Debate: Lessons learned in lockdown – a one-day remotely delivered training on low-intensity psychological interventions for common mental health conditions

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Background

The coronavirus pandemic has highlighted the need for remote interactions between therapists and patients in child and adolescent mental health services. A growing evidence base has demonstrated the efficacy (Bennett et al., 2019) and acceptability (Rooksby, Elouafkaoui, Humphris, Clarkson, & Freeman, 2015) of remotely delivered low-intensity therapies for common child and adolescent mental health conditions such as anxiety, depression and challenging behaviour. Low-intensity cognitive behavioural therapy (CBT) utilises materials such as self-help books or online computerised content. When it is supported by a practitioner, the support is typically provided in briefer sessions, over a shorter course and the practitioner is usually prequalification. Similarly, there is evidence to suggest that remote delivery of CBT training and teaching is both effective and acceptable (Jackson, Quetsch, Brabson, & Herschell, 2018).

We have been providing low-intensity therapy as part of a study investigating the effectiveness and acceptability of a drop-in centre for children and young people attending Great Ormond Street Hospital (GOSH) and their families. In order to facilitate broader dissemination and implementation within the paediatric hospital, we had planned a 'low-intensity therapy training day' for staff and volunteers. With the UK being placed in lockdown one week before our scheduled 'face-to-face' training day due to COVID-19, there was a need for rapid adaptations to be made to the content, structure and format of the training day, to suit the online environment.

Adapting training to remote delivery

The training was coordinated and delivered by mental health clinicians via the videoconferencing platform 'Zoom'. The training content was not adapted from its original planned 6 hours in length, yet in recognition of frequently reported difficulties such as 'video call fatigue' and 'digital eye strain' (Blehm, Vishnu, Khattak, Mitra, & Yee, 2005), the duration of each session was abbreviated, and more frequent breaks were built in. The content covered the core areas of low-intensity CBT in children and adolescents, with a particular focus on seven key areas: (a) principles of guided self-help, (b) information gathering and risk assessment, (c) goal-based outcomes, (d) evidence-based strategies for anxiety, (e) depression, (f) challenging behaviour and (g) recommended self-help resources.

We had originally planned small group exercises with discussions, but recognised this may pose a challenge over Zoom although 'breakout rooms' are an option. We therefore adapted our online training to include other interactive components such as the chat function. Furthermore, 'Mentimeter', an audience response system accessed either online or through a phone app, was used throughout the presentation to create multiple choice questions, polls and open questions so as to encourage participation (Hussain & Wilby, 2019). We also included video illustrations to make the training more varied, maintain engagement and replace some of the clinical role-plays we had planned for the face-to-face workshop.

Additionally, anonymised 'clinical vignette' exercises combined with the chat function were used to stimulate discussion and demonstrate core aspects of low-intensity CBT. The training finished with a question-and-answer session led by two clinical psychologists with extensive experience of teaching and supervising low-intensity CBT therapists, allowing participants the opportunity to clarify their understanding, learn about further online training resources and discuss solutions for potential challenges with remote delivery.

Throughout the training, everyone was asked to turn off their videos to enhance bandwidth and mute their microphones – unless participating – to remove background noise. With consent from all participants, the training day was recorded. Some participants had initial difficulties with navigating the software, yet these were quickly resolved, highlighting the value of scheduling in

time at the start of training sessions to iron out technical difficulties.

A total of 24 participants (23 females and 1 male), all with a background of working within mental health services, completed the low-intensity training. Of these, 17 were assistant psychologists (APs); 14 at GOSH across 10 different departments and three from University College London Hospital, three were placement students and 4 were volunteers at GOSH.

Training day evaluation

A brief online questionnaire was developed to measure the attendees' understanding of each of the areas covered. Each area was rated on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree), with total scores ranging from 7 to 35. All 24 participants completed the questionnaire the week preceding training and again within one week post-training.

Repeated-measures t-tests were used to compare total pre- and post-training scores, as well as pre- and post-training scores per area covered. Total scores significantly increased from pretraining ($M = 23.59$, $SD = 6.75$) to post-training ($M = 34.05$, $SD = 2.08$), $t(21) = 9.21$, $p < .001$. Additionally, scores on each of the seven areas were significantly higher post-training compared with pretraining ($p < .001$).

Feedback from participants following the training demonstrated satisfaction with the remote delivery. Participants commented that the content of the presentation was 'clear',' well-prepared' and 'informative'. They also noted that the 'delivery came across really well' and appreciated how well the team had 'integrated the technology into the teaching'. One participant added 'It was so appreciated that you decided to run it remotely, as it felt like our development was still a key priority – I hope it will continue to roll out to teams and supervisors are interested in taking this forward.'

Lessons learned

Whilst our previous experience of remotely delivering therapy prepared us for adapting therapy to online and telephone delivery, the coronavirus pandemic saw a need for extending remote-delivery methods to all service activities including staff training and workshops. Findings showed that the one-day low-intensity training day increased knowledge and understanding in all key areas measured, and was positively received, providing further evidence for the effectiveness and acceptability of remote delivery.

Benefits
Remote delivery provided notable benefits regarding access to training for both trainees and tutors. Without the need for clinicians and trainees to travel to and from training, the time on the day could be used flexibly, with clinicians and experts joining for distinct segments of the day such as the Q & A session at the end. As the training day was recorded, trainees who were unable to attend had the opportunity to watch the training in full. Additionally, remote delivery offers the potential for individuals from across the UK, and potentially further afield (including from low- and middle-income countries), to attend. In addition, remote delivery removed several service costs such as the need to rent out a training space and reimburse the travel expenses of guests or speakers.

Beyond accessibility and costs, further benefits to this format of delivery include the increased confidence of participants able to contribute anonymously via Mentimeter, who might be more reluctant to participate in a face-to-face setting. Furthermore, as low-intensity interventions are often remotely delivered, delivery of training in the same format might provide opportunity for modelling of some of the nonspecific skills needed for remote work (Bennett-Levy, McManus, Westling, & Fennell, 2009).

Limitations
It is important to note that whilst these results are promising, this training day was intended to be an 'introduction' to low-intensity therapy and a means to signpost participants to a number of existing resources for ongoing learning and development. It is intended for participants to continue receiving ongoing training within their current role at GOSH through observations, joint-cases and supervision with qualified low-intensity therapists and clinical psychologists. This training day should therefore be viewed as a pragmatic beginning rather than an end-point or alternative to full training. However, such supervision could also be provided remotely (Bender & Dykeman, 2016). Another drawback of remote delivery is that it reduces the opportunities for networking compared to face-to-face training.

Our findings also need to be viewed in the context of several limitations including the small sample size and the pressure participants may have felt to demonstrate improvement due to clinicians' time and expertise put into organising and facilitating the training. The relationship between self-reported and objective understanding of key areas is unclear, particularly given the lack of direct observation of trainees in role-play.

Concluding remarks

These preliminary findings support the acceptability and effectiveness of a remotely delivered training day as a pragmatic introduction to low-intensity CBT. Given the necessity of remote working in response to COVID-19 and benefits of remote delivery, as well as rapid developments in technologies helping to address some of the challenges raised, going forward, remote delivery could continue to be beneficial for increasing access to much needed evidence-based interventions. As we emerge from lockdown, let's not leave the lessons we learned behind.

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Ethical information

No ethical approval was required for this article.

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