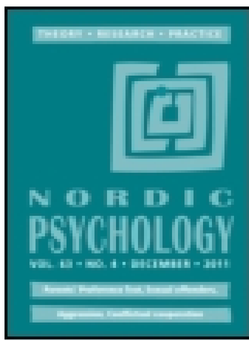

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RESEARCH ARTICLE

Competence building in child mental health -A Norway-Cambodia transcultural experience

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Abstract

The prevalence of mental health and neurodevelopmental disorders in young people is high in low- and middle-income countries. Collaboration between institutions from high-income countries and institutions in resource-poor settings may enhance professional competence. This may be a key to bridging the gap between service needs and ability to meet those needs. However, there are challenging issues in transferring knowledge from a Western context to a different cultural and socioeconomic situation. The aim of the present study is to describe significant aspect of a transcultural competence building project in Cambodia in child mental health from the perspective of the staff. A Norwegian expert team developed and implemented a program at Centre for Child and Adolescent Mental Health (Caritas-CCAMH) in collaboration with the staff two weeks per year over a 14-year period. The study has a qualitative approach using thematic analysis of the transcripts from a focus-group interview with 11 staff members at the end of the 14-year period. The multidisciplinary staff described a learning process characterized by collaboration in planning and implementation. Mixing theory and practice in clinical case discussions with a bio-psycho-social perspective was perceived as the cornerstone of the teaching process. A pedagogical strategy that involved constant reflection back and forth enabled the customization of the content and method of capacity building despite the differences in socio-economic conditions and learning styles. This model of continuity, low-investment, and low-intensity capacity-building may enrich the child and adolescent mental health settings in low- and middle-income countries.

Keywords: Competence building, mental health, children, adolescents, low-and middle-income countries, Cambodia

In acknowledgment of the burden of mental health problems in low- and middle-income countries (LMIC), the World Health Organization (WHO) developed the Mental Health Action Plan 2013–2030 (World Health Organization, 2021) to expand services for those with mental health disorders in low-resource settings. Basic and structural elements like poverty, nutrition,

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This article has been corrected with minor changes. These changes do not impact the academic content of the article.

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housing, and inequality are of substantial importance concerning mental health for young people in LMIC. A subdomain of particular importance is the mental health of children and adolescents (Erskine et al., 2015). Investing in the mental health of children and adolescents is a global priority given that 50% of mental health disorders commence by the age of 14 years and 75% by the age of 24 years (Lu et al., 2018). Though strategies for the prevention, and treatment of mental health problems among children and young people are well documented (Kieling et al., 2011; Klasen & Crombag, 2013; Patel et al., 2018), the gap between the service needs and the availability of services remains wide due to inter alia funding constraints, misplaced priorities, and a lack of human resources (Rocha et al., 2015).

There are multiple domains through which strengthening the provision of mental health services to young people in LMIC can be done. The World Health Organization Assessment Instrument for Mental Health Systems (World Health Organization, 2005) pointed to the following domains: policy and legislative frameworks, mental health specialist services, mental health in primary health care, human resources, public education and links with other sectors, monitoring, and research (Juengsiragulwit, 2015). According to the WHO Mental Health Gap Action Programme (mhGAP) (World Health Organization, 2008), mental health disorders rely heavily on health personnel resources rather than on technology and equipment. The mhGAP goal is "to get the right workers with the right skills in the right place doing the right things" (p. 18). Therefore, enhancing human resources, including adequate and appropriate training, is necessary for upscaling mental health interventions for young people.

There are several mental health projects worldwide with documented evidence concerning the enhancement of human resources and capacity building in LMIC. These projects target health professions in specialist health care (Kohrt et al., 2015) and primary health care (Akol et al., 2017; Kokota et al., 2020; Murray et al., 2011). "Scaling up," "task-shifting" and "dissemination" are central concepts. These concepts refer to providing mental health care through transference of competence from specialist-trained personnel to health-care workers. Some of these projects are partnerships between inter-disciplinary teams of mental health professionals from developed and developing countries (Fricchione et al., 2012; Juengsiragulwit, 2015; Tareen et al., 2009). Having experts and trained health personnel from high income countries to travel to LMIC to teach colleagues there, raises several political, ethical, scientific, and practical questions. For example, to what degree are host country personnel recognized as equals, to what degree are local and regional resources brought into various programs, and to what degree is it possible to implement care strategies from culture to culture in a seemingly context-free manner? Acknowledging these overall ethical and political concerns, the current study focuses on practical issues as experienced by host LMIC personnel. The study is based on a capacity-building program conducted over 14 years at the Centre for Child and Adolescent Mental Health in Cambodia (Caritas-CCAMH). The team has been visited annually by mental health and pediatric personnel from Norway. To the best of our knowledge, there are few reports of capacity-building programs seen from the local staff members' point of view.

The setting: the Cambodian-Norwegian capacity building program

The Cambodian health system collapsed during the Khmer Rouge era, and the two decades of internecine war made the situation worse because trained personnel were unavailable to

provide quality services (Jegannathan et al., 2015). Cambodia is a post-conflict country with an emerging economy in Southeast Asia. The estimated population in 2020 was 16.72 million, and approximately 85% of the Cambodian population lives in rural communities. The few mental health facilities that exist are in urban centers. Caritas-CCAMH Takhmau, Phnom Penh, is a public-private partnership between Ministry of Health Royal Government of Cambodia and Caritas Cambodia (Centre for Child & Adolescent Mental Health, 2022) and the pioneering service for children with mental health problems in Cambodia. Since 1995, the Caritas-CCAMH team has provided clinical services for children and adolescents with mental health and neurodevelopmental disorders (MNDD). The main problem presentations among patients include developmental problems (mainly autism and intellectual delay, 60%), neuropsychiatric problems (mainly epilepsy and tic disorders, 20-25%), and psychological problems (mainly psychosis and anxiety disorders, 10-20%). Currently, the staff at Caritas-CCAMH performs around 5,000 consultations per year at their main clinic and remote service centers. Until 2000, providing clinical service was the focus, whereas currently additional emphasis is given to human resource development, capacity building, outreach services to remote provinces, research and documentation, in accordance with recommendations from Fricchione et al. (2012).

The Caritas-CCAMH team is multidisciplinary team comprising three primary care nurses trained on the job, two psychiatric nurses, a special educator, a physiotherapist, three psychologists, two general physicians, a pediatrician, and an expatriate child psychiatrist. Most of the staff have credentials in education, but their training in child and adolescent MNDD is short and basic. Training is mainly based on the coaching at Caritas-CCAMH as there are no formal training course available in the field of e.g., special education, occupational, or speech therapy. To overcome this challenge, the Caritas-CCAMH team has established collaboration with institutions in Egypt, India, Norway, Singapore, Sweden, Thailand, and the United Kingdom. The Caritas-CCAMH staff can access training in some of these institutions, and professionals from these institutions visit Cambodia. The staff is given the opportunity to follow English language courses as employees at Caritas-CCAMH.

The Norwegian team (NT)

The NT comprised the same pediatrician and child and adolescent psychiatrist from 2005–2018 and was supplemented by a child psychologist from 2013–2018. The NT has had yearly two-week stays at Caritas-CCAMH. The NT's expertise covers both somatic medicine and mental health. In a LMIC like Cambodia, the physical impact of inter alia poverty, abuse, birth complications and sequelae connected to infectious diseases on mental health is substantial. Teaching health personnel about young people's mental health in this context requires competence in both somatic and mental health. The aim of the program has been capacity building in the multidisciplinary team working at Caritas-CCAMH.

Annually, the NT presented summaries from meetings with the Caritas-CCAMH staff at the end of their stay to obtain their verbal evaluation and suggestions for the next year's program. Workshop participants also gave structured evaluations of the workshops concerning e.g., content, workload, relevance, and teaching methods. In addition, every year the NT presented a written evaluation to the sponsors of the program (listed under "Funding").

This material provides the basis for the section "Program: Planning, topics and implementation" below.

The program: Planning, topics, and implementation

This competence building program is "a bottom-up" program. There has been no manual-based teaching and hence no fidelity measures. Instead, the teaching program was developed and evaluated through dialogue and collaboration between the two teams. The staff at Caritas-CCAMH has up to 20 years of experience in the field, and some have taken part in teaching programs abroad. There is little turnover in the group. Still, they felt a need for new and more elaborated knowledge and skills in central issues in their daily work. We took this as the starting point, and from year to year built a program on the expressed needs in collaboration with the staff. The topics and schedules were discussed via e-mail beforehand and settled in meetings on the first days of the visit at Caritas-CCAMH. The schedule was regularly revised according to progress of the training program during the two weeks. Over the years, the management group at Caritas-CCAMH took more responsibility not only for the practical organization of the workshops, but they also increasingly contributed with expertise and experience during the workshops. The topics proposed were usually based on the verbal and structural evaluation of the previous year's sessions, as a need for repetition or a desire for further development of specific topics. Clinical issues at Caritas-CCAMH, for instance new patient groups and developmental plans for Caritas-CCAMH could also be discussed. Repetition of material from previous years often preceded implementation of new issues. The NT took part in the clinical work at Caritas-CCAMH and at their satellite clinics in villages and remote sites. As part of the program, the NT followed consultations and discussed specific cases with the staff.

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

The NT used English as their teaching language, and members of the staff translated. In the early stages only a few staff members managed this, but during the years more of them used this opportunity to practice their English skills. The translation process from English to Khmer and often back to English was of course time consuming but gave an opportunity to reach a deeper understanding of the different concepts. The NT developed handouts from the theory sections, most of which were translated to Khmer. The participants often brought with them the handouts from earlier years to the lessons and used them as basis for building in new knowledge.

Usually, the teaching sessions took place before and after the clinical appointments, but at times, the entire day. For the first six to eight years, the education was an opportunity

Table 1. Topics and teaching approaches, 2005–2018.

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

*The different topics and teaching approaches were repeated from year to year, marked with "+", while new topics and approaches were added.

for the entire staff, and the aim was to build on their common knowledge base concerning understanding in and assessments of MNDD in young people. Later, the different professional groups also had separate teaching sessions according to their clinical tasks, and personnel from collaborating organizations, such as Non-Governmental Organizations (NGOs), were invited in.

In addition to lectures, the teaching comprised case discussions, practical training using role-play, small group discussions, use of one-way mirror observations of live cases, and reviews of videos of clinical consultations and groups. Case presentations were a central element. The second year, members of the staff took over this task and prepared case presentations according to the planned topics. The cases were examined using structured models (Garlov, 2006; Winters et al., 2007) to raise awareness about the advantages of assessing mental health problems of young people from a bio-psycho-social perspective (Engel, 1977). In addition, awareness of individual resilience (Masten, 2007) was repeatedly addressed.

Reflexivity in teaching and analysis

Reflexivity has been a pedagogic tool during the development and implementation of the program, and a theoretic support during the analysis (Malterud, 2016). To overcome some of the challenges in transferring Western competence to a foreign context, the NT assumed that collaboration and local anchoring might be useful. We therefore used relevant cases to illustrate the topics with thorough case discussions, and evaluations of both oral and structured feedback from the participants as a base for further progression of the program. These strategies are in accordance with reflective practice education (Clara, 2015; Mann et al., 2009). Therefore, concepts of *reflection-in-action* and *reflective practice* (Mann et al., 2009; Schön, 1991) have been normative for planning and implementation of the program. Schön (1991) claimed that mastering the complex relation between theory and practice is based on the capacity to reflect in action and relates to one's conduct while undertaking the task. This allows both teacher and learner to modify what (s)he is doing while doing it. Mann et al. (2009) argued that facilitating reflection, as described above, may assist learners in connecting and integrating new learning into existing knowledge and skills. The learners may need feedback on both the content and the process of their reflections.

Aim of the study

The aim of this research project is to describe experiences and practical concerns from the perspective of the local staff of a transcultural program in capacity-building in child mental health in LMIC. Such knowledge is important for Western clinicians with an ambition to support LMIC health professionals.

Material and method

With reflexivity as a frame of reference for developing the capacity building program, the content and aims of the program changed and developed throughout the 14-year period. Furthermore, the program was not initially planned as a research project. For these reasons, we could not perform a reliable evaluation based on pre-post testing (Patton, 2012). To

examine the process, we chose qualitative research approach with focus-group interviews (Kitzinger, 1995) as the data collecting method to gain insight from the staffs' point of view. A qualitative research approach is indicated when the purpose is to gain insight into people's thoughts, feelings, and intentions (Brinckman & Kvale, 2015). Focus group interviews are useful and efficient when the informants have a common background, and the research question is restricted (Morgan & Bottorff, 2010). The participants are encouraged during the interview to exchange experiences and points of view.

Data collection and participants

We conducted a focus-group interview at CCAMH with 11 Caritas-CCAMH staff members who had taken part in the program for at least two years. The interview took place in the clinic and lasted for 90 minutes. The participants worked together daily and knew each other well. We wanted to recruit all members, but for practical reasons the final sample comprised 11 staff members. The sample comprised three nurses (two women, one man), two psychologists (both women), one special educator (woman), one social worker (woman), one speech therapist (woman), one occupation therapist (man), one art therapist (man), and one program administrator (woman). They had been employed at Caritas-CCAMH for two to 20 years (M = 10 years). Because Caritas-CCAMH has a rather stable personnel group we made efforts to include two members who had been employed for only two-three years to get their impressions as novices. We distinguish quotes from novice and senior staff in the results section. The interview was audio taped and transcribed verbatim. Two of the authors administered the interview. PP was the moderator and BJ the secretary. The main questions were about the participants' overall impressions of the clinical program, the influences of the program both personally as clinicians and in Caritas-CCAMH, what topics had been valuable, what had not been valuable and their suggestions for further training (see Appendix).

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

Analysis

The results are based on a thematic analysis (Braun & Clarke, 2006) of the text from the transcription of the focus-group interview, translated into English. Thematic analysis is a straightforwardly described process of a cross-case analysis of qualitative data (Braun & Clarke, 2006). The analysis began by all authors reading the transcripts and exchanging immediate impressions and thoughts. Then, JB and MH read it thoroughly and identified subordinate interpretations/sub-themes. MH integrated them into four overarching themes forming the result section of the present article (see Table 2). The concepts of reflection on action and reflective practice (Schön, 1991) were used as theoretical support (Malterud, 2016) during the analysis. During this process we continually went back to the written material from the development of the project to seek validation for our interpretations of the transcripts.

Table 2. The analytic process from thorough reading of the full text to the identification of sub-themes and the search for overarching themes.

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

*Norwegian team.

Results

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

Participatory learning process ("all topics were relevant because we chose them")

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

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

Another senior participant added:

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

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

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

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

The value of integrating theory and practice ("theory applied with cases and skills is crucial")

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

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

A novice added:

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

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

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

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

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

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

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

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

Learning in real clinical situations ("it opened my eyes widely")

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

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

Some elaborated further on this and recalled from other sessions that the therapist must reach a consensus with the parents on the nature of the problem, how to understand it and what to do about it. They remembered the repetition of the concept of "therapeutic alliance." After observing the NT's consultations and having had their supervision on real consultations on video or through the one-way mirror, they said they felt more comfortable starting a consultation. One senior male nurse said,

> "They have offered us skills on how to sit with clients, how to listen to clients and how to ask [questions]. Those are skills that we do in practice with clients, not [just] theory."

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

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

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

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

Self-confidence and job satisfaction ("the changes are not only for clients, but us as well")

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

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

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

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

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

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

Discussion

The current study of a Cambodian-Norwegian continuing professional development (CPD) program seen from the perspective of the Cambodian staff has shown that the knowledge and skills exchange held in the framework of dialogic partnership, particularly over a significant period, contributes to learning across cultures. The participants emphasized the participatory learning process, i.e., that the program and the teaching methods is developed in collaboration, the value of integrating theory and practice illustrated by cases, roleplay, and real cases, and learning from the NT in clinical situations. They said that this capacity building program had given them self-confidence and job-satisfaction.

Our findings are in accordance with Mamauag et al. (2021) from an adaptation of a parenting program for families in the Philippines. They claim: " … continuous dialogue, reflexivity, openness, and adaptability among collaborators and stakeholders were key ingredients in the process of transporting and culturally adapting intervention programs." Over the years, the topics of teaching moved from normal development towards developmental delay and bio-psycho-social problems. This knowledge base, combined with clinical cases and the teachers' demonstrations and active participation in the daily clinical work, provided a platform for the staff to adapt basic relational attitudes, build self-confidence and enhance job-satisfaction. Kokota et al. (2020) recently examined a two-day training program on mental health topics for primary health professions in Malawi. They found that scores in knowledge and confidence in identifying mental disorders were significantly higher immediately after the training and six months thereafter. The participants' attitude towards mental illness and mentally ill was not changed when scored by instruments that measure benevolence, authoritarianism, and primary health ideology. Possibly, the strength of our program is its long duration (across 14 years) and stability that seems necessary to build competence in therapeutic skills like empathy and therapeutic alliances.

The concepts of *reflection in action* and *reflective practice* (Mann et al., 2009; Schön, 1991) guided the development of the program and provided a conceptual background for the analyses. We found that these concepts were helpful in promoting the changes the participants describe "in thoughts, feelings and behaviour" and "in ourselves and in Caritas-CCAMH." Participants provided examples of collaborative planning, frequent feedback and repetition upon the participants request, all requiring that the teachers can modify the teaching process while performing it. They evaluated the facilitation of reflection highly in

terms of the content and the process in the integration of theory and practice. The extensive use of cases from the clinic and the NT's participation in the clinic and demonstration of clinical procedures seemed to have promoted this. Naidu and Kumagai (2016) have commented on exporting the concept of reflective practice for a global medical education audience. They claim that globalization of medical education demands critical reflection on the reflection itself. They urge educators to "aspire to turn exportation of educational theory into a truly bidirectional, collaborative exchange in which culturally conscious views of reflective practice contribute to humanistic, equitable patient care." In the actual project, we have put emphasis on collaborative learning, and the participants used the word "partnership." It is probably impossible to eliminate the cultural "white spots" or taken-for-given perspectives in Western clinicians' performances (Summerfield, 2008), but we would argue that we have paid critical attention towards our practice. We have learned that reflective practice combined with critical reflection on practice have secured the relevance of the project, as is supported by the present evaluation from the staff. Our conclusions are in accordance with the recommendations for "Value-driven Training Innovation" in global mental health from the Society for the Study of Psychiatry and Culture (Kohrt et al., 2016).

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

Our project was limited to two weeks annually, according to what is possible for professionals in clinical work in our home country to take part in over years. It is a continuous low-intensity project. Some participants mentioned that they would have preferred that the NT came more frequently and for longer stays. This indicated that the current two-week framework for exchanging competence is perceived as suboptimal concerning learning therapeutic methods and interventions targeting specific mental health diagnostics. The time span each year may be too short despite the repetition over years. Continuous development of mental health service tasks requires another kind of continuity and intensity in addition to what our project can offer, e.g., longer stays, more focused implementation of evidence based therapeutic methods, surveillance, and fidelity checks, and online follow-up. However, considered these practical limitations, we find it important to emphasise the opportunities the current framework provides according to the participants. The lessons learned in the current project have relevance as a basic premise regardless of what kind of program is implemented.

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

Strengths and limitations

To our knowledge, few studies have brought forward the staff's experiences from CPD projects mediated by Western experts to a team in child and adolescent MNDD in LMIC. Our participants emphasized the importance of learning by participation, integration of theory and practice and modeling, which have got little attention in the literature regarding capacity building in a global context. Although we do not have any before-after evaluation of the effect of the program, we claim that these results are important elements in a successful transfer of knowledge cross cultures.

The empirical data to this project is from one focus group only. We wanted to include as many as possible of the staff, and 11 of the staff were available in addition to the two who administered the interview. We might have divided this group into two, and possibly got some more aspects and deeper understanding (Kitzinger, 1995). However, CCAMH is a busy clinic, and it turned out to be difficult to get enough participants to run two groups. Despite this limitation, we got rich, varied, and valid descriptions, and we are aware that there are more aspects that our project did not catch.

We chose to follow the principles of thematic analysis (Braun & Clarke, 2006). This method does not give opportunity to deeper and more reflective analysis of data. We evaluated it to be suitable for our data and context because we had to translate the interviews from Khmer to English and probably lost some nuances and cultural situated expressions. The current analysis has several possible biases. The first is that the documents following the development of the project were recorded by the NT from their perspective except for the participants' structured evaluation after each session. The second is that the leader of the psychology team at Caritas-CCAMH (PP) headed the focus-group discussion and the manager (BJ) was present but did not take part in the discussion. The participants may have been reluctant to bring negative experiences to the attention of the leaders and their colleagues (Coar & Sim, 2006), and the lack of negative accounts from the program may be a result of this. In this context, we could only, to a small extent, expect to get negative comments about the program, although the participants also reported some challenges and sort-comings. We could not get the complete picture, but we evaluated what the staff said and analysed it with this bias in mind. We therefor determine the results to be new and valid, although not complete. In later evaluations we will avoid having the leaders present and use more structured approaches in addition.

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

Implications

Our results bring forward attitudes and perspectives from a CPD characterized by collaboration, short intervals of training, duration over years and a stable team of experts from

abroad. We believe this knowledge can be a valuable contribution to take into account in the implementation of the different interventions developed, performed, and evaluated to enhance the mental health of children and adolescents in LMIC (Akol et al., 2017; Kokota et al., 2020; Leijten et al., 2016; Mamauag et al., 2021; McCoy et al., 2021; Murray et al., 2011; Tareen et al., 2009). The most salient points are:

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

Conclusions

To conclude, the model described herein of low investment and low intensity may be feasible for Western professionals with the ambition to support institutions for child and adolescent mental health in LMIC over years. Our program is still in progress, while at a current Covid-19-related break. This actual evaluation in the perspective of the staff has given us some important issues to consider, but also support our basic approach of collaboration and reflexivity. There will be many relevant topics to fill in in the future within the frames of a 14-days workshop a year. In addition, the analysis of the material from the focus group with the staff brought forward valuable knowledge relevant for adapting structured and evidence-based interventions to enhance the clinical competence in a clinic for child-and adolescent mental health in LMIC like Cambodia.

Ethical approval and consent to participate

According to the Regional Committee for Medical and Health Research Ethics, Western Norway, the Act does not apply to this project.

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

Consent for publication

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

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Data availability statement

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

Authors' contributions

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

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Appendix

Interview questions

1. In general, what are your views on collaborating with professionals from other countries to build the capacity of mental health professionals in Cambodia?
2. Are you aware of the project "Knowledge Exchange Cambodia – Norway" and have you taken part in it? What is your overall impression of this collaboration? Do you have some good memories or some bad memories you can share?

3. What about the project's influence on the multidisciplinary teamwork at CCAMH? Can you give some examples of changes in clinical practice as a result of the project?
4. What about the influence of the training on your own clinical knowledge and skills? Can you elaborate on this and give some examples (for instance, an important message that you took/gained)?
5. What topics from the teaching/clinical demonstrations do you especially value and why?
6. Was there any topic/theme that you consider NOT relevant to Cambodian context? Can you give examples and explain/elaborate?
7. What other topics would you suggest for the future training and why?
8. What message/ideas you would like to suggest for future cross-cultural collaboration such as Cambodia-Norway?