he is able to keep in touch with his peers in the group despite the ongoing pandemic. Through these sessions he has learned to cope his problems. While they have not gone away, he has learned not to let them affect him as strongly as before.

### Challenges:

He felt like they are only talking during the sessions now - at the CBO they were also doing exercises. Often, he felt like he could not participate in the session freely due to the frequency of unmuted participants leading to a chaotic and unmanageable environment. This also made it difficult to concentrate. He feels it is very easy to get distracted from the topic of discussion during remote sessions. Sharing the device with his family was also a bit limiting. He had to miss some parts of the sessions when they received a phone call from a friend or a relative.

” There wasn't any documentation, and there was a large amount of information presented every time. There was a lack of flexibility in conversation in the online session compared to sessions conducted in-person. Many participants didn't know how to use the app, others opened their microphones when they shouldn't, it was a mess.”



# Seyma. She is a psychologist.

## Previous Experience:

She has seven years of experience working as a clinical psychologist. Her first job as a psychologist was at a local hospital. Next, she worked as an MHPSS Practitioner with an INGO before starting her specialised training.

## Skills / Training:

She has a Master's degree in clinical psychology and in 2018 she went for a degree in "CBT and Short term dynamic therapy". She has adapted her skills for remote therapy by self-training using different guidelines, resources, and learning on the job. Over time, she has figured out what she considers to be best practices and has a sense of what works and what doesn't work for remote services.

## Current Role:

After her degree in 2018, she started her current job, which gives her better pay. It also involved cross-border service provision, which she had not done before. She provides psychotherapy sessions on the phone to clients in Syria.

## Weekly Tasks:

She works from 9 am to 6 pm, often not even having time to take breaks. She provides 12 to 15 individual sessions (90 mins each) and about two to three group sessions (90-120 mins each) each week. She also has to do daily data entry (one or two hours per day). Each week she has to attend supervision sessions which can be outside working hours.

## Sees Opportunities in:

She had high-risk cases that were saved because of on-line sessions. She is glad remote services are picking up. She hopes they will continue even after the pandemic restrictions ease off. In Syria, there is a massive lack of mental health professionals, and so she feels remote services are one of the best ways to bridge that gap.

## Identifies Challenges in:

Most of her clients cannot have their videos on, so she has to manage with audio only. She often notices she has designed activities for her clients that they

have trouble doing because they don't have the basic resources, like pens, coloured pencils, etc. Over time, she has become better at adapting her activities to these constraints, but she always worries that they may not be as effective. She feels that there is a lack of concrete guidance for practitioners and it frequently changes. They were first told to use Skype, then they were told to use Microsoft Teams. They were told not to use WhatsApp and Messenger. She feels it is difficult to adapt to client preferences. She recognises that having an empathetic view as a practitioner is difficult when tired.

## Personal Impact:

She works long hours but she realises that her work makes a lot of difference and has an impact on her clients' lives. This keeps her motivated, although she takes it very hard when she feels she can't help some clients. Her organisation communicates a lot about the well-being of staff, which makes her feel good about the job. However, she often feels that despite their positive rhetoric, the organisation's leaders often do not opt for decisions that would actually support staff well-being, such as making sure workloads are appropriately sized, or making investments in staff-care practices.

## Self-care Practices:

She has good support from her family. She takes the time to do extracurricular activities like sports and cooking. She ensures that childcare has been taken into account when working. She also seeks therapy when needed.

## What's Missing:

She feels lost when it comes to catering to different client needs (trauma, children, etc.) when providing services with remote modalities. Because she has relied mostly on her self-taught remote service provision skills, she is unsure whether her client needs are adequately met or whether the existing referral pathways are mapped accurately. She would appreciate more guidance and support. She thinks that there needs to be more awareness raising on the availability of remote services.



## Adam. He is a case manager.

### Previous Experience:

He graduated with a BA in Psychology in 2019 and immediately started his current job. He had been working for less than one year when the COVID-19 pandemic hit.

### Skills / Training:

When he initially joined the organisation, he was given training in sensitive referral mechanisms and psychological first aid. Soon after the first lockdown in response to COVID-19, he received guidelines and SOPs from his organisation, and was provided one training on the guidelines as well as an introduction to Zoom. However, there was no structured training provided for offering remote services.

### Current Role:

He works with a local NGO, situated in a rural area, working as a Case Manager.

### Weekly Tasks:

His work tends to be quite hectic. Each week he screens about 6-7 new clients (90-120 mins each). He manages 10-12 existing cases (60 mins each), providing basic counselling and referral services. He is responsible for the planning of monthly remote awareness sessions for the community. He also has to conduct follow-up documentation and data entry (1-2 hrs per day).

### Sees Opportunities in:

He sees the remote services to be cost effective for beneficiaries, especially if they are refugees. They tell him how much money they are now saving because they do not have to spend money on transportation. They also tell him that they have to do fewer arrangements with families or children to attend a session. He is part of the community he serves and that helps in building rapport with his clients, despite the remote set-up.

### Identifies Challenges in:

He has observed that his clients have no privacy at home to do remote sessions. He feels that he did not have enough experience with in-person services before moving to remote modalities, and does not feel confident in the care he provides. He finds it difficult to manage cases remotely simply by referring to the guidelines. He feels that he needs more supervision. Although they come to him only once in a while, he thinks that he does not have the right set of skills for the tasks he has to perform when dealing with high-risk cases. He lives in a remote area with poor internet connection and this leads to disruptions in the sessions with his clients.

### Personal Impact:

He feels overwhelmed with the workload. He works long hours, picks up his phone whenever people call him. He feels obliged to do so because he belongs to the same community. He cannot maintain a boundaries between work and his personal life.

### Self-care Practices:

He tries to get in touch with his friends on Fridays when the centre is closed. He finds this time to be very rejuvenating. He does bring his backlog work from the week to complete during the weekend though. He is part of a WhatsApp group with other case managers and colleagues where they get to discuss cases and get feedback. This is very helpful for him.

### What's Missing:

He wants to get more training with role plays and case studies. He also feels he requires more supervision. He thinks that there should also be an increase in staff in the team to share the workload. He would like to have more time for himself.





## Reem. She is a MHPSS officer and supervisor.

### Previous Experience:

She has 14 years of experience, working in the field of Mental Health. She worked as a psychiatrist for the first 8 years of her career before taking up the job as an MHPSS project manager in different organisations (NGOs/INGOs).

### Skills / Training:

She is trained as a psychiatrist. At the start of her current role, she was trained in providing staff supervision but there was no additional training provided on how to do so remotely.

### Current Role:

Currently, she works as an MHPSS Officer and Supervisor at an INGO. She manages the INGO's mental health portfolio, supervises 5 members in her team (who currently provide remote services), and also provides direct psychiatric intervention to clients, when needed.

### Weekly Tasks:

Providing staff supervision is an additional responsibility that she has to undertake on top of her role of her role as a project manager, which is a full-time role in itself. She has to conduct 5 individual supervision sessions (60 mins each) providing both therapeutic supervision and guidance as a team leader. She also hosts a group supervision session (60-90 mins) each week. She has to continuously work on staff training and providing technical support. Sometimes she also provides psychiatric intervention to clients referred to her by her team.

### Sees Opportunities in:

Remote supervision has been relatively easy for her, it is also time-saving. She likes it that now she can have group sessions with people that are based in different areas. This allows the supervisees from different places to join and talk about their cases. She has noticed that this is an enriching exchange of knowledge and experience.

### Identifies Challenges in:

For the supervisees it is more preferable to get individual supervision in-person, she has been told that they find it more useful that way. She has realised that it is not easy for the practitioners to provide services from their homes. The issue of privacy comes in, e.g. their children might interrupt or sometimes the client is sharing sensitive issues and feels overheard. She has also noticed that the quality of service provided declines because of staff being over-worked or due to a high demand for services. As a psychiatrist, she finds it difficult to monitor medication adherence by clients while providing services remotely. It is also challenging to follow up on referred cases.

### Personal Impact:

It gets a bit too much for her sometimes: she has to provide oversight for the whole program, including all donor engagement; she has to solve her staff's issues and provide them continuous guidance on difficult cases; and she also provides direct services to clients. She feels that having monthly project targets for both the number of sessions and the number of clients served adds to her work pressure.

### Self-care Practices:

She strictly follows the rule of not working during the weekends, though she often works 10+ hours during the week. Over the years, she has realised the importance of healthy work-life-balance. She values the exchange of experiences between colleagues a lot, it helps to realise that she is not the only one facing these challenges.

### What's Missing:

She wants more insight on how to train staff on reflective practices when doing supervision. As a team leader, she is always looking for further resources to share with her team (such as guidelines, training materials). She is very keen to set up structured systems for the care and well-being of staff. She feels what they have now is just a temporary solution to get by that requires more long-term approaches as well as supervision.



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