Creating a Sustainable Future: Task-shifting for Adolescent Mental Health Care

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FKXNQA001

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Submitted in fulfilment of the requirements for the award of the degree

Master of Arts in Psychological Research

Faculty of Humanities

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July 2022

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Abstract

South African adolescents face many historical, political, social, cultural, and economic influences in their lives that are perpetuated based on race and class. Unfortunately, the availability of mental health treatment for at-risk adolescents is inadequate in the current mental healthcare system in South Africa. Project ASPIRE is a counselling mental health programme designed for registered counsellors to deliver age-appropriate mental health services to meet the mental health needs of adolescents in community-based settings. This study aimed to explore the facilitators and barriers to task-shifting in Project ASPIRE through the views and experiences of the registered counsellors, the supervisor, and the adolescents. The researcher conducted semi-structured interviews and used the framework analysis method and thematic narrative analysis to analyze the data. The facilitating factors associated with making the intervention successful were intervention-related factors such as the value of the counselling techniques, flexibility and adaptability of the structure of the sessions and content relevance; supervision and supervisor-related factors such as ongoing supervision and monitoring and evaluation assessments; counsellor-related factors such as patient-tracking duties and upholding diversity, equity and inclusion; and adolescent-related factors such as intrinsic motivation and accessible and appropriate counselling services and sites. The barriers associated with posing challenges to the conditions, design, and structure of the ASPIRE counselling programme were intervention-related factors such as weak referral pathways and the amount of reading required by the patient handbook; contextual factors such as the multiple deprivations that severely disadvantaged Black adolescents and the impact of the COVID-19 pandemic; supervisor-related factors such as experiencing imposter syndrome, lacking cultural sensitivity training for the Xhosa population and high case volumes; and counsellor-related factors such as the constant disruption of work and supervision schedules caused by fulfilling patient-tracking duties and appointment availability issues. Moving forward, the ASPIRE principal investigators must strategically address the unique challenges that the adolescents, counsellors, and the counsellor supervisor experienced because of the conditions, design, structure, and the limited workforce of the ASPIRE counselling programme to improve the intervention for future trials.

Keywords: adolescence; mental health treatment gap; adolescent mental health services; task-shifting; lay counsellors; sustainable future.

Acknowledgements

I want to thank the principal investigators of Project ASPIRE, Katherine Sorsdahl and Bronwyn Myers, for inspiring my master's dissertation. Your endeavour to design a counselling programme for counsellors to meet the mental health needs of adolescents from underprivileged communities is progressive. Also, I greatly appreciated your generosity, support, and cooperation throughout my research process.

Thank you to all the adolescents, counsellors, and the counsellor supervisor who participated in my study. In particular, the counsellors and the counsellor supervisor were very kind and responsive to my WhatsApp messages and emails after data collection. I appreciated your answers to my questions because they led to rich data collection and analysis.

Also, I would like to thank Professor Floretta Boonzaier for the consciousness-raising of decolonial feminist approaches to doing psychological research differently to advance social justice. The processes of learning and unlearning that I encountered in the course were valuable for me to think differently about the ethical framework that this study could have used to centre my reflexivity and the participants' agency and voices to advance social justice and challenge the status quo.

A big thank you goes to my primary supervisor, Cathy Ward. I am grateful for your compassion and understanding after my mother passed away. One of the greatest lessons that I learned from you when you supervised my honours thesis was learning to speak with authority in my writing. During my research master's degree, I learned the importance of being gracious and respectful towards others in difficult situations while getting your main point(s) across to them and being realistic with my timelines of completing my master’s dissertation, considering life's curveballs and delays.

Also, thank you to both Cathy and Crick Lund, my co-supervisor, for providing me with valuable and constructive feedback on my research proposal and dissertation.

Thank you to UCT Mastercard Foundation Scholars Program for providing me with financial support to complete my degree.

A special thanks to my father and sister for their undying support, faith, love, and words of encouragement during all the challenges I faced in obtaining this degree and processing my grief. Even though my mother could not physically, mentally, and emotionally support me when I was analyzing my data and writing my thesis, I felt her presence and continuous encouragement from the spiritual realm, which kept me going.

Also, I am beyond grateful to God: The creator, and my ancestors for making it possible for me to succeed against all the sickness, trials, pressure, sorrow, trouble, and envy that were obstacles along my path.

Lastly, I want to thank myself for never giving up, sticking to my aspiration of obtaining my master's degree no matter what and having faith as small as a mustard seed that everything will work out just fine.

Chapter 1: Introduction and Literature Review

As South African adolescents experience violence and trauma (Ward & Dawes, 2012; Ward et al., 2018), exposure to alcohol and drug abuse (Kilpatrick et al., 2000), poverty (Cluver et al., 2013), social media use (Guinta & John, 2018) and high rates of HIV infection (Zeegers et al., 2010) within the context of their lives - addressing their mental health challenges should be a priority. In this research paper, the term "adolescent" signifies a young person between 10 and 19 years old (WHO, 2014). There is a growing impetus for our National Department of Health to prioritize providing dedicated age-appropriate mental health services for adolescents in community-based settings to promote equity within the mental healthcare system and achieve health equality (Tomlinson et al., 2022). In recent years, the coronavirus disease 2019 (COVID-19) pandemic has exacerbated conditions of inequality in homes and communities with complex vulnerabilities (Gittings et al., 2021). Adolescents are one of the most vulnerable populations with limited mental health service provisions in low and middle-income countries; the gap between their mental health needs and resource availability is concerning and needs immediate attention for a sustainable future (Kieling et al., 2011; Ramaswamy et al., 2022).

Adolescents' mental health needs are unmet because there are scant mental health services for adolescents and too few available mental health practitioners. For instance, a report in 2007 using the World Health Organization's Assessment Instrument for Mental Health Systems on the services available to meet children and adolescents' mental health service needs revealed that only 48 (1.4%) of 3,460 outpatient mental health facilities, 2 (3.8%) of 41 community-based psychiatric beds and 0.18 (1%) of 18 beds per 100,000 population across 23 mental hospitals in South Africa were made available for them (World Health Organization [WHO], 2007a). A survey completed in 2005 revealed that 0.28 psychiatrists, 0.32 psychologists, 0.40 social workers, 0.13 occupational therapists and 10.08 nurses per 100,000 population were available (Lund et al., 2010b). The number of available psychiatrists per 100,000 population improved to 1.52 per 100,000 around 2017 (WHO, 2017). Unfortunately, the number of available psychiatrists in middle-income countries is 5 per 100,000, whereas in high-income countries, it is 15 per 100,000, substantially higher than in South Africa (Bateman, 2015; Burns, 2011). The number of available psychologists and occupational therapists per 100,000 improved to 2.5 and 0.90 around 2019 and 2018, respectively (Ned et al., 2020; Padmanabhanunni et al., 2022).

Adolescence is a transitional phase marked by a period of bodily, cognitive, social, and emotional changes that can make young people vulnerable to developing mental health problems. Using the disability-adjusted life years (DALY) metric, worldwide mental illness is the sixth dominant cause of ill health in adolescents (Gore et al., 2011). The DALY metric is a time-based measure that sums the overall number of years of optimal health lost due to early death and living with a disability due to diseases in a population. Depression is the fourth, and anxiety is the ninth leading cause of illness and disability amongst 15 to 19-year-olds across the globe. Globally, suicide is the third highest cause of mortality for this population. Adolescents living in low and middle-income countries are 90% more susceptible to suicide (WHO, 2019). In South Africa, nine per cent of all teenage mortalities are suicides, and 90% of these teenagers lived with a mental illness before passing (South African Depression and Anxiety Group, 2020).

Adolescents in low and middle-income countries have a 90% mental health treatment gap (Skeen et al., 2016). That means most adolescents living with mental disorders in low and middle-income countries do not have access to the care they need. In South Africa, there is no national representative study of common mental disorders for adolescents to determine their prevalence rates of mental disorders (Tomlinson et al., 2022). However, some studies conducted in the Western Cape have shed light on the possible prevalence of mental disorders and the adolescent treatment gap. Kleintjes et al. (2006) concluded that 17% of children and adolescents live with diagnosable mental disorders from a consensus from a systematic literature review. They identified these common mental disorders: Generalized anxiety disorder, post-traumatic stress disorder, major depressive disorder, and dysthymia (Kleintjes et al., 2006). A recent situational analysis of children and adolescent mental health services and systems was conducted in the Western Cape, revealing that less than 10% of children and adolescents who need a formal diagnosis and mental health treatment will ever access these essential services (Mokitimi et al., 2022). Attending to the mental health needs of adolescents is very important to reduce their global burden of disease and help adolescents, especially those from socially and economically deprived homes and communities, reach their full developmental potential (Gittings et al., 2021).

Task-shifting mental health interventions for adolescent mental healthcare is a proposed means to support and improve adolescents' access to and availability of appropriate mental health services and overall well-being, in line with the WHO Global Mental Health Action Plan (WHO, 2013) devised to help increase the provision of mental health services in low-resource settings (Yasamy et al., 2011). Generally, task-shifting involves the reasonable

delegation of particular tasks performed by specialist health workers to non-specialist health workers to expand the available health workforce and efficiently increase access to health services (WHO, 2007b). In the mental health context, task-shifting involves mental health specialists training and supervising non-specialist healthcare workers to deliver mental health interventions in primary healthcare settings more efficiently and effectively (Republic of South Africa Department of Health [RSA DoH], 2013). The redistribution of mental health services through a task-shifting approach can help achieve health equity and address the current shortage of mental health workers in the country (WHO, 2007b). Hence, a viable solution to improving access to adolescent mental healthcare in primary healthcare settings is task-shifting mental health services to lay counsellors. Some policies, such as the National Mental Health Policy Framework (NMHP) and Strategic Plan (RSA DoH, 2013), have endorsed the integration of well-trained non-specialist workers in primary healthcare settings to increase the mental health workforce and deliver evidence-based psycho-social interventions with mental health specialists playing a supervisory and supportive role to them. Nevertheless, other significant policies in South Africa do not explicitly endorse the integration of lay counsellors into primary healthcare settings for mental health services, such as Section 27 of the Constitution (RSA Department of Justice and Constitutional Development, 1996), the Mental Health Care Act (RSA, 2002), the Child and Adolescent Mental Health Care Policy Framework (RSA DoH, 2003) and the National Health Insurance Bill (RSA DoH, 2019). If these policies were to explicitly support task shifting or the integration of lay counsellors in mental health services and the mental healthcare system, that would help to advance social justice by delivering basic mental health counselling at a primary healthcare level.

Several studies internationally and locally have shown that task-shifting mental health services can be effective. For example, in Zimbabwe and India, studies have shown that trained and supervised lay counsellors can effectively deliver treatment for common mental disorders for adults in primary healthcare facilities (Chibanda et al., 2015; Patel et al., 2010). A pilot study in South Africa showed that trained and supervised lay counsellors effectively delivered group-based counselling to patients aged 18 and above with comorbid depression and HIV/AIDS (Petersen et al., 2014). These studies, amongst others, identify several facilitating factors for policymakers, researchers, and health practitioners to task shift mental health treatment to lay counsellors effectively.

Some factors that facilitate task-shifting psychological interventions include content relevance. Munodawafa et al. (2017) study on lay counsellors' experience of delivering a

task-shared psycho-social intervention for perinatal depression in Khayelitsha, South Africa, found that it helps counsellors easily remember and conduct the counselling intervention when the content is enlightening and valuable to them and the participants. Also, having extensive training can help build counsellor self-efficacy, i.e., a counsellor's confidence in their capabilities to effectively conduct counselling sessions in an intervention (Larson & Daniels, 1998). Providing ongoing, structured, and emotionally supportive supervision sessions to lay counsellors can help reduce their psychological distress and monitor their skills development post-training. Specialist mental health practitioners can provide adequate supervision and enhance monitoring and evaluation of quality assurance activities of the intervention (Mendenhall et al., 2014). Also, when lay counsellors need referral support for severe mental health cases, specialist mental health practitioners can make those referrals or attend to those cases as soon as possible (Petersen et al., 2011). While conducting the sessions, having a counselling manual guides lay counsellors in delivering the targeted intervention for specific mental disorders (Chibanda et al., 2011). Also, when lay counsellors are proficient in the local language of the participants during counselling sessions, participants find it easier to connect, trust and understand them (Munodawafa et al., 2017).

Even though there are several facilitating factors to task-shifting mental health interventions, systemic barriers and contextual factors need addressing to ensure the integration of lay counsellors in the healthcare system. Some of the most prevailing systemic challenges for staff in the South African context are the lack of infrastructure and office space for private consultations, heavy workloads and a shortage of staff to deliver services. Another challenge is the lack of recognition of healthcare workers taking on new designated roles in the mental healthcare system (Mendenhall et al., 2014). Structural barriers for patients include long-distance travel to the facility, long waiting times, overcrowding, uneasiness about confidentiality and privacy, and dissatisfaction with health workers (Crockett, 2012; Murphey et al., 2013). Social factors include a lack of trust in public health services, non-scientific beliefs that healthcare workers would preferentially treat physical illness over mental illness, and a lack of the clinical empathy that mentally ill patients seek from them (Mendenhall et al., 2014). The socio-cultural context of the intervention setting is fundamental for identifying community mental health workers who can assist with detecting and treating mental health conditions and care (Mendenhall et al., 2014).

Beyond these barriers, some counsellor and supervisor-specific factors might inhibit the implementation of task-shifting mental health interventions, such as fear-based counsellor anxiety and imposter syndrome. Additionally, some counsellors may lack confidence in their

newly acquired skills due to having a short training period which is typical for lay counsellors. Counsellors' anxiety may come from fear of deviating from the manual-based approach to counselling and the stress of emotional support provision (Munodawafa et al., 2017). Counsellors need their supervisors to discuss the delivery of the sessions, how to overcome challenges, and ask questions about different aspects of an intervention (U.S. Department of Health and Human Services, 2019). Also, supervision in task-shifting enables supervisors to ensure fidelity to the intervention and check in with counsellors on their project-level well-being, participants' progress and needs outside supervision sessions, such as needing more training or emotional support (Rocha et al., 2021). Sometimes supervisors are not trained therapists, which can be problematic in clinical settings where counsellors must uphold ethical practice (Vasquez, 1992) and utilize a theoretical and practical approach to sessions (Gold, 2004). It is ubiquitous in task-shifting mental health interventions to appoint suitable candidates to perform supervisory duties for lay counsellors who do not have professional qualifications as registered mental health practitioners. However, when confronted with imposter feelings and distorted self-concept in a new role, supervisors may experience self-doubt, fear, and low self-esteem (Cope-Watson & Betts, 2010; LaDonna et al., 2018). Other barriers include a shortage of a task-sharing workforce (i.e., lay counsellors, primary healthcare workers and specialists) with mental health training and inadequate compensation of lay counsellors for training and delivery of services that can affect counsellor motivation (Mendenhall et al., 2014).

Little is well-known about the facilitators and barriers of task-shifting in mental healthcare, specifically for adolescents. However, the broader therapy literature about the treatment of adolescents suggests that many adolescents are motivated by others to begin therapy (de Haan et al., 2013). Also, they are more likely to drop out of treatment prematurely for various reasons. These include dissatisfaction with the counselling sessions, which they show through non-engagement and silence (Gibson & Cartwright, 2013). Also, when the adolescents perceive that they have achieved everything they set out to gain from the sessions and when life circumstances make it difficult for them to come to therapy, they often drop out (O'Keeffe et al., 2019; Swift & Greenberg, 2012). Autonomy and agency are important developmental milestones in both adolescence and the therapeutic process for successful treatment (Gibson & Cartwright, 2013). Adolescents often exhibit autonomy and agency by controlling when and what they choose to share with their therapist (Gibson & Cartwright, 2013; Lovgren et al., 2019). That can lead to adolescents conceptualizing positive therapeutic relationships as friendships that are sincere, tolerant, trustworthy, supportive,

attentive, and respectful (Binder et al., 2011; Everall & Paulson, 2002; Gibson et al., 2016; Lavik et al., 2018; Lovgren et al., 2019; Sagen et al., 2013). General adolescent psychotherapy research has found these distinctive facilitators and barriers in the treatment of adolescents, which are likely to appear in a task-shifting approach to delivering adolescent mental healthcare. Besides this, on the one hand, the task-shifting strategy offers the potential for cost-effective and brief mental health interventions in healthcare facilities to meet the mental health needs of citizens living with mental disorders in low-resource settings. However, on the other hand, this approach may not be able to reach some of the most vulnerable adolescents, particularly in rural areas, who may not have access to both healthcare and mental healthcare service provisions. Thus, additional intersectoral partnerships and innovative approaches might be necessary to reach the most vulnerable adolescents in settings with extreme social and economic adversities (Cluver, 2020).

Addressing social determinants of mental disorders and systemic barriers to treatment for adolescents, such as stigma, discrimination and having to be accompanied by an adult to access health services, can help achieve social justice. Also, it can reduce the number of adolescent mental health cases that go undiagnosed and untreated (Kessler et al., 2007) because of oppressive socio-political conditions that influence health and mental healthcare. Mental health treatment for 6 to 23-year-olds typically does not begin until a considerable number of years have passed since the onset of the mental illness - yet almost half of all lifetime mental disorders start at 14 years old (Kessler et al., 2005). Training community health workers to deliver adolescent mental health services may help address adolescents' mental health problems and avoid mental health problems in adulthood and even in late adulthood.

Scholarship on task-shifting mental health interventions typically investigates the effectiveness of training and supervising lay counsellors to treat common mental disorders in general healthcare facilities for adults (Chibanda et al., 2015; Patel et al., 2010; Petersen et al., 2014). However, there is a neglect of the experiences of those who work to deliver, supervise, and receive care. Therefore, in this study, I aimed to explore the views and experiences of registered counsellors, the counsellor supervisor, and adolescents in a task-shifting research study to assess the intervention, supervision and supervisor, counsellor, and adolescent-related factors associated with the facilitators and barriers to delivering the psycho-social intervention. Investigating specific facilitators and barriers to effectively implementing the mental health counselling programme for adolescents may enhance the

fidelity to the mental health treatment and, hopefully, a relevant move towards meeting the mental health needs of adolescents in South Africa for a sustainable future.

Research Questions

1. How do adolescents, lay counsellors, and the counsellor supervisor describe and make meaning of their experience in the ASPIRE counselling programme?
    1.1. What facilitating factors do adolescents, lay counsellors, and the counsellor supervisor describe that facilitate task-shifting adolescent mental healthcare in the ASPIRE psycho-social intervention?
    1.2. What barriers do adolescents, lay counsellors, and the counsellor supervisor describe when participating, delivering adolescent mental healthcare, and supervising within Project ASPIRE?

Chapter 2: Method

Research Design

This study's primary goal was to describe and understand the experiences of adolescents, counsellors, and the supervisor in Project ASPIRE and to assess the facilitators and barriers to delivering the psycho-social intervention. Qualitative research was most suitable for this study because it allowed me to interpret the meaning-making and experience of participating and working in Project ASPIRE from the participants' perspective. The context and participants' subjectivities were vital in this study - and as such, a qualitative approach was best suited. Also, a qualitative approach is appropriate where a topic has limited research, such as in this exploratory study within a low-resource setting such as South Africa (Salkind, 2010).

Qualitative research has many implications on how and what is produced based on a researcher's positionality, investment, and expectations within the research project. Thus, reflexivity in qualitative research helps to acknowledge the effects these may have had on the research encounter and the interpretation of participants' perspectives (Dodgson, 2019).

Context and Setting

In contemporary times, Apartheid's segregation legislation legacy has meant that many Black people, referring to Black Africans, Coloureds, and Indians (Seedat et al., 2009), live in socio-economic, educationally, and culturally marginalized locations in South Africa (i.e., rural areas and townships[1]). These marginalized communities typically have few to no leisure activities and recreational facilities. Also, residents in these disadvantaged communities constantly experience poor service delivery of sanitation, electricity, and housing. The Black population in Post-Apartheid South Africa also inherited poor quality education because of Apartheid's unequal and racialized policies (Dawes et al., 2007). In South Africa, young people who live in these marginalized areas are typically more likely to experience high levels of unemployment and engage in experiences and behaviours that can negatively affect their mental health and lives. These experiences and behaviours can sometimes be alcohol and substance abuse, risky sexual behaviour, interpersonal violence, and violent crimes (Asante & Lentoor, 2017; Govender et al., 2019; Russell et al., 2014; Ward & Dawes, 2012).

[1] Townships are under-serviced, often informal, peri-urban settlements in South Africa that are legacies of the Apartheid legislation that dictated Black people should live on the outskirts of major cities and travel long distances to work in cities.

Project ASPIRE is a joint study conducted by the South African Medical Research Council (SAMRC) and the University of Cape Town (UCT). The study received funding from the Joint Global Health Trials Initiative through the United Kingdom Research and Innovation group. It is a randomized controlled trial that enrolled 100 adolescents (15 to 18 years old) living in highly underprivileged communities around Cape Town and recruited them from community-based organizations that serve at-risk youth and their families. All the adolescent participants underwent a baseline assessment of their depressive symptoms and alcohol use. The inclusion criteria for participants consisted of those who screened positive for depression measured by the Centre for Epidemiological Studies Depression scale (CES-D 10) with a score of ≥10 (Baron et al., 2017). Or moderate to severe drinking with a score of ≥5 on the Alcohol, Smoking and Substance Use Involvement Test-Youth version (ASSIST-Y) (Humeniuk et al., 2016). They also reported at least two episodes of heavy episodic drinking (≥5 drinks) on one occasion in the month before the baseline assessment.

Additionally, the adolescents who participated in Project ASPIRE live in violent locations around Cape Town, such as Nyanga, Langa, Delft, and Paarl, to name a few (Etheridge, 2019). These adolescents are vulnerable to widespread violence and trauma exposure in the home, school, and community (Ward & Dawes, 2012; Ward et al., 2018). Also, there are high rates of HIV infection in the 15 to 24 age group, and HIV infection is associated with a greater likelihood of developing depression (Rehle et al., 2007). Exposure to violence and trauma in multiple interpersonal domains is associated with significant emotional and behavioural problems, specifically post-traumatic stress disorder and substance misuse (Ward & Dawes, 2012).

Further, living in conditions of poverty is associated with food insecurity, poor mental health, malnutrition, low levels of education, inadequate care, and neglect, which can negatively affect cognitive functioning (Dowdall et al., 2021; Lund et al., 2010a; Savahl et al., 2015). Unfortunately, mental health services are highly inaccessible in rural areas and townships because of few available mental health practitioners (Lund et al., 2010b) and a lack of funding and sourcing of mental health interventions (Cluver, 2020). All of this is perpetuated based on class and race, which needs the advancement of social justice to bring change to this devastatingly pervasive context.

With careful consideration of this context, the principal investigators of Project ASPIRE tailored the intervention to mitigate the negative influences of these social and economic conditions on adolescents' participation in the counselling sessions and commitment to attending the counselling programme (Sorsdahl et al., 2021). Project ASPIRE

is an intervention adapted from an adult-oriented intervention comprised of three Motivational Interviewing and Problem Solving Therapy (MI-PST) counselling sessions with an optional fourth session (Myers et al., 2018). The WHO (2016) recommends these as counselling techniques to reduce the mental health treatment gap. The literature suggests that using MI and PST together can lead to reduced levels of depression and bring about a change in alcohol and other substance use disorders in patients with these mental health problems and even those with comorbid depression and substance use disorders (Naar & Safren, 2017; Riper et al., 2014; Sorsdahl et al., 2015). The objectives of MI-PST are to encourage participants to change their risky behaviours and improve their problem-solving skills. In doing so, participants will cope with stress and manage their life problems better. Also, when stressors and life problems are unmanaged, they become risk factors for substance-related disorders, severe depression, and other psychological and medical conditions later on in life (Sorsdahl et al., 2014). Hence, Project ASPIRE assessed whether the adolescents had severe depressive symptoms and problematic alcohol and substance misuse to build their skills and healthy coping mechanisms to facilitate their desired change and recovery from their mental health problems (Sorsdahl et al., 2021).

The programme primarily used the SAMRC's clinical research site in Delft. It is a convenient building with easy access to several highly underprivileged communities and community-based organizations that provide services for at-risk youth and their families. Also, it has comfortable private offices to encourage learning and interaction, a reliable printing system, essentials such as electricity, water and sanitation, and a kitchen and sitting area to have lunch and light refreshments. The location of the site is safe. Also, the adolescent participants were provided with refreshments when they arrived at the Delft site and other community settings to attend their counselling sessions. The principal investigators provided transportation for those participants who would have to travel long distances between the community settings and their homes or school. The fieldworkers would transport the adolescent participants to and from their homes or school to the Delft site or community settings to ensure their safe and timeous arrival and departure. Furthermore, there were no economic costs to the adolescent participants nor their guardians for the transportation, food, counselling sessions and the handbook they received during their participation in Project ASPIRE (Sorsdahl et al., 2021). Since the interviews with the adolescents were telephonic, the principal investigators generously provided me with airtime to contact the adolescents to schedule and conduct the interviews.

In low-resource settings, having funded and sourced mental health interventions for adolescents is progressive in contexts of deprivation, such as South Africa, that need to bridge the mental health service gap for adolescents with accessible, available and appropriate mental health services (Petersen et al., 2010). Since Apartheid's structural inequality legacy has disadvantaged the poor, they experience poor service delivery and a lack of access to resources. In line with this, the principal investigators sought to move mental health counselling beyond primary healthcare (PHC) facilities to community settings to meet the mental health needs of adolescents (Sorsdahl et al., 2021). The literature suggests that adolescents are typically less inclined to seek mental health services in PHC facilities because of stigma, negative attitudes of healthcare workers, long waiting times, lack of designated space to service them in clinics, and long-distance travelling (Musakwa et al., 2021). Also, adolescents' religious and cultural beliefs about their mental health condition can influence their decision to whether or not to seek formal mental health services (Goodwin et al., 2016).

Furthermore, there is a service gap for adolescent-oriented services, where young people may prefer to access services directly (Ito, 2013; McBain et al., 2012). Hence, the principal investigators recognized the need to bridge the service gap for adolescents. Also, this is the age of onset for mental disorders that develop in adulthood and late adulthood (Kessler et al., 2005).

Upon completion of the baseline assessment (i.e., screening for depression and alcohol use), all participants received the first session of the study, which lasted for an hour. It included the following components: Screening for depression and alcohol use, providing screening results and psycho-education about the disorders and the effects of alcohol use and depression on young people. Then, based on the severity of the clinical presentation of the symptoms, the counsellors used motivational interviewing techniques with participants to enhance motivation to reduce alcohol use or activate behavioural changes to address symptoms of depression. Setting personal goals and developing a plan for action at the end of the session helped achieve this objective (Sorsdahl et al., 2021).

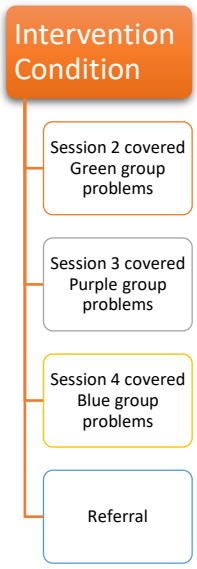
The adolescents were randomized to either the enhanced-usual care (i.e., the control condition) or the intervention condition. In the control condition, participants received enhanced-usual care that only consisted of referral to treatment. In the intervention condition, participants received the first session plus only three more MI-PST counselling sessions and referrals to usual care providers for further follow-up, which is different to the original adult-oriented intervention (Sorsdahl et al., 2021). In sessions two to four, the counsellors covered

a myriad of problems the adolescents were experiencing in their lives and used colours to identify issues covered in each session. The colours represented the following:

- **Green group problems:** Any kinds of problems that one would be able to solve. Such issues include day-to-day matters, fighting with a boyfriend or dealing with peer pressure from friendship circles.
- **Purple group problems:** Any thoughts and feelings troubling the adolescents immensely but did not affect what was important to them or pursuing their goals, such as worrying about not being good enough for others.
- **Blue group problems:** Any circumstances one cannot change and would have to learn to live with it, such as dealing with grief or being diagnosed with a chronic medical condition.

Figure 1

Intervention Condition Session Outline After the First Session

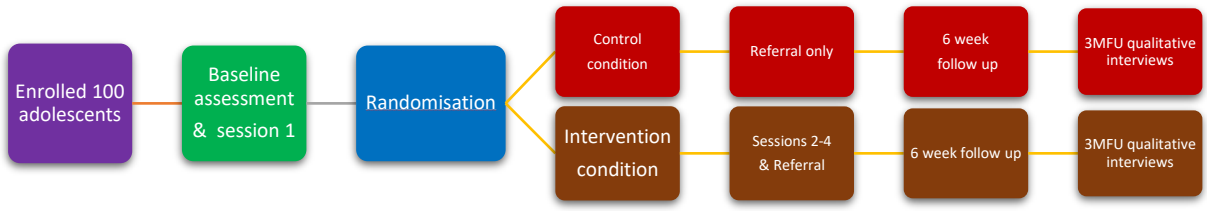


All the adolescents in both conditions had six weeks to complete their treatments (Sorsdahl et al., 2021). Then, follow-ups were conducted at this point to check progress. In particular, if the adolescent participants in the intervention condition had not completed at least two sessions within those six weeks, they would not be able to move on to the third session (i.e., they had forfeited the third session). The programme regarded adolescent participants in this situation as having ‘timed out’ of continuing their counselling sessions

because their sessions within Project ASPIRE were considered complete. However, the programme offered these adolescents the option to continue their sessions only after completing their follow-ups. At the end of the trial, fieldworkers collected qualitative information at the three months post-intervention follow-up on adolescents' treatment experiences on Project ASPIRE. As a token of their appreciation, the programme gave the adolescent participants a cash voucher when: (1) they joined the counselling programme, (2) after attending all four sessions and (3) after completing their three-month post-intervention follow-up interview (Sorsdahl et al., 2021).

Figure 2

Project ASPIRE Trial Design



Three experienced and trained counsellors delivered the counselling sessions face-to-face in community settings before the COVID-19 pandemic (Sorsdahl et al., 2021). When the COVID-19 pandemic occurred, the sessions were conducted telephonically due to COVID-19 concerns. A counsellor supervisor supervised them throughout the study. Each counselling session was conducted individually with each adolescent and subsequently had a motivational component, psycho-education on problem-solving techniques and a chance to practice their new skills through exercises and take-home tasks. Participants also learnt steps to address significant problems that can be solved or not. They also learnt emotion regulation techniques and strategies to manage negative intrusive thoughts. Participants received a handbook with a summary of the content covered in the counselling sessions and worksheets to practise their problem-solving skills. The participant handbook also guided the counselling and was made available in the local languages of English, Afrikaans, and isiXhosa (Sorsdahl et al., 2021).

The study duration was one year: From enrolment, participants in the intervention condition received four MI-PST counselling sessions over six weeks. Ideally, each counselling session was supposed to be five days apart (Sorsdahl et al., 2021). Nevertheless, they were sometimes at least a week or two months apart due to scheduling issues both adolescents and counsellors had from their commitments and responsibilities. The duration of each counselling session was approximately 45 minutes to an hour.

The counsellors received 40 hours of training. Their training programme strengthened their competencies in the common types of mental illness, conducting alcohol misuse and depression screening tests, and basic counselling principles, such as the importance of confidentiality. Additionally, their training programme consisted of competency testing their skills in MI-PST through role-playing and case examples, providing referrals, alerting, and attending to distressed participants (Sorsdahl et al., 2021). The training programme's components followed the structure of the patient handbook to familiarise the counsellors with and reinforce the content and format of the counselling sessions. Before the counsellors embarked on training, they completed an evaluation of what they already knew, believed and were practising about providing psycho-social support for common mental disorders. After completing the training, the results of these assessments guided the evaluation of the effectiveness of the training programme.

When the counsellors began to implement the intervention, the counsellors had ongoing in-person and online or telephonic clinical supervision and debriefing sessions held in a group setting once a week and by a registered counsellor (Sorsdahl et al., 2021). In turn, a Masters-level psychological counsellor supervised the counsellor supervisor. The supervision sessions comprised reviewing barriers to implementing the intervention (such as logistics), a report-back of participants' progress and debriefing about challenges, and feedback from fidelity checks about the quality of intervention delivery helped improve the intervention. After each counselling session, the counsellors made clinical notes, which the counsellor supervisor assessed during their weekly supervision sessions. Supervision also served as a chance to continuously revise skills and knowledge gained during training when the counsellors needed to. If the fidelity checks indicated that some counsellors required more training than they received before delivering the intervention, they received it. Each counsellor received a training and supervision logbook that tracked the hours they dedicated to attending training, supervision, and debriefing sessions. The supervision sessions were audio-taped for fidelity purposes and assessed. The feedback these quality assurance activities provided helped improve the quality of supervision sessions.

The inclusion criteria the principal investigators set for choosing these counsellors were that they needed to be registered counsellors (Sorsdahl et al., 2021). Registered counsellors are mental health practitioners who are formally qualified to conduct mental health screening and basic assessments and deliver mental health interventions to improve the daily functioning of persons and groups (Health Professions Council of South Africa [HPCSA], 2019). On the other hand, the supervisor needed to be registered with the HPCSA and had previous experience in providing supervision. Also, it was advantageous if they had previous experience with the intervention (Sorsdahl et al., 2021).

All the counsellors had extensive experience counselling in various settings, from working in research settings with non-profit organizations to healthcare facilities and mobile clinics. Two counsellors had previously worked together on Project MIND, counselling adults with chronic diseases such as HIV and diabetes and common mental disorders such as depression (Jacobs et al., 2021). Additionally, two of the three counsellors were registered counsellors registered with the HPCSA. The other counsellor is a social worker registered with the South African Council for Social Service Professions. Two counsellors identify as Black African females and working-class, and the third counsellor identifies as a Coloured male and middle-class. The female counsellors were aged 38 and 41, respectively, and the male counsellor was 32 years old when they began working in Project ASPIRE.

The counsellor supervisor had relevant supervisory experience before supervising counsellors on Project ASPIRE. She had been a supervisor on a project called Teachable Moments, which similarly was a task-shifting model. During the Teachable Moments programme, she provided supervision sessions between ten and twelve lay counsellors trained to counsel adults on alcohol and harms reduction in emergency settings. Also, during her time working on this programme, she was part of the initial training the lay counsellors underwent for the intervention. Other responsibilities included listening to session recordings (if they were in English), performing fidelity checks on them, advising and using role-plays to encourage improvement. The counsellor supervisor was familiar with checking counsellors' fidelity to using MI-PST counselling techniques in the Teachable Moments Projects. The counsellor supervisor identifies as a White female and middle-class. She was 30 years old when she began working for Project ASPIRE.

Sampling and Participants

The participants in this study included counsellors who delivered non-specialist mental health counselling to adolescents in the ASPIRE counselling programme. All three counsellors, and the counsellor supervisor who worked on Project ASPIRE, were invited to

participate in semi-structured interviews. Additionally, I conducted eight interviews with adolescents who participated in Project ASPIRE three months post-intervention. After completing these eight adolescent interviews, I noticed that participants were giving similar answers to questions; as a result, I was obtaining no new information in the interviews. Thus, I knew I had reached data saturation. When this happened, I ceased performing further interviews as I had accomplished my research purpose (Saunders et al., 2018). Thus, purposive sampling guided the recruitment of participants in this study because their views and experiences were crucial in understanding any barriers and contextual factors they might have encountered in pursuit of answering the research question (Etikan et al., 2016).

Adolescents

The principal investigators randomly selected the adolescent participants from the intervention condition, and then I interviewed eight adolescents about their experiences of the counselling programme. I completed these interviews with them at three-months post-intervention. I did not ask the adolescents about their race and class. However, when I received Excel spreadsheets with their details, I had access to their names, ages, gender, and primary and alternative cell phone numbers that were their own or their primary caregivers' cell phone numbers.

Counsellors

I interviewed all the counsellors, and these interviews explored their (i) feelings of competency around delivering the counselling, (ii) views about the training and supervision content and format, and (iii) thoughts about participants' commitment to the counselling programme, and (iv) challenges that they had faced with delivering the intervention in community settings instead of primary healthcare clinics, as well as (v) suggestions they may have had on how to improve the adaptability of the counselling intervention for adolescents.

Counsellor supervisor

I interviewed the counsellor supervisor to find out (i) whether the counsellors maintained the skill set learned in training (for example, the use of a motivational interviewing counselling style), (ii) her views about the counsellors' quality of intervention delivery, (iii) her experience of supervision and (iv) whether the counsellors delivered the objectives of the intervention during counselling sessions.

Procedure

I used in-depth, open-ended, and linguistically appropriate semi-structured interviews with participants who consented to participate in the study. Also, the semi-structured interviews were dialogical encounters intended to foster a safe space to co-create knowledge

and build rapport, understanding, flexibility and equalize power relations in the researcher-participant relationship (DiCicco-Bloom & Crabtree, 2006; Hydén, 2014). The dialogical encounters allowed me to change the proposed questions as influenced by the direction of the conversation and probe into interesting and important insights that participants provided (Creswell & Poth, 2016). Utilizing open-ended questions for the semi-structured interviews allowed participants to lead the conversation in an unexpected direction.

Upon receiving full ethical approval for this research endeavour (*see Appendix A and B*) and before starting data collection, I performed some interviews over the phone and others online, as described below. I used the following informed consent process to conduct semi-structured telephonic interviews with the adolescents:

1. I contacted the parents of adolescents under 18 to get their informed consent for their child to participate in a telephonic interview (*see Appendix C*). Also, I contacted adolescents aged 18 years old and above to explain the purpose of the study and answer any potential questions.
2. Then, I set appointments for an in-depth telephonic interview with interested and available adolescents.
3. At the beginning of the study interview, I read aloud the consent form to the adolescent to obtain assent if they were younger than 18 or informed consent if they were older than 18 (*see Appendix D*). That gave them a chance to ask any questions they needed answers to from me. Thus, I obtained verbal informed consent from each parent and adolescent where required, which was recorded and appeared on the transcripts of the study interviews.

I used the following informed consent process to conduct semi-structured online interviews via the video conferencing platform Microsoft Teams with the counsellors and the counsellor supervisor:

1. I emailed the relevant consent form to the three counsellors and the counsellor supervisor beforehand.
2. At the time of the interview, I briefly went through the consent form (*see Appendix E*) and answered any questions they had about the study.
3. Then, I proceeded to record the consent process. I asked the three counsellors and the counsellor supervisor to say “Yes” or “No” to participate in the online interview and be audio-taped.

Furthermore, these in-depth study interviews with the adolescents followed the specified Project ASPIRE end-of-study interview schedule (*see Appendix F*) I received from the principal investigators. Then, the in-depth study interviews with the counsellors and counsellor supervisor took place per the interview schedules I developed (*see Appendix G and H*).

All the interviews lasted about an hour. The interviews were telephonic and online due to the ongoing COVID-19 pandemic. Where online interviews were not possible, I used the voice calling feature on WhatsApp to conduct the interviews.

Data Analysis

I initially used the framework analysis method to lay the groundwork for developing a coding framework of facilitators and barriers that shaped adolescents, the counsellors and the counsellor supervisor's experiences in Project ASPIRE and subsequently used the thematic narrative analysis to interpret them (Crawford et al., 2008; Lund et al., 2011; Mendenhall et al., 2014). Using the framework method provided a great tool for managing and mapping large amounts of textual data from the qualitative interviews (Gale et al., 2013). The framework method analysis helped me to systematically categorize and organize the data into a coding framework that I could constantly compare and contrast with other parts of the data set using NVivo 12 qualitative data analysis software. In the initial phase of my analysis process, I used the following steps for the framework method analysis (Gale et al., 2013):

1. I listened to each audio recording to ensure it was transcribed verbatim and added more detail where they were left out.
2. I familiarised myself with the interview data by listening to all the audio recordings; this greatly helped since the principal investigators of Project ASPIRE outsourced the transcription process to external transcribers.
3. After familiarization, I read the transcripts line by line and generated a code that described what I had interpreted in the paragraph. I broadly used a deductive approach for coding most of the participants' responses since participants gave specific answers to specific areas of interest to the research inquiry. Then, I applied 'open coding' for the rest of the responses to ensure I had coded all other aspects of the data set. I based these codes on the meaning I attributed to participants' responses or relevant literature that supported my interpretations.
4. When I finished coding the first two or three transcripts, I grouped codes into categories with clearly defined labels to develop a working coding framework.

Several iterations emerged as new codes arose from the rest of the transcripts. After coding the last transcript, I finalized the coding framework and subsequently met with my supervisors to discuss the naming of the categories and the organization of the coding framework.

5. When applying the coding framework to interpret the data, I used thematic narrative analysis guided by Riessman's (2008) procedure.

Thematic narrative analysis is appropriate for focussing on the content of the individual accounts and understanding the construction of participants' narratives from their perspective (Riessman, 2008). Participants' experiences of completing the counselling programme, delivering the intervention, attending supervision sessions, undergoing training, and being a counsellor supervisor on Project ASPIRE, were rich in descriptions. Thus, using the thematic narrative analysis enabled me to think reflexively about participants' personal experiences and my interpretation of them.

For the second phase of my analysis process, I used the following steps for the thematic narrative analysis:

1. After developing the coding framework, I identified and refined the key themes and sub-themes that reflected the facilitating factors relating to the intervention, supervision, supervisor, counsellors and adolescents and the barriers related to the intervention, context, supervisor, and counsellors.
2. The themes were analyzed further from a narrative approach by paying attention to participants' social language, manifest meanings, subject positioning, the nuances in their stories, the extended accounts of growth and the challenges experienced in their involvement in Project ASPIRE and the complexities implicated in their experiences (Riessman, 2001, 2008; van Niekerk & Boonzaier, 2019).

The framework method complemented the thematic narrative analysis of the interview transcripts. For this reason, it enabled me to systematically generate themes by comparing and contrasting the data set while also placing each perspective in context by keeping other aspects of each account connected in a single framework (Gale et al., 2013). In turn, the thematic narrative analysis complemented the framework method by allowing me to construct a critical reflexive dialogue throughout the results section about the existing categories and codes of the developed coding framework of the interview data (Riessman, 2001; van Niekerk & Boonzaier, 2019).

Theoretical Framework

I used an interpretivist paradigm in this study to guide the analysis of its data because it helps researchers understand and generate insight into the internal reality of participants' subjective experiences and truths about a research inquiry (Broom & Willis, 2007; Terre Blanche et al., 2006). Using this paradigm meant that what I could know about the research inquiry was based on the participant's subjective experiences, and there are multiple ways of understanding the complexities implicated in their experiences in Project ASPIRE. Each personal experience contributed to knowledge about the facilitating factors and barriers of task shifting in Project ASPIRE. Through my established researcher-participant relationships in the research encounter, I got to hear and 'see' the participants' appraisal of the counselling programme from their perspective. Shared patterns of manifest meanings that participants assigned to the research inquiry helped to contextualize the inferences drawn from their responses to the interview questions (Terre Blanche et al., 2006).

In the healthcare research context, mental health researchers have frequently used the interpretivist paradigm to gain insights from various stakeholders. Mendenhall et al. (2014) used the interpretivist paradigm in their PRogramme for Improving Mental healthcare (PRIME) study to draw new insights into stakeholders' perceptions of task-sharing mental health services and the complex factors they perceive to make this approach acceptable and feasible across multiple sites in five countries: Ethiopia, India, Nepal, South Africa, and Uganda.

Chibanda et al. (2011) conducted a randomized controlled trial in Zimbabwe. They used the interpretivist paradigm to gain insight into lay counsellors' and clients' views about the effectiveness of a brief mental health intervention delivered by well-trained and supervised lay counsellors and generate ideas on the feasibility of scaling it up. Mental health researchers, service planners and policymakers can use these insights from different stakeholders to improve planning and implementation considerations that can help increase universal and equitable access to mental health services to meet the mental health needs of citizens (Ellen et al., 2018; Schaaf & Topp, 2019).

Ethical Considerations

The ethics of this research nurtured a relational space for the participants and myself to have an open dialogue within the confounds of the participant’s comfort in answering questions posed to them (Banister et al., 1994). Throughout this study, I maintained the institutionalized standard ethical protocols that my lecturers in research methods courses had taught me at the university level. It regulated and disciplined me in thinking and doing

research in particular ways. I followed these standard ethical protocols: *Do no harm, informed consent, beneficence, confidentiality, and privacy*. I sought ethical approval from the Research Ethics Committee of the Department of Psychology at UCT to interview the counsellors and the counsellor supervisor for this study. The existing ethical approval of Project ASPIRE from UCT's Human Research Ethics Committee (576/2018) (*see Appendix A*) covered the adolescent interviews. Ethical clearance was obtained from the UCT's Humanities Faculty Research Ethics Committee (*see Appendix B*) to cover the counsellors' and counsellor supervisor's interviews. The study followed the ethical guidelines and principles of the International Declaration of Helsinki and the South African Guidelines for Good Clinical Practice for research involving human participants (RSA DoH, 2020; World Medical Association, 2013).

Do no harm

Previous unethical research, such as the Stanford Prison Experiment (Zimbardo et al., 1971) and Milgram's obedience experiment (Terre Blanche et al., 2006), inflicted pain and suffering on participants to answer research questions in the discipline of Psychology. The ethical protocol of my study centred on using good ethical practice to challenge this exploitative history and contemporary harms through the research endeavour. The counsellors and the counsellor supervisor received a list of psychological services in their informed consent form that they could contact on their own if they required psychological assistance to cope with emotional triggers from some aspects of the interviews. The procedure I would have had to follow if adolescents experienced distress from any question during the research encounter would have been to refer them to the principal investigators. Then, they would have ensured they could access services to help them cope with their emotional triggers from some aspects of the interview. However, none of the adolescents needed a referral.

Informed consent

Before interviews took place, I conducted a verbal consent process by reading out the information on the consent form to garner willingness to participate in the research (*see Appendix C, D and E*). Additionally, participants received a copy of the informed consent form about the objectives, procedures, and potential risks of participating in the study (Miller et al., 2012). Participants were made aware that they could withdraw at any stage from the study without any consequences. Therefore, the provision of sufficient information, participants' full competence and understanding, freedom to decline or withdraw from the study at any point and voluntary participation were adhered to (Wassenaar, 2006).

I ensured that participants received a complete description of the study and understood that their participation in this study was voluntary by giving them consent forms (*see Appendix D and E*). Also, I conducted telephonic and online semi-structured interviews (*see Appendix F, G and H*) due to COVID-19 concerns.

Beneficence

There were no direct benefits to participants in this study. However, the intended benefit was to produce research outcomes that could potentially have participants' narratives influence future improvements in the quality, conditions, structure, and design of the ASPIRE counselling programme. Hopefully, this will assist in expanding the reach and impact of mental health services for adolescents.

Confidentiality and privacy

During interviews, I upheld the non-disclosure of participants' names to protect their identities with respect. In the same consent form about their understanding of the study aims, possible risks, benefits, and alternatives, I requested an indication of consent to record each interview. I used a voice application on a laptop device to record the telephonic interviews and recorded the online interviews on Microsoft Teams to capture the audio. Only I had access to the recordings during data collection and analysis. The transcription of all the study interviews was funded by the principal investigators of Project ASPIRE and conducted by external transcribers, which they used for their research. The digitally recorded interviews and transcriptions were encrypted with passwords and stored on a password-protected computer. Also, I saved the names of the counsellors and the counsellor supervisor on the portion of the transcripts that have their informed consent captured where they agree to be interviewed and recorded. Furthermore, I saved the part of the transcripts with the actual interview information separately without the names of the participants. In my analysis section, I used each participant's role in Project ASPIRE instead of their names to further uphold confidentiality.

Rigour

In qualitative research, researchers use four criteria to evaluate and ensure the trustworthiness of a study. Those criteria are credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1986). Studies in health research with a qualitative approach have used these criteria (Forero et al., 2018; Morse, 2015; Nkhalamba et al., 2021; Okyere et al., 2017; Schou et al., 2012).

The credibility criterion evaluates the compatibility between the experiences shared by the participants and the meanings researchers attribute to them (Lincoln & Guba, 1986). I

first achieved credibility in this study through prolonged engagement with the data (Okyere et al., 2017). I spent about two months listening to the audio recordings of the interviews and thoroughly reviewing the transcripts to ensure that the transcriptions accurately captured participants' responses verbatim. Then, I established most of the codes according to specific areas of interest of the study. I did the rest of the coding according to the meaning I attributed to the participants' responses and the relevant literature I found on the issues the participants described. My supervisors and I had two meetings, at the beginning and toward the end of analyzing my data, to discuss the initial codes and the coding framework that I was going to apply to analyze the data, respectively. As a result, I revised and updated the existing categories and codes developed in the coding framework as advised by my supervisors before writing up the study results. The codes established for each category of participants helped to ensure consistent coding throughout the analysis. My supervisors and I agreed upon the identified themes and sub-themes after I gave them the first and second drafts of this study's results section. I spent between three and four months putting together participants' experiences in a synthesized and coherent manner with the guidance of my supervisors, which helped to support further the credibility of the interpretation of the study findings.

Second, the interviewing process and technique helped enhance the credibility of the data collected and the results (Forero et al., 2018). The counsellor supervisor of Project ASPIRE organized a pilot interview for me with one of the counsellors to help increase my knowledge of and familiarity with the adolescent interview protocol. The use of a semi-structured interview approach allowed for focused but flexible conversation in each interview. All interview protocols included several probing follow-up questions that allowed participants to give more in-depth answers.

Third, assessing the trustworthiness of my authority as the investigator was another way to increase the credibility of this study through the following characteristics postulated by Miles and Huberman (1994):

1. *Experience of the phenomenon within its research context:* I had one year of experience conducting mental health research with adult patient users and different categories of health workers using a task-shifting model in community-based clinics.
2. *Investigative skills:* When I began collecting data for this study, I had two years of experience conducting qualitative interviews, mainly structured and semi-structured interview procedures.

3. *Theoretical knowledge and skills:* I had undergraduate and post-graduate experience in qualitative research methods and skills to code and interpret qualitative data systematically.

Four, I used a triangulation strategy of considering the multiple views and experiences of the counsellors, adolescents and the counsellor supervisor involved in Project ASPIRE to enhance further the credibility of the study findings (Nkhalamba et al., 2021).

The dependability criterion evaluates the consistency of the study results. Researchers must give detailed information about the methods used in data collection and analysis so that if other researchers try to replicate their study with the same or similar participants in the same research context, the findings will be the same or similar (Lincoln & Guba, 1986). In line with this, I have systematically given clear and detailed descriptions of the research methods used in this study to facilitate the replication of a similar study by other researchers, even though this would prove to be difficult considering differences in contexts, temporality and people.

The transferability criterion evaluates the degree to which readers can apply the study results to other contexts (Lincoln & Guba, 1986). Nevertheless, this is not to generalize the study findings. Instead, researchers are required to give detailed descriptions of the object of study within a specific context. In line with this, I have provided detailed descriptions of the research context and settings and the purposive sampling method in this Method chapter to allow the reader to decide on the possibility of applying the study results to other contexts. Thus, purposefully selecting participants and community-based settings that differed from each other ensured the transferability of the study (Petty et al., 2012).The confirmability criterion assesses the extent to which study results are the product of the inquiry and not of the interests or biases of the researcher (Lincoln & Guba, 1986). I achieved this through practising reflexivity to acknowledge, understand, and reflect on my positionality, social identity, preconceived ideas, expectations, and investment because these matter and can affect the research process (Davison, 2007).

Research is political, and the personal is political. A researcher's positionality is their stance concerning their research study and can have implications on aspects of the study. For instance, it may influence their research questions during the data collection phase or how they interpret the data (Qin, 2016). With this understanding, my research topic is a continuation of my honour's thesis. It looked at the possibility of expanding the role of lay

counsellors in three community-based clinics to meet the mental health needs of adult patient users in the Cape Winelands Health District, Western Cape, South Africa.

Being unfamiliar with the state of adolescent mental healthcare in South Africa and having no experience working in a counselling environment allowed me to develop an outsider's stance on the research topic. I also recognize that this position may have limited my perceptions and subjectivity during my data collection. However, reading up on literature helped fill in the gaps in my perceptions and subjectivity when I interpreted my data. My invested interest in my data became about raising awareness of the plight of adolescent mental healthcare to promote social justice and equality.

The questions that I asked my participants influenced the findings to reflect on the conditions that facilitated Project ASPIRE to succeed in reducing adolescents' mental health symptoms and the challenging circumstances that impacted the experiences of adolescents, counsellors, and the counsellor supervisor in the counselling programme.

I expected to find that the delivery of the MI-PST counselling sessions helped reduce adolescents' mental health symptoms because the literature suggested it would be effective in treating depression and substance use disorders. As a result, I expected the adolescents and counsellors would mostly give positive representations of their experiences on Project ASPIRE. Generally, the principal investigators made several considerations to control the influence of transportation issues and safety concerns about the counselling sites. Also, they made further considerations to control the influence of the cost of the counselling sessions and handbook. It would have negatively affected adolescents' commitment and the counsellors' delivery of the intervention if they did not. There were many facilitators and fewer barriers to task-shifting the counselling programme for adolescents. However, these barriers posed critical and unique challenges in the context of these adolescents living in post-Apartheid South Africa, during the COVID-19 pandemic and in a low-resource setting.

My social identity, particularly my age, class, and level of education, was different from most of my participants. However, my race and culture were similar to many of my participants. I believe my social identity had little influence on the established relationships between participants and myself in the research encounter because I did not disclose my race, class, and gender to all my participants in the data collection phase. I also did not expect them to share their social identities with me because my study did not aim to investigate the intersections between race, class, and gender relations and how these relations may have influenced their experiences on Project ASPIRE.

However, after months of coding my data and beginning to write up my analysis, I came across intersections of race, class, and gender in my findings, so I asked the counsellor supervisor and counsellors to disclose their race, class, and gender. I wanted to interrogate the impact of these intersections on the therapeutic relationships between counsellors and adolescents. I have no certainty that my participants did not make assumptions about my social identity based on my name, the sound of my voice and the language they were comfortable speaking to me over the phone. I do not have evidence of shifts in my dynamic with them in the interviews that would support whether their assumptions about my identity may have influenced the responses they gave me that would have affected the findings I produced.

Also, I had no familiarity or personal relationships with my participants before the data collection phase to ensure no bias or conflict of interest was in the study. My shared Blackness, isiXhosa language and culture with most of the participants, particularly the half of the adolescents and two of the counsellors, may have made them feel at ease to give detailed accounts of experiences in their mother tongue. That led to critical interpretations of the data, especially my views on matching adolescents with counsellors based on race, culture, and language.

When I received the details of the adolescents on Excel spreadsheets, I thought that the adolescents were attending school or might have matriculated from high school based on the ages I saw on the spreadsheet. Also, since the communities they recruited the adolescents from were underprivileged and marginalized such as Paarl, Delft and Gugulethu, I believed the adolescents would be of Black African or Coloured descent based on Apartheid's segregation legislation legacy. I thought the counsellors would have been lay counsellors with no formal background in mental health counselling. Nevertheless, I believe the term lay counsellor in Project ASPIRE was used to acknowledge that they are not formally qualified psychologists or therapists to deliver specialized care even though they have a formal background in mental healthcare. These initial perceptions made me evaluate how I wanted to relate with them and build good rapport in the relationships I established with them in the research encounter.

The adolescents are likely to have perceived me as a fieldworker or research assistant of Project ASPIRE since I introduced me to them this way as I conducted their three-month post-intervention follow-ups. I also felt like it since their interview questions were not my own, and the interview questions guided the adolescent interviews according to the research

of Project ASPIRE. Their perception of my occupation and how I felt about it had the following methodological effect on the interview process:

1. If the adolescents experienced any distress from answering the questions, I would have had to tell the principal investigators. Then, they would ensure the distressed adolescents received the psychological assistance they needed to cope with those experiences.
2. I believe the adolescents might have felt comfortable with the follow-up interviews since they were expecting to be interviewed after three months beforehand. Also, their six-week follow-ups (i.e., assessments) might have prepared them for the questions I asked them during these interviews.
3. I am not a mental health counsellor. I did not say this to them. However, that could have made them feel unsettled with disclosing their personal experiences beyond answering the questions I asked and mostly discussing their positive mental healthcare experience and outcomes after participating in the counselling programme.

I did not disclose to the adolescents that I was a research master's student interested in using their responses as part of my study data since the ASPIRE informed consent forms portrayed that a fieldworker or research assistant would be interviewing them. So, I went along with this. Our dynamic might have shifted if the adolescents knew I was a master's student. The information they disclosed would have changed based on their perception of my level of education and their appraisal of the interview. For example, the counsellor supervisor knew about my level of education, and her interview responses would form part of my study data for my master's thesis. During my interview with the counsellor supervisor, there was a moment where she explicitly identified a facilitator that fitted her appraisal of the study aims. For example, while talking about her team dynamics, she stated that whenever they had an issue, they would speak up and address it as soon as possible. She added, "So, I would just say communication is definitely a facilitator here". Then, there were other times whereby she was subtle about identifying facilitators and barriers of her own experience as she was narrating it to me during the interview. It seemed as though she kept reminding herself of the study aims and possibly wanted to be helpful by identifying facilitators and barriers of her own experience. Even though I had no intention of deceiving my participants about my study aims, it is apparent that the dynamic of an interview can change based on perceptions of

study aims and the researcher, which can influence participants' responses in study interviews.

Therefore, it is vital to establish and maintain rigour throughout a study in qualitative research. As evidenced in this Method chapter, I have systematically given clear and detailed descriptions of the appropriate research methodology used for data collection and analysis to ensure the trustworthiness of this study.

Chapter 3: Results

The interviews with the participants of this study revealed many facilitating factors and barriers to successfully delivering the intervention and challenges to effectively meeting adolescents' mental health needs. Table 1 presents the descriptive characteristics of the participants in this study.

Table 1

Descriptive Characteristics of Participants

	Age	**Gender**	**Race**	**Class**	**Professional Mental Health Category**
Adolescent 087	17	Male	*	*	*
Adolescent 027	18	Female	*	*	*
Adolescent 075	15	Male	*	*	*
Adolescent 025	17	Female	*	*	*
Adolescent 001	18	Female	*	*	*
Adolescent 011	19	Female	*	*	*
Adolescent 012	15	Male	*	*	*
Adolescent 023	16	Female	*	*	*
Counsellor 1	32	Male	Coloured	Middle-class	Registered Counsellor
Counsellor 2	41	Female	Black	Working-class	Social Worker
Counsellor 3	38	Female	Black	Working-class	Registered Counsellor
Supervisor	30	Female	White	Middle-class	Registered Counsellor

*Note: * means the details for these descriptors were either unavailable or not applicable to the adolescents.*

Table 2 shows the themes and sub-themes from the data captured from participants' responses to the research questions. Those themes are described below in greater detail.

Table 2

Themes and Sub-themes of Results

Chapter 3: Results
Facilitators to Task-shifting a Counselling Programme for Adolescents
Intervention-related factors
Values of Problem-solving and Motivational Interviewing Techniques.
Flexibility and adaptability of the structure of the counselling sessions.
Content relevance.
Supervision and supervisor-related factors
Formal and informal supervision sessions.
Monitoring and evaluation assessments.
Counsellor-related factors
Duties.
Diversity, equity, and inclusion.
Adolescent-related factors
Intrinsic motivation and personal commitment.
Buy-in' of family, friends, and significant others.
Accessible counselling services and sites.
Barriers to Task-shifting a Counselling Programme for Adolescents
Intervention-related factors
Weak and non-responsive referral pathway.
Too much reading affected adolescents' interest in the patient handbook.
Contextual factors
Multiple deprivations severely disadvantaged Black adolescents.
Impact of the COVID-19 pandemic.
Supervisor-related factors
Imposter syndrome.
Persistent anxiety about professional standards.
Fear of failure.

	Masking.
	Lack of cultural sensitivity training for the Xhosa population.
	High case volumes and working part-time.
Counsellor-related factors	
	Patient tracking was disruptive to counsellors' work schedules and posed a safety threat.
	Appointment availability issues.
	The stress of avoiding 'time outs.'

5.1 Facilitators to Task-shifting a Counselling Programme for Adolescents

5.1.1 Intervention-related Factors

5.1.1.1 Values of Problem-Solving and Motivational Interviewing Techniques. All the counsellors perceived the problem-solving and motivational interviewing counselling techniques to be effective and complemented each other because of their empowering nature. As a counsellor said:

Counsellor 3: "Motivational interviewing works and problem-solving technique worked very well. I think it was extremely effective. Because it's not like the traditional method whereby you tell and tell, at least they were given the platform to raise their own concerns and to talk openly about the issues that they are going through."

There emerged values of the counselling techniques between the counsellors' interactions and the adolescents, which participants perceived as making the counselling techniques effective. These were the following:

- Be intentional about connecting and delivering the intervention.
- Create a positive affective presence with adolescents.
- Develop autonomy.
- Support and encourage adolescents' self-efficacy.

Intentionality was a significant aspect of delivering the intervention. The first step was to be intentional about building rapport with the adolescents through active listening, understanding the conditions and context of adolescents' lives and, as a result, counselling with a raised consciousness. The counsellors pointed out different factors that made them easily connect with the adolescents.

The steps in the training that dealt with *building rapport with the adolescents* were viewed as crucial steps to having a successful therapeutic relationship - as it facilitated adolescents' engagement and developed trust with the counsellors during the counselling sessions. As this counsellor said:

Interviewer: "How easy was it to connect with the participants?"

Counsellor 2: "Oh, it was easy. I think because … especially when you first do counselling, you build a rapport with the client. So, what made it easy to connect with the participant is to first build the rapport right, you introduce yourself with the participant and then you inform the purpose of the session and then ... it was easy, I would say it was not that difficult because you build the relationship with the client."

The counsellors utilized *active listening* to help the adolescents to open up to them, and it helped to understand the adolescents better. It reassured them that the counsellors were listening to them. As the counsellor said:

Counsellor 3: "Because these kids need that skill of problem solving and also motivational interviewing, even those who are struggling to open up it gives them that reassurance that there is someone listening who hears them and understands them because when you don't understand, you reflect and ask them whether you understood them correctly and then when they struggle to talk you try to make examples linking from whatever they were talking about …".

Understanding the conditions and context of adolescents' lives made it easier for counsellors to deliver the intervention. Because the counsellors came from a working-class background while growing up, they could identify with the circumstances these adolescents are exposed to in relation to their race, class, gender, and culture, thus making it easier for the adolescents to relate to them. In other words, sharing a similar positionality with the

adolescents made it easier for counsellors to understand and show compassion towards their situations in their families, schools and communities, personal struggles, and experiences. As the conversation with this counsellor reveals:

Interviewer: "What made you see the need to deliver the intervention?

Counsellor 3: "I grew up in these communities and some of the challenges I see them happening so it's quite easy to talk from experience and also being a teenager who grew up in the rural areas, in the location, where there are no resources where you just have to start from scratch with regards to finding ways of solving your own problems. I think it was much easier for me because I have experience in actually trying to solve my own problems as a teenager. So, I find it easy talking to these teenagers about simple steps they can take with regards to them solving the intervention. No, [I meant] with regards to them applying the intervention in their own lives and actually being part of the community, it's actually easy to come up with examples that they are familiar with."

Interviewer: That's true. I hear you. Okay. How easy was it to connect with participants?"

Counsellor 3: "For me, I didn't have any difficulty connecting with the adolescents because I grew up in communities whereby as an adult you become a role model to the next generation, you become the go to person for the children who come after you. So, for me it was not difficult because those are the people, I find it easy to connect with and to actually lower my standards with regards to how I communicate the message because I feel as though in our time, these things were not available …. so, for me to provide it to our kids was quite easy because I know what I wanted when I was the same age as them. I understand these are difficult matters, and it is not easy to talk to parents about the things we talk about with these kids in counselling. Other parents don't have knowledge of these matters, and as someone with knowledge of such things, I didn't struggle connecting with them."

We live in a country with a high prevalence of gender-based violence against women (Enaifoghe et al., 2021). I respected how the only male counsellor in Project ASPIRE was counselling with a *raised consciousness* by being aware that some female adolescents might

feel uncomfortable with him, especially in the first session, and mentioned how he seeks to make them feel comfortable. When I asked if there was anything that made it challenging for adolescents to build rapport with him, he said:

Counsellor 1: "Um, not that I can think of. Uh, perhaps, one thing that could maybe be is that maybe during the first session, especially maybe with female clients, they don't know what to expect. For some of them, it's their first time you know, doing counselling, and now they are here with a stranger who is a male. Um, so, sometimes it can take a bit … it can take a bit of a while for them to come … to, to get out of their shell. So, I think that's probably like the most common thing with them, but I try to make it as you know, um, as informal and as, you know, comfortable for them as possible."

A positive affective presence made it easy for the adolescents to speak freely with the counsellors. Affective presence refers to the consistent and stable feelings people tend to elicit in their social interactions, whether positive or negative (Eisenkraft & Elfenbein, 2010). Moreover, positive affective presence is the positive feelings that those around you may experience in your presence (Berrios et al., 2015). All the adolescents stated that they felt comfortable during the counselling sessions. Half of them said that there was nothing else they needed the programme to do to make them feel more comfortable with the counsellors. Also, nearly all of them never felt frustrated with the counsellors and felt understood. Generally, the adolescents perceived the counsellors as likeable and non-judgemental. As the adolescents said:

Adolescent 023: "Uhm, I had a few different counsellors. They were … like how can I say, they explained to me …".

Interviewer: "Mm-mhm."

Adolescent 023: "They made me feel welcomed [and] comfortable. So, I basically felt, I didn't feel uncomfortable. They made me feel welcomed and like I could speak to them about anything that's bothering me or whatever. So, it was nice; they were nice."

Interviewer: "Okay. I understand. Is there anything that frustrated you about the counsellor?"

Adolescent 087: "No, nothing at all."

Interviewer: "Mm-hm. I'm just wondering, did you feel the counsellor understood you?"
Adolescent 087: "Yes, yes, yes. He totally understood me."

Interviewer: "Which parts of the counselling did you enjoy?"
Adolescent 027: "Um, the questions."
Interviewer: "Uhm-hmm."
Adolescent 027: "And the way it was asked and the people and the way they were like nice to me, and they didn't judge me. I liked them."

Many adolescents felt like their counsellor cared and showed compassion towards their situation. The adolescents revealed three ways the counsellors showed they cared about their situation: Firstly, they exhibited an interest in understanding them and showed compassion towards their mental health problems through providing adequate counselling. Secondly, preventing self-doubt about overcoming mental illness was a powerful way to show compassion. Thirdly, explaining information clearly and getting their message across in an understandable manner to the adolescents. As these adolescents said:

Interviewer: "What would you like to tell me about your experience of the counselling?"
Adolescent 075: "That uh … they try to understand others, and they do their best in order to help people … you know … they counsel."

Interviewer: "Okay. Do you think the counsellor cared about your situation?"
Adolescent 087: "Yes, yes, yes. He did."
Interviewer: "And why?"
Adolescent 087: "Because most of the stuff we spoke about, he also came through … he also told me that he also came out of that like the past week or so, so he also went through the same situation that I was [in]."

Interviewer: "How do you feel about the counsellor who provided the programme to you?"
Adolescent 025: "The counsellor was actually good. The counsellor made me understand what he was talking about and explained to me, and yeah, he actually helped me a lot."
Interviewer: "Mm-mhm. Okay. And they actually clearly explained the information?
Adolescent 025: "Yeah."

Helping to develop their autonomy encouraged the adolescents to devise solutions to their problems, thus, facilitating their independent-thinking, problem-solving and decision-making skills with guidance and support from the counsellors. As these counsellors said:

Interviewer: "Um, [do] you remember [that] I asked you about the problems you were experiencing in your life? Um, so, how did you use the skills and information you learned during counselling to address the problems that you had before?"

Adolescent 025: "If I have a problem, and then how do I go …, how can I say now. Now it's like I will calm myself down first before I make decisions. Because sometimes, when you make quick decisions and then it is actually not the right decision. You must actually work through all the, how can I say, options that you can get and then go with the best one. So, you can solve your problem."

Counsellor 1: "And, um, yeah, I would say, and when it comes to the problem solving, um, it did, you know, it provides them with structured steps in how to … for them to go about dealing with their everyday problems. And for many of them that I've worked with now, I've seen that you know, how, you know, how these steps with them applying it, how it has helped them to solve some of their common issues like, you know, issues related to school, or issues related at home. So, yeah, definitely, I've, I've experienced in the sessions how effective it was with them."

The different aspects of the counselling techniques and the counsellors affirming their good qualities and capabilities to achieve the desired change in their lives through engagement supported and encouraged the development of *adolescents' self-efficacy.* As the counsellors said:

Counsellor 1: "From my experience that, um, I've seen, you know, it helps you first and foremost, like the motivational interviewing component. It helps in terms of, like, you know, the communication. Because obviously, the communi- … the motivational aspect is more aimed at the communication style with them. So, it helps in, you know, in facilitating interaction, in facilitating, you know, dialogue with them, especially when you maybe find some of

them who find it a bit difficult or challenging to engage and to be interactive. So, using open ended questions, you know, helps throwing them out. And, um, it also helps them with, um, you know, just engaging. Um, you know, affirming some of their good qualities."

Counsellor 2: "The motivational interviewing and the problem solving [counselling techniques] it was very effective because the reason why for example, problem solving, neh, you give the participant the platform to come up with their own solutions, you see, because they know their problems. So, it made it easy for them because ... it was effective I would say because you give them that platform to come up with their own solutions on their [own] problems. They had their own problems, neh. So, like and you say, "even if you feel like it is not a problem or even if you feel like it is a small problem come with it and talk about it and come up with a solution". And that caught their attention because it helped them to come up with their own solutions like to schedule their problems and then they come up with a solution using those five steps they were using. It was effective in that way because those steps they were using were helping them to solve their problems."

The patient handbook supported adolescents' self-efficacy as it was a helpful counselling guide during the sessions. At home, it served as an explicit memory retrieval cue for encoded information during the sessions (Wheeler & Gabbert, 2017) and helped reinforce behavioural change per the objectives of the intervention. As the adolescents said:

Interviewer: "Okay, what did you think about the handbook itself?"

Adolescent 025: "I do think that the handbook was good. Because why the counsellor mos[2] counsels me from the handbook and then gave the handbook to me. So, when you're at home and if you're feeling down, you can just go check-in your handbook and just read. I actually read my handbook and then I actually felt much better, because why, I would think about the answers that

[2] "Mos" is an Afrikaans word, which loosely translates as adding certainty to the statement.

I gave, and I would remember what the counsellor said to me. That would actually make me feel much better."

Below is a summary of some of the main points an adolescent made in his interview with me:

Interviewer: "And then you said the counsellor advised you to use the handbook timetable …"

Adolescent 087: [intervenes] "Yes, at the back of the booklet. Yes."

Interviewer: "Yes, in the booklet, to be able to write down everything you do every day which pertains to your habits."

Adolescent 087: "Mm."

Interviewer: "Am I right?"

Adolescent 087: "Yes, yes, yes. You are right."

Interviewer: "Oh okay. Then from there I think you were able to see how much your drinking was at the time. Am I right?"

Adolescent 087: "Yes, yes, you right."

Interviewer: "And then it helped you to see that you had an issue, and it made you realize that you have to quit the smoking and the drinking."

Adolescent 087: "Yes."

5.1.1.2 Flexibility and adaptability were crucial to the structure of the counselling sessions. Structured interventions help counsellors deliver the targeted intervention and remain focussed on the purpose of each counselling session (Diamond et al., 2002). However, it was crucial to allow counsellors to make the structure of the counselling sessions more flexible to enhance their clinical judgement to move sessions or some content from particular sessions around to meet adolescents' mental health needs. As a counsellor said:

Counsellor 3: "How I did the sessions, for example, I had a client that came for session two, and he was due for session three, which is dealing with purple group problems, but the client revealed in the session that he needs … [pauses to rephrase] ... the client is going through blue group problems which is bereavement, grief and what, what. He recently lost someone while a tragic event or someone was stabbed to death etc. So, what I did was I changed

> those sessions. I took session … and then I did session three when the client needed it. And then, I touched on … I did session four and then touched on session three. And then, I discussed it in supervision that I used clinical judgement because the client needed the last session before the third session. But it wasn't an issue. The PIs were actually happy about that. So, I'm saying flexibility will work better on those sessions."

5.1.1.3 Content relevance. The training content the counsellors underwent was relevant as it helped equip them with the necessary knowledge and skills needed for their role. Also, they learnt new practices and gained new knowledge about counselling for common mental disorders. Some counsellors had prior experience delivering problem-solving and motivational interviewing counselling techniques, respectively. Nonetheless, all counsellors, whether experienced or not, said that the content was understandable, which made it easier to assimilate the information and adapt to the structure of the intervention. As these counsellors said:

Interviewer: "Were there new practices about assisting participants with common mental disorders that you learned?"

Counsellor 2: "Yes, we had practical things that I learned, such as if you are experiencing a problem, you must have a log of positive thoughts, you must have a worry time. You see? These are the techniques that I noticed they assist participants with mental disorders."

Interviewer: "What new knowledge did you gain about counselling common mental disorders?"

Counsellor 2: "Oh, yes, there is [the] knowledge that I learned over there in the ... pertaining to when a child is depressed that is there are things, we take for granted those such things like you know what when you are experiencing ... when depressed you must play music, you must maybe take a walk. You must do things like that."

Interviewer: "Yes, taking a walk can help so that you get … [inaudible] … from the sun ..."

Counsellor 2: "Yes, those are the things that these children can do, and I didn't have knowledge about how effective they can be. So, I have learned such things about managing common mental disorders."

Interviewer: "What did you learn that was new to you in the training program?"

Counsellor 3: "Um, what can I say now, because MI I already knew about it. Maybe the steps into problem solving but because in my previous job, I mean I received training for the second time here. Because in my previous job I was trained by the same people. I mean we did the same training."

Interviewer: "What did you think about the content of the training programme before you began counselling the adolescents?"

Counsellor 1: "Um, yeah, no, the training programme was good. Uh, I have no issues with that. Um, yeah, I had previous experience of problem solving or doing problem solving therapy. So, um, it was, yeah, it was straight-forward. It was just obviously now adapting to how this intervention is structured. So, but yeah, it wasn't challenging at all and obviously, you know, after the training we had the opportunity to do like practise runs and by finding our own clients and practising it on them."

Counsellor 2: "The content of the program equipped us, and it was detailed … I would say the format ... oh, the content of their training program is very understandable, easily adaptable."

Moving from the content of the training from the counsellors' perspective to the content of the counselling from the adolescents' perspective, they considered it educational. Half of the adolescents agreed that the most valuable knowledge they gained was learning about the effects of alcohol and substance abuse on the human body. That made them realize the consequences of their drinking habits and substance use which motivated them to change their behaviour. When I asked the adolescents what they had learned that was new to them, they said:

Adolescent 012: "The effects of alcohol in your body."

Adolescent 023: "Uhm, like, I don't like, drink alcohol anymore like I used to always, and I don't smoke. Like I got a lot of information from them, that like actually strike hard like to learn more about these things that I was doing."

All the adolescents mentioned they would recommend the counselling programme to

their friends and people in their age group. They believe the content covered in counselling sessions will help them with the different problems adolescents face today. As the adolescent said:

Interviewer: "Would you recommend the programme to your friends?"

Adolescent 001: "Oh yes, most definitely."

Interviewer: "How useful do you believe this programme is or might be helpful to your friends?"

Adolescent 001: "Just because it was helpful to me … the thing is we are teenagers …You, see?"

Interviewer: [Intervenes] "Yes."

Adolescent 001: "It will be helpful just because, as teenagers, we face different problems

5.1.2 Supervision and supervisor-related factors

5.1.2.1 Formal and informal supervision sessions. The formal weekly peer group supervision sessions allowed for collaborative problem-solving of issues and shared learning as the counsellors could learn from each other's strengths and weaknesses. The supervisor used a reflective supervision style to facilitate the sessions that enhanced their competencies and professional capacity. Through reflecting on their sessions and getting honest feedback from the group, counsellors gained insight to improve their delivery of the counselling sessions. As the supervisor said:

Supervisor: "And then we would go on to case discussions. So, um, the counsellors then have a turn to talk about the case ... almost from, from priority, from the, um, highest priority to the lowest priority, so they generally start off with clients that they either had difficulty with or maybe it was a good session, and they'd like to talk about it. So, they would give us ... um, when I say "us," as we said as a team, we talk about the client and what the session was, what were some of the challenges they experienced and then what they did, so some of the content that they went through. And then we would either give advice or we would ask questions, have you done this? Have you checked this? If they had any challenges, we would try and trouble shoot those."

These weekly peer group supervision sessions were preferred even though individual supervision was available because of the richness of the expertise, support and feedback from the supervisor and other counsellors.

Counsellor 1: "Um, I think sometimes I even prefer to have group supervision because why it's nice to get feedback from … um, from all my colleagues, supervisor and, um, other counselling colleagues, you know, to get their inputs as well. Um, I think it's very useful because now you get even more input, even more expertise about certain things."

Counsellor 2: "Both, I would prefer both because with group supervision, you learn together and from one another or some of the skills that have been used by my group, and we were able to help each other there in case maybe you are facing a challenge that maybe your colleague also faced. Then, you will help each other to come up with solutions on that challenge you had in group supervision."

Additionally, informal supervision sessions complemented these formal peer group supervision sessions. Informal supervision sessions afforded counsellors the liberty to contact the supervisor via WhatsApp messaging or call to ask questions or for further assistance outside the weekly supervision sessions. The weekly formal peer group supervision sessions and being able to message or call the supervisor at any time provided more than enough support and supervision sessions.

Counsellor 1: "Yeah, normally we have a supervision session once a week and then but also, yeah, but also in between, you know, whenever the need arises, and there's something urgent to discuss or to get feedback on, um, the supervisor is available. I think it's, yeah; I think we are doing it right; it's more than enough. The supervisor is available like in real-time, so if any, you know, issues arise, so we can, you know, just send a message on WhatsApp and then she will respond as soon as possible. So, I think having it once a week with the flexibility of having, you know, the availability in real time for trouble shooting, logistical issues, maybe even, maybe distressed situations. I think that it's more than adequate."

5.1.2.2 Monitoring and evaluation assessments. The supervisor utilized three assessment tools to monitor and evaluate counsellors' delivery and fidelity to the intervention: The counsellors' clinical notes, fidelity checks and the ENhancing Assessment of Common Therapeutic factors (ENACT) assessment tool (Kohrt et al., 2015) adapted for the South African context. ENACT is a standardized measure that assesses common factors of mental health treatments, including task-shifting interventions with non-specialist mental health workers across different cultural settings (Kohrt et al., 2015). The fidelity checks were performed by listening to each counsellor's session recordings. These monitoring and evaluation assessments held the counsellors accountable for maintaining high-quality intervention delivery. The supervisor continuously monitored and evaluated counsellors' fidelity to using the problem-solving and motivational counselling techniques, adherence to the informed consent process and confidentiality, their practice of cultural sensitivity and core therapeutic competencies and skills required to deliver the intervention adequately.

The supervisor thought the monitoring and evaluation assessments revealed many contributing factors to effective intervention delivery. One of them was the counsellors' devotion to meeting adolescents' needs through internalizing the programme's overall intent to such an extent that they could adapt the structure of the sessions to meet the adolescents' needs better. As the supervisor said:

Supervisor: "I kind of learnt what to listen out for, what to look out for. Um, how ... how ... cause if you look at the intervention, yes, you can tick off that they've explained what the process is, explained this but have they internalised it? Have they made it their own in the counselling session itself? And those recordings that I listened to; the fidelity checks that I set up – I have like an Excel sheet that I made – did the counsellor do this on a Likert scale from 1 to 10? So, it would say: Sometimes, not all the time. So that gave me … yeah, that really helped in terms of how they internalized the session or how they adapted the session for that specific client instead of just doing this cookie-cut mould sessions with everyone. So, I think that helped me, um, give, you know, very detailed feedback or could help me say where they could improve on their sessions."

Additionally, being committed, showing compassion, sincere genuineness, and care about the counselling services they provided were characteristics that appeared to facilitate

the high-quality delivery of the intervention and effectiveness of the problem-solving and motivational interviewing techniques, as the supervisor said:

Supervisor: "You can definitely see, uhm, you know, on certain days when someone wasn't as invested in the counselling programme as that they should have been maybe. But it also revealed that you know, these counsellors are really invested in the programme, having to do, you know, maybe one or two of the same sessions over and over again, every day and every week, just yeah, it shows resilience in itself. And so, they are very invested, when I listen to the counselling sessions, um, and the fidelity checks, it just shows, um, a lot of compassion. It shows that you know, these individuals really care about the services that they are providing, and they are sincerely genuine."

When the supervisor performed these monitoring and evaluation assessments before their weekly scheduled supervision sessions, it helped the supervisor give detailed and insightful feedback to the counsellors and suggestions for improvement.

Supervisor: "… [when] I'd listen to the session and done the scoring, I kind of know what the counsellor is saying to me in the supervision [session]. I can adapt and tailor my response that is very specific for that counsellor and that they know exactly what to do when they leave the session."

The principal investigators of Project ASPIRE performed fidelity checks on the supervision sessions, and the counsellors could also give their feedback concerning the supervision sessions. When both the counsellors and supervisor received feedback, they immediately incorporated it and made any changes required for the next session. Overall, the counsellors believed that the quality assurance activities accurately perceived their capabilities to deliver the intervention.

Counsellor 3: "I am very hard on myself individual at times. Because sometimes, when they say, "[Counsellor 3], you are good at this, " I act surprised, as though I just woke up from sleeping, because I'm always wanting to do my best all the time. So, I am the kind of person who is always looking for the negative comments, something to improve on. So, it was helpful; it kind of helped me to be at ease with myself."

Counsellor 1: ”Yeah, I think so. I think so, um, I don’t know how else to respond to that, but I definitely think that, yeah, so far, we have received good feedback.”

Even though the counsellors perceived the quality assurance activities as accurate, some counsellors took it upon themselves to monitor and evaluate their own skills development and fidelity to the intervention by reflecting on their engagement with their patients and the feedback they receive from their patients. They performed a comparative analysis between the supervisor's fidelity checks and their perceptions of their capabilities and delivery of the intervention, which only strengthened the accuracy of the perceptions and delivery of the intervention. Also, it reminded them that meeting the adolescent's needs was the priority and conducting the session to their best ability was crucial. A counsellor said:

Counsellor 1: “I also think that like I always … I constantly test myself as well. Um, I don’t only rely on the quality assurance activities, but I also rely on … I also do like my own … I also regularly assess myself, er, in terms of like, you know: How the sessions is going? Um, how engaging is the sessions? What is the feedback of the clients? Um, you know, all those things, you know, are normally like, um, it’s normally, it’s almost like a … how can I say? Just for myself, like, almost like ticking the box where you look at certain things: You look at communication. You look at dialogue. How interactive the session is. You look at maybe how engaged the client is. You know, so all those little subtle things. Um, it’s normally an indication that, um, you know, the counselling sessions are, you know, are going well. Um, so, yeah.”

Interviewer: “On that, I’m just wondering how objective were you on yourself?

Counsellor 1: “No, that's a very good question. Obviously, there is a lot of bias that comes with that because, you know, you obviously assess yourself, um, but that is why the quality assurance activities, the external feedback is there. So, you know, then I try and match how I feel about certain sessions against the feedback that I’m receiving. So, if there is a big gap in how I feel about the sessions and the feedback that I’m getting, then obviously there is a cause for concern because then it means I’m not, um, you know, there is either things that I'm … that how I’m seeing things that is not maybe correct or vice versa or maybe the feedback that I’m getting is maybe different to how

> I perceive the counselling should be delivered. Um, so, I think it's constantly having those two, um, looking at it together … um, you know, to … and obviously we speak about these things also in the supervision session to say that: "You know, I felt this way during this session, I feel like I didn't do that, um, like really well because of this, and this, and this". But then, you know, the supervisor will say, "Well, like, you know, I've listened to that, and I really think that, you know, the reason for you doing that is because of this, but I think that under the circumstances that was probably like the best way to deal with that situation." So, I think looking, yeah, looking at … I'm not looking at in isolation, but I'm just using it, all those … drawing upon all those things together, but, um, yeah, but I do think that it's really important for you to constantly, you know, assess yourself although there might be a bit of bias in there as well. Um, but I think that if you really think about that, the client is obviously the most important, um, individual, you know, in the session and everything that you assist that client with, so doing the session to the best of your ability is really important and always keeping that those objections in mind, um, can help you to be a little bit more objective. Um, then, overly bias. But I can't dismiss there will always be bias, I mean, when you are going to assess yourself."

5.1.3 Counsellor-related factors

Below are factors that emerged from the counsellors' experiences on Project ASPIRE, which supported their delivery of the counselling sessions and garnered good treatment outcomes from their patients.

5.1.3.1 Duties. As part of the counsellors' duties, they had to locate adolescents who missed their sessions in their communities. This retention strategy helped counsellors get reasons for their non-engagement (i.e., non-attendance of counselling sessions and no contact over the phone), ranging from needing to do house chores to being contact-avoidant. When the counsellors would perform their patient-tracking duties, it was to engage and encourage them to continue with the sessions at the Delft counselling site, making delivering the intervention easier. As mentioned below:

Counsellor 3: "Okay, like before lockdown, other participants would give the following reason[s]: Their parents are working, and they have to be at home and take care of their siblings and do household chores – things they are supposed to do in their homes. For others, it was school-related issues. There was this other participant we had to leave them behind while we were very close to their house because we could see they were already high from smoking or something. And then we thought that taking him to a session wasn't going to help. You see? He was already high."

Interviewer: "Okay."

Counsellor 3: "Other participants were just avoidant and did not say what it is they are avoiding; they would not give us reasons."

Interviewer: "You would go into the community to try to track them for …?"

Counsellor 1: "For their sessions. So, if they miss out on sessions and we can't get them, um, by phone, um, or locate them by phone, you know, then, um, our last resort is then to go into the community to go check on them, to visit their home maybe. Because sometimes, you know, it does happen where they may be moved from their location, maybe they moved from one, um, maybe from their parents to a relative, or maybe from a relative back to their parents. So, it's just for us then to, you know, to try and locate them and, um, to make contact with them again so we can continue the sessions."

5.1.3.2 Diversity, equity, and inclusion. Working with racially and culturally diverse counsellors fostered the flexibility to refer patients to a counsellor who speaks their mother tongue. It provided the patient with the best treatment outcome as they could express themselves freely and feel more authentic and understood. For the counsellors, it promoted acceptance and respect for their patient's cultural context, including language. As a counsellor said:

Counsellor 1: "I think maybe about a year ago or so, there was one client that was referred to me, but it was an issue of [a] language barrier, um, the person couldn't speak English or Afrikaans like my two primary languages as well, and that individual was more obviously fluent in Xhosa and, um, couldn't really communicate in English. You know, he could say like here and there a word or two, but it wasn't really ... you know, um, it wasn't going to be

beneficial to continue with that session. So, I had to ask my other colleague to step in, to rather take over the client and then to do the client in his own mother language instead. So, that was the only time I thought that I needed like assistance."

I followed up on this with counsellor 1 with a question about matching adolescents with counsellors based on race, culture, and language, and he did not think this was necessary. There were other sufficient conditions to provide the best possible mental health treatment instead of matching adolescents and counsellors based on race, culture, and language. He described these as having the flexibility to refer patients to a counsellor who speaks their mother tongue. Also, having the counsellors understand and acknowledge these adolescents' lives context could lead to the best mental health treatment.

Interviewer: "On that, I'm just wondering what you think about matching an adolescent with a lay counsellor based on race, culture, language, all of those things."

Counsellor 1: "To a certain extent, we do that. Right? But we also don't want to be ... because remember this is er, um, we are trying to assist everyone where possible, and we don't want to be almost like ... um, because if we do that, that will almost seem like we're doing race-based counselling. Because I understand the context you're coming from, um, but I mean, I've seen so many clients already whose primary language is Xhosa, but they can also speak English very well, um, and I've had no issues whatsoever with them. I think that we...as long as we have that flexibility, like in that situation, for instance, that right at the beginning I realised that: "Okay, this client is going to benefit more of having the session in his own language", then having the flexibility to then, to then speak to the client and say, "Okay, this is the situation, um, I honestly believe that you would benefit more, um, you know, to speak … to have the counselling session in your own language. What do you think about it?" And then we give our client then the opportunity to decide. Um, I think having that flexibility … I think is much better, um, instead of just saying that whenever we're recruiting in Gugulethu and Khayelitsha, this is your clients [Counsellor 3], then and when we're recruiting in Mitchell's Plain and Delft, this is your client [Counsellor 1]. [Do] you understand? Um, I think there is an argument to be

made for that, but I really think that how we've been going on so far, I think that, you know, that 99% of that time, it has worked really well."

When I followed up on this question on matching adolescents with counsellors based on race, culture, and language with counsellors 2 and 3 via WhatsApp messenger, they echoed different sentiments to counsellor 1. Their sentiments were for matching adolescents with counsellors based on race, culture, and language. They have noticed how difficult it is for some adolescents to develop a working alliance with a counsellor who does not share the same ethnicity and mother tongue. So, they seem to suggest that it might be beneficial to consider adolescents' preferences for being matched with a counsellor whose cultural background, race, and primary language match their own to improve their counselling experience. As these counsellors said:

Counsellor 3: "I think it would be beneficial. I believe sometimes; clients struggle to express themselves when confronted with anything different from their normal background. That includes language, race, and culture."

Counsellor 2: "Language was a barrier as some clients couldn't speak English. So, matching adolescents would be beneficial since some kids are dropouts or might not be able to articulate themselves in English. As a counsellor who is a Xhosa person, it is easier to counsel someone from the Xhosa culture and [who] speaks Xhosa."

5.1.4 Adolescent-related factors

5.1.4.1 Intrinsic motivation and personal commitment. What got these adolescents to go from staying at home or going straight home after school to attending counselling sessions? Essentially, adolescents reported that something personally rewarding and significant to the adolescents influenced them to go to the counselling sessions. These personal rewards included wanting to beat leisure boredom since some had finished their high school studies and were at home most of the time. However, one also wonders how much their participation was motivated by the R100 cash voucher over having nothing else to do. Others wanted to gain people, life, problem-solving, anger and stress management skills. Additionally, others wanted to learn to help themselves and, in turn, help others facing similar mental health struggles. They also wanted to learn how to communicate better,

express themselves freely, become confident and independent and heal from past trauma. As these adolescents said:

Interviewer: "Why did you agree to be a part of this programme?"

Adolescent 023: "Uhm, there is one lady, I don't know [her name], but she came to fetch my friend, and I was there at that moment. So, she asked if we would like to join, and we took the voucher and whatever. So, I was like yeah, it's fine. I have nothing else to do. So, I'll just go ahead with it."

Adolescent 011: "Because I am unemployed, and I had nothing to do. And I was always at home."

Adolescent 087: "Um, it's actually, um, because many people is in this situation, neh[3]? And it's like, I was like [a] part of this program now, and at the end of the day, I can be able to help other people that is in also the same situation that I was."

Adolescent 075: "Because of uhm… I wanted to know how to be around people and how to act around others as well and how to manage my anger."

Adolescent 027: "So, I just wanted to accept it because I thought it could help me with my problems and it would make me much more …, um, how can I say now, it would make me much more calmer dealing with my issues and stuff by problem-solving..."

Adolescent 012: "The program helps, and it teaches you .... when you grow up … like if you had challenges while you were still young, you can be able to talk about things you were not able to talk about. I think for me, it was that."

Besides these reasons, which motivated them, the adolescents were personally committed to attending the counselling sessions as some of them even made sacrifices to attend the sessions. As these adolescents said:

[3] "Neh" is an Afrikaans slang word, which loosely translates to adding an emphatic assertion to a statement.

Interviewer: "Okay. Uhm, did you ever experience anything which could have kept you away from your counselling appointments?"

Adolescent 023: "No. So far, I've been to all of them. But … If, like, it came [to] a situation like I don't go, then it must be because I'm at college, or I am busy doing something, so yeah.

Adolescent 011: "Sometimes it wasn't [convenient to attend] because I had [other] stuff to do. But then I sacrificed not doing those stuff to just go there."

From the counsellors' perspective, providing an R100 cash voucher was an issue of contention regarding the adolescents' motivation to participate in the intervention. As these counsellors said:

Interviewer: "Um, can I ask you about something else? Do you think the fact that there was a cash voucher that might have influenced them to attend the programme or not?"

Counsellor 2: "Heke[4], yeah …. The encouragement of the voucher for me it's something which I don't think was encouraging them because …. they were told even before they attend the sessions that "you're getting it once and you will only get it after six weeks". So, they knew that they won't be getting the voucher."

Interviewer: "[Intervenes] Like every time they attend [a session]?"

Counsellor 2: "Yes, on every session, and when they get to my sessions, I would also tell them that "I want you to attend sessions this week and next week. I want you here". I am not talking about the voucher. You, see?"

Interviewer: "Yes."

Counsellor 2: "So, I wouldn't say they were coming because they were expecting a voucher."

Counsellor 3: "Sometimes you can see the participant is not interested in what you are saying, and they are more interested in getting the voucher and then what I will do with it afterwards. Some participants would ask if are they going to get a voucher if they attend the session. You see, now it becomes tricky

[4] "Heke" is a Xhosa word, which loosely translates to adding an emphatic expression to a statement or being glad that a person asked a question on a topic they wanted to talk about in a conversation.

> because you don't know if they are attending the session because they want the intervention or they are attending the session because they want the voucher. You, see?"

One can only wonder whether the desire to achieve behavioural change and gain skills to enhance their self-development might have trumped the influence that the incentive of a cash voucher could have had on their motivation and commitment to attend the counselling sessions. It appears that the cohort of adolescents I interviewed for my study was motivated to join Project ASPIRE to achieve behavioural change and gain skills. However, maybe for some adolescents in the counselling programme, as a whole, the cash voucher might have been an incentive.

5.1.4.1.1 'Buy-in' of family, friends, and significant others. Acceptance of adolescents' family, friends and significant others and their willingness to actively support their participation in Project ASPIRE encouraged many to continue attending the sessions. The positive perception of the counselling programme, adherence to ethical principles and the evidence of positive change in the adolescents reportedly motivated family and friends to support adolescents' commitment to participating in the counselling programme. As the adolescents said:

Adolescent 087: "Okay, my mom and them did not have a problem with me attending the program because the [fieldworker] explained to them about what the program is about and what we are actually doing by the program. But she also told them that, um, the stuff we discuss there by the program it doesn't go out to other people; it stays as a secret [confidential]."

Adolescent 023: "Oh. Um, it's only that one friend of mine that we went together there. Uhm, my mommy … And my family knew. Um, they thought actually it was a good idea that I opened up and now that they see a change in me, actually. So, they think it was a good idea."

Adolescent 025: "My parents did know. I took a friend along, and I took my boyfriend also along [inaudible]. They actually motivated me to go. So, it was really helpful though from [inaudible] … They [would] help motivate me to go."

Adolescent 027: "They viewed it as a positive aspect in my life."

Adolescent 001: "They did not see anything wrong [with it] because they noticed the difference."

5.1.4.2 Accessible counselling services and sites. Luckily, the adolescents did not have to travel long distances and did not experience long 'waiting times' to access counselling services. The provision of transportation to and from their home to the counselling site and vice versa made it easier for them to attend the counselling sessions. Also, community settings served as a convenient way to access counselling services. As the adolescents said:

Interviewer: "How easy was it to attend the counselling programme?"

Adolescent 025: "It was really easy. Because I, um, the people that was there that came to pick us up and dropped us at home."

Adolescent 012: "Yes, it was easy. The counsellor came to meet me here. In Gugulethu. At a centre. It was a place like a firefighter centre."

5.1.4.3 Appropriateness of the counselling sites. The majority of the adolescents had no preference for a different counselling site. The selected community settings, such as the library, the firefighter centre, the Delft site, and other sites, were comfortable and adequate physical spaces to receive counselling. The environment of the counselling sessions was clean and maintained, there was privacy, and they received refreshments upon arrival at the site.

Interviewer: "What did you think about the community settings that the counselling took place?"

Counsellor 2: "Community setting because the one we were using for counselling was very conducive because we were taking the children to the office where they are free to talk and able to share their experiences. So, it was conducive. The environment: The setting was very, very, very conducive. Because it was not like in a healthcare centre where [somebody] will go in and fetch one child in between or in some of the children; we were just fetching them in their homes and come with them in the office. So, it was conducive."

Adolescent 087: "It was a nice environment, it was clean, it was tidy. You can see the place is tidy; it's nice to work and to learn."

Adolescent 027: "It was nice."
Interviewer: "Was it clean? And all of those things?"
Adolescent 027: "Yes, and they give you coffee and bread."

Adolescent 075: "We were indoors. At least ... [inaudible]."
Interviewer: "At least what? Er-huh?
Adolescent 075: "At least it was a place for people."

5.2 Barriers to Task-shifting a Counselling Programme for Adolescents

5.2.1 Intervention-related factors

5.2.1.1 Weak and non-responsive referral pathway. There was no clearly defined referral protocol for severe cases that would entail effective and efficient access to health facilities. Consulting the supervisor about a distressed patient was the only available and appropriate protocol for counsellors to use when faced with a distressed adolescent in a counselling session or when they had severe cases that needed a referral. Additionally, counsellors had access to a referral service page separate from the patient handbook with a list of usual care providers to contact to refer adolescents for further follow-up. Moreover, counsellors had referral slips and could send information about the adolescent's diagnosis and treatment administered via email (it was communicated via WhatsApp messaging to the researcher) to the health facilities. Beyond this, the counsellors had a limited functional referral pathway to ensure continuity of care due to backlog and no integrated care pathway (Give et al., 2019). As these counsellors said:

Counsellor 2: "We had a referrals page separate [from the patient handbook], and then you know once you do your counselling, and you see the client needs to be referred to an NGO. Then, you will have a page that you will use to refer the client, the participant."

Counsellor 3: "You know what, [in] most of my cases, they refused to be referred; I never referred any client. But I also feel that our referral pathway is not clear enough. Why I say so is that we don't have a concrete place where we will

> say you go from here to there because a person started their story with you. We don't have our own place where we refer. For example, we have to refer to the same DSD [Department of Social Development] that has a backlog. We have to refer to the same NGOs that are not sure where they will begin, they have their own backlog as well, but we must refer to them. So, I feel like it is not strong enough, especially for teenagers."

There was no two-way communication and coordination between the counsellors and the health facilities. The counsellors could not follow up to receive feedback from health professionals based in those health facilities on the diagnosis and treatment provided to the adolescents. The intervention would have benefitted from having an effective referral system to enhance the functional links between the primary healthcare system and adolescents with continuous and regular feedback between health facilities and counsellors (Give et al., 2019). As the supervisor said:

Supervisor: "I think we would have all benefitted from some ... um, like maybe some ... like how we can refer to adolescents to certain, um, maybe a social worker or how we can follow up. I think that would have been great."

Additionally, the supervisor expressed how the counsellors would like to play a role in helping the adolescents address the multiple deprivations they face in their lives. However, the referral protocol tied their hands by limiting their agency. As the supervisor said:

Supervisor: "And then also with us is, sometimes feeling helpless in the debriefing sessions when counsellors are asking for advice, and you know our training as counsellors tell us to do a specific thing, but the project role for ASPIRE expects us to do something different. So as counsellors, if someone wants to go to school or if they don't have food or there's danger, we're trained to refer and to seek immediate help, either through social workers or other organizations, and we really struggled with the fact that we had to take a step back with these adolescents, even though it may have been hunger, even though it may have been that they can't go to school or ... Before we refer, we were kind of prompted to rather help them try [to] resolve it themselves which I think it felt like, you know, it's a big expectation to have for someone. And so, we struggled a little bit. I think all of us in the

> debriefing sessions to try and give reasons why we shouldn't be referring this client for more specialised services, and you know why we should rely on the project to try and help these clients. So, yeah, that was a challenge for us, as well."

5.2.1.2 Too much reading affected adolescents' interest in the patient handbook. The patient handbook was unsuitable for adolescents with learning disabilities or low cognitive function, as the long texts led to them losing interest. That made it challenging to deliver the intervention as the amount of reading done in the counselling sessions required good cognitive functioning and learning ability to understand the concepts. As a result, the counsellors had to overextend themselves to engage these adolescents in the sessions. As this counsellor said:

Interviewer: "So, what did you find difficult about delivering the intervention?"

Counsellor 1: "Um, I would say, the difficulty about delivering the intervention is: Whenever we come across clients that, you know, with, say, perhaps learning difficulties or who aren't, you know, high functioning, um … that's where that's where it really becomes difficult. Because why? The information that we share, it requires a bit of reading. Um, you know, and it requires one to have, you know, a decent level of understanding to grasp the concepts. In my experience, whenever I came across, like not too many, like a few clients that, you know, that you can sense there is some, you know, learning difficulty issues. That's where it really becomes, you know, challenging, and you have to try and make it as … um, you know, concrete as possible. You have to use illustrations, maybe more, just to almost like help to paint them a picture instead of like reading words or for them to read words. So, so that was that was probably like one of the main difficulties, um, of, of delivering the intervention."

5.2.2 Contextual factors

5.2.2.1 Multiple deprivations severely disadvantaged Black adolescents. The deprivations that severely disadvantaged Black adolescents in Project ASPIRE included living in overcrowded houses, dysfunctional families, and lack of money to buy a cell phone, among others. It slowed down their therapeutic progress by affecting their motivation,

commitment, engagement, and participation in the counselling process. One of the Black female counsellors painted a picture of this from what she observed while performing her patient-tracking duties in the communities. Also, she shared what she noticed about how some of these deprivations affected the adolescents and feelings of despair and powerlessness come through from the ways she speaks about the adolescents' vulnerabilities.

Counsellor 3: "… during the time before lockdown, we had to go to their communities and see where our participants live. In my assessment, sometimes I felt as though we were perhaps not being serious. Because the participant leaves us holding this book of the session, and they go home and arrive to, for example, a mother who is illiterate and doesn't care about what is happening right now. And something else I noticed was some parents in our communities do not play an active role in what is going wrong in the lives of their kids. For example, some participants would come to the sessions without having eaten a warm meal and then you are busy reading this handbook. Now, you see, you are dealing with two different situations: The child is hungry in this moment; they haven't eaten, and you are busy telling them about something that is in the handbook that they must read."

"It's very tricky because I feel like teenagers still need support from their parents and what I have noticed during my assessments while doing the home visits is that parents have given up. They feel like a child who has a drug problem or have dropped out of school because many of them have dropped out of school. The parent does not view it as a problem that they must follow-up on as the parent. They take it as it's the choice of the child, and they have failed themselves. Parents have other responsibilities, and the child may not be the only problem they may have, you see?"

Interviewer: "That is a difficult circumstance.

Counsellor 3: "It's difficult, it's difficult, and then you expect the child to go back to an environment that has no problem solving, problems are just left as is which become worse and worse than before it's like they say, "You will see how to get yourself out of this problem because you put yourself in that situation. You, see?"

Interviewer: "… which is unfair because you are a child."

Counsellor 3: "Yes, it is very unfair because you expect a child to act like an adult and do something that even the parents couldn't do. You, see?"

Interviewer: "Please tell me about your experience of the counselling site."

Counsellor 3: "Oh, okay. The place was okay when we move them into the community setting. But my issue is we take them from their environment and bring them to a controlled environment in a way because everything is arranged for them to be counselled etc. There was privacy, and there was everything that made the counselling environment conducive. But then, when we take them back home, it was a bit tricky because if they were going to do all their activities where we counselled them, it was going to work. But now, when you take the child away from this environment and back home with a handbook and homework that needs to be done, even the people at home are curious; they want to know what was it that they attended and whether the child said anything humiliating or embarrassing about them [in the counselling sessions]. So, there was something that couldn't balance well. As a result, some adolescents wouldn't do their homework."

"But otherwise, the site where we took the adolescents, there were like … there were those who participated well, and then there were those who you can see are lost. I mean, even after having tea and a sandwich, they are utterly lost; they don't know what is going on, and you hold a session just for the sake of conducting it 'til the end."

5.2.2.2 Impact of the COVID-19 pandemic. During the COVID-19 pandemic, the counsellors conducted telephonic counselling sessions, which affected adolescents' commitment and engagement. They could easily avoid sessions by ignoring the phone when the counsellors called to counsel them over the phone. If they decided to pick up the phone, the counsellors mentioned they were closed off and less engaging than when they attended face-to-face counselling sessions. It might have been premature to utilize telephonic counselling sessions as a viable solution to continue the counselling programme during the pandemic without doing the necessary formative research to prepare the adolescents for the shift and assess whether it would be feasible. As this counsellor said:

Interviewer: "What do you think affected participants' attendance?"

Counsellor 3: "I think the lockdown affected us a lot. Like over the phone, there are so many challenges. Sometimes they don't pick up the phone. It's easy to avoid a session over the phone than when you must fetch a participant and bring them [to the counselling site]. So, I think they are still used to the face-to-face one."

Counsellor 3: "But then, during the lockdown where we had to do sessions over the phone which was a bit tricky. And I feel like our participants are not ready for a telephone intervention; they are not ready for an online intervention because it is something new. They prefer their sessions to be done face to face, and also, my experience of the session, like face-to-face and over the phone, is actually different. They are so closed up when you are doing it over the phone, but when you [are] doing it face-to-face, it's quite easy for them to talk about things and actually engage in a session."

Interviewer: "Mm-mhm."

Counsellor 3: "So, over the phone, they seemed to be annoyed, and they are just doing it. They just answer what you are asking them about. They don't give you something tangible that you can use in the session. You, see?"

Interviewer: "I see."

Counsellor 3: "Their commitment over the phone and face-to-face is quite different, I can say."

Also, conducting telephonic counselling sessions during the COVID-19 pandemic was difficult and was exacerbated by the uncertainty of school closures. Moreover, the general conditions of the lockdown worsened adolescents' conditions of deprivation in their homes and mental health issues. As this counsellor said:

Counsellor 1: "… now during the pandemic that, you know, school system or the school calendar or thing was in like chaos and many times learners didn't know whether they need to go to class tomorrow or whether they should not go to class, and now you reschedule, and then tomorrow it comes, and then they actually need to be at school now you need to reschedule again. … And also … um, yeah, I just think that sometimes there is circumstances where they live, um, does play an impact on them because, like many times, the clients that we see their depression scores are quite high, um, on the screener. They

going through quite a lot and, you know, many times they don't feel like, you know, they just want to be left alone, they just want to be by themselves, they don't feel like talking. So, sometimes that could also play a role."

The shift to telephonic counselling sessions disproportionally affected marginalized and underprivileged adolescents. Because they either could not speak freely over the phone with no private space to talk openly in their homes since they often lived in overcrowded homes or did not have a cell phone to participate in the telephonic counselling sessions. Those who did have access to a cell phone either lived in an area with poor network quality, or their phone speaker did not work, or if it did work, it was faulty. These disadvantageous circumstances in our low-resource setting posed unique challenges in delivering the intervention for the counsellors' and adolescents' engagement in the sessions in the context of the COVID-19 pandemic. In light of this, the programme should have appropriately considered ways to manage them. As these counsellors said:

Counsellor 2: "And the pandemic also affected their attendance. Because now .... it necessitated us to phone our participants, and then when we call them, you might find that they are home but not alone, and they can't speak on the phone. [Do] you see? Or maybe they are with their friends. I mean, this COVID caused another thing, we had to phone them, and then when we did, maybe the participant does not have the space to take the call in their home ... like in a separate room."

Interviewer: "Yeah."

Counsellor 2: "And then they must listen from wherever they are, and they can't talk; they are not free to speak, or many of their friends are over [at] their house, the house is overcrowded, and the participant can't speak. Those are some of the things that affected ..., but it is COVID. You, see?"

Counsellor 1: "And also recently, there are times when certain clients don't have, you know, cell phones or they do have cell phones, but, you know, there's maybe some issues with it, maybe the speaker isn't working, or maybe they located in an area with this poor network quality. And that has an impact on, you know, the intervention. I would, you know, I would think. Because

> why? Every time you're so focused on trying to hear what the client is saying, you know, in between the the network noise or the, you know, the speaker being faulty. So, it takes away a bit of the, um, you know, almost like of, of the … your ability to deliver the intervention optimal. So that was also sometimes an issue."

5.2.3 Supervisor-related factors

5.2.3.1 Imposter syndrome. Imposter syndrome describes the persistent feeling of incompetence despite experience, education, accomplishments, talent, and capabilities that qualify an individual to deserve an accolade or a new position. Those with imposter syndrome fear others will discover them as someone not meant to be in their role. They can experience self-doubt, low self-confidence, and fear of being an academic fraud (Sakulku, 2011). During my interview with the supervisor, three factors led me to believe she had experienced imposter syndrome in her supervisor role at Project ASPIRE. These causes were the following:

- First time supervising other registered counsellors.
- First time performing supervisory duties on counsellors deemed to be on the 'same level' and are her close friends.
- Returning from maternity leave with no support from principal investigators.

The causes outlined above centre on starting a new position after returning from maternity leave and ranking higher in seniority with colleagues she once worked alongside. Unfortunately, such new transitional experiences in one's life can cause one to compare themselves to others and doubt their abilities (LaDonna et al., 2018).

5.2.3.1.1 Persistent anxiety about professional standards. Before working at Project ASPIRE, the supervisor never supervised other registered counsellors. She previously led lay counsellors, people with no formal mental health counselling qualifications. More specifically, the level of lay counsellors she previously led were typically people who studied towards a degree in Psychology, had some volunteering experience working for non-governmental organizations and had little to no training in mental health. On this account, working in Project ASPIRE was the first time she performed supervision duties on counsellors who have (i) the same qualifications as her and (ii) were some of her close friends, and (iii) had previously worked together in the same roles as counsellors or

supervisors on other interventions. These new transitional experiences in the supervisor role in Project ASPIRE triggered "it would have been better if" statements.

Those statements are imposter syndrome in action because, in this role, she was an appointed supervisor to counsellors 1 and 3. Unfortunately, this caused her to question her ability to do her job. When I asked: What did she find difficult about providing the supervision sessions? Initially, one can interpret her response as describing the difficulty of leading friends. However, she had naysaying thoughts. Those included thoughts about it would have been better if their roles were the same as in previous working situations rather than "us supervising each other," which signifies her deep-seating insecurity and pervasive psychological experience of perceived professional inadequacy (Clance & Imes, 1978). As she said:

Supervisor: "Okay, so before working on Project ASPIRE, I wasn't necessarily involved in supervising other registered counsellors. So, a lot of my supervision was mainly focused on lay counsellors that had been trained to administer psycho-social interventions …. I've been working close with [Counsellor 3] and [Counsellor 1] for a couple of years, so we're all very familiar with the intervention. But this was the first time that we had such distinct roles in a project. Usually, the three of us were either delivering the intervention together, or we were assessing the intervention together or providing supervision together. So, this is the first time that their roles were very different from my roles."

Interviewer: "What did you find was difficult about providing the supervision sessions?"

Supervisor: "… what made it difficult for me to do my supervision duties … I think it's just mentioning the fact that we're friends, you know, we're friends and colleagues, so what could they maybe have done differently to help me, is maybe it would have been good to have had, like just for example [Counsellor 1], myself and [Counsellor 3] as the supervisors and have different counsellors, um, you know, deliver the intervention [*the recording went silent*] supervised, instead of us supervising each other."

5.2.3.1.2 Fear of failure. Additionally, I noticed a continuation of the supervisor's pervasive psychological experience of perceived professional inadequacy by magnifying the competence, skills, and knowledge of two counsellors in the group as being more than her.

Thus, creating this belief that they possibly could have better performed her supervision duties. People who experience imposter syndrome will often attribute their appointment in a new position or success to luck, good timing or knowing the right people and discredit their hard work, expertise, and experience in landing a new role and achieving success (LaDonna et al., 2018). It makes me wonder what the supervisor credited her appointment in the supervisor role because the principal investigators reported that they appointed her because she had previous experience providing supervision.

Despite objective evidence of being a suitable candidate for the job, the supervisor's pervasive psychological experience of professional inadequacy was consistent with a fear of failure caused by the belief that she fell short of what was expected (Sakulku, 2011). She believed that the principal investigators expected her to perform the clinical supervision sessions with an authoritative supervision style similar to a more senior mental health professional such as a clinical psychologist. She perceived the principal investigators had an inflated perception of her abilities, which resulted in her lack of self-confidence in her ability to perform a more senior role to the counsellors, especially in the presence of counsellors 1 and 3. Combined with feelings of inadequacy, self-doubt, and low self-esteem, she adopted a peer supervision method to perform the supervision sessions to equalize the power relations to avoid being authoritative in the role. As the supervisor said:

Supervisor: "… I think I feel silly sometimes because I feel like we're all on the same level, you know. Sometimes I think maybe [Counsellor 1] and [Counsellor 3] possibly know more than me. So, my experience was more … it wasn't me being a supervisor and them being counsellors, although that is our set up, and we do give feedback, and you know we do treat it as very professional. But it was a lot to do with peer supervision for me almost. Because I could learn a lot from them in terms of how to … how we could change the counselling, how we could administer it and how something can be done differently. Or they would give feedback. So, I think that it was more of a peer supervision than [a] hierarchy of someone more senior is doing the supervisor [role]. Usually, we're supervised by clinical psychologists, for example. And you know that's definitely a bridge. A psychologist is different. They're more professional, they're more senior, and there was not that dynamic in our group. So, it was more of conversations and just to add; maybe sometimes the PIs thought that there

> was a bit more of a – for lack of a better description, a hierarchy. And so, it was difficult at times when you almost had to do something more management, or you know, not reprimanding, but maybe they were worried about counsellors sticking to the time or something like that. And that was quite challenging for me to have to be assertive and to say like, "No, you shouldn't do that or should do this." Because that's not the dynamic of our working relationship if it makes sense?"

The most significant contributing factors to the supervisor experiencing imposter syndrome were playing a supportive role in the beginning stages of Project ASPIRE and then having to take maternity leave and return to starting a new supervisor role with no briefing about what the principal investigators expected of her in the role and the format of the supervision sessions. Thus, she soldiered on to a fault by making the role her own to measure up. Young (2011) identified five types of people with imposter syndrome: Perfectionists, superheroes, experts, geniuses, and soloists. I believe she is a soloist type of competence whereby people with this imposter syndrome choose to accomplish things independently to prove their worthiness for a role. They often regard asking for help as a sign of failure. In this case, the supervisor perceived asking for help from the principal investigators as a sign of failure. She needed to ask them to brief her on the assigned protocols for the supervisor role, what they expected of her, and the format of the supervision sessions. As the supervisor said:

Supervisor: "I was initially involved in the start-up of the project. We were doing a lot of theatre testing [on] how we can adapt this adult intervention for young people. And [then] I went on maternity leave just as the project was about to roll out to start. By the time I got back, we had been obviously a couple of weeks into the programme, and so one of the challenges I found was that, although I'd been involved in the start-up, the initiation, I'd missed quite a big chunk. I felt that I was thrown into the deep end when I started with the supervision. There had been numerous clients seen and numerous feedbacks [was] given. They had already assigned certain protocols for the supervisor role, so I felt very lost. I wasn't really sure what the format was supposed to be. I wasn't necessarily sure what was expected of me. But I carried on; I kind of just settled into the role and made it for myself."

5.2.3.1.3 Masking. When I asked the supervisor these two questions: What difficulties had she experienced during debriefing and what things she found were beyond her expertise, her responses sounded reflective in conversation. However, when I revisited my interview with her by reading the transcript as I coded her responses - I felt confused and frustrated when I read her answers to these two questions. It had not yet dawned on me that she experienced imposter syndrome in her supervisor role as I came across these responses. It felt like I was reading one of the counsellor's answers, but I knew I was going through the supervisor's interview transcript. So, eventually, I asked myself what made the supervisor give an authentically reflective response from the perspective of a counsellor instead of her role in Project ASPIRE. The answer was that she spent her time working in Project ASPIRE with deep-seating insecurity of being ousted as someone who is not sufficiently capable of doing her job. She often masked her anxiety by playing the supervisor role in front of her colleagues (Pedler, 2011), especially in meetings where the principal investigators were present. Whereas, during supervision sessions, she would be one of them (i.e., the counsellors) because they were "supervising each other".

Her responses below uncover the front she gave to others and demonstrate her desire to have had the counsellor's experience by being appointed as a counsellor alongside counsellors 1 and 3 while working in Project ASPIRE. The use of the critical words "we", "us", and "as counsellors" denotes how easily she finds a sense of belonging in the role of counsellor, as seen through her perspective-taking of the counsellor's experience in Project ASPIRE. That gives the impression that she could not show up authentically in the supervisor role, making her feel like an imposter. As these responses reveal:

Supervisor: "… And then also with us is, sometimes feeling helpless in the debriefing sessions when counsellors are asking for advice, and you know our training as counsellors tell us to do a specific thing, but the project role for ASPIRE expects us to do something different. So, as counsellors, if someone wants to go to school or if they don't have food or there's danger, we're trained to refer and to seek immediate help, either through social workers or other organizations, and we really struggled with the fact that we had to take a step back with these adolescents, even though it may have been hunger, even though it may have been that they can't go to school or ... Before we refer, we were kind of prompted to rather help them try [to] resolve it themselves which I think it felt like, you know, it's a big expectation to

have for someone. And so, we struggled a little bit. I think all of us in the debriefing sessions to try and give reasons why we shouldn't be referring this client for more specialised services, and you know why we should rely on the project to try and help these clients. So, yeah, that was a challenge for us, as well."

Interviewer: "What things did you find were beyond your expertise?"

Supervisor: "Yeah, I think, just like I say, we were trained in brief interventions or in short-term counselling, and I felt like a lot of the services that the participants specifically needed were more for social services or, um, maybe the Department of Education. You know, we were very limited in that we could only teach them skills to help themselves. And not necessarily solve the problems for them which may have been their expectation."

5.2.3.2 Lack of cultural sensitivity training for the Xhosa population. The counsellor supervisor is bilingual in English and Afrikaans. The Western Cape Province has a predominantly Afrikaans and Xhosa population. So, some counsellors conducted their counselling sessions in isiXhosa, and when this happened, the counsellor supervisor could not effectively perform fidelity checks on those counselling sessions. Because of the language barrier, she had a limited understanding of the cultural context and dynamic of the sessions and expressions of sincerity and sensitivity towards the adolescents' problems. Also, the language barrier further affected her ability to advise counsellors on the best possible help to provide those adolescents and give constructive, detailed, and insightful feedback during supervision sessions. As the supervisor said:

Supervisor: "… one of the biggest challenges I experienced is that a lot of our communities have got Xhosa population, and so if our counsellors were to do the sessions in Xhosa, I'm unable to provide adequate, quality, um, like fidelity checks, I'm not able to do [it] because I don't understand. So, I [am] always worried about if something gets lost in translation or something gets lost in the essence. So, I do feel a bit of ... um, yeah, very overwhelmed in that sense. And I just want to make sure that I understand the context and I understand the dynamic in which the session is taking place so that we can optimize it and provide people with adequate help."

However, having these sessions translated helped mitigate some of the effects of the language barrier. Nevertheless, it was insufficient, as the counsellor supervisor did not have cultural sensitivity training for the Xhosa population. That would have helped her gain the cultural competence she needed to conduct fidelity checks ethically and effectively on sessions conducted in isiXhosa. As the supervisor said:

Supervisor: "There were instances, and this is where I feel like I, um, may have lacked, you know, when I listen to a counselling session for [Counsellor 3], for example, I'm not sure, um, around the cultural context of the counselling. So, it might sound like maybe she is being disrespectful to the client, but maybe she's not, you know. So, um, I did have some of her sessions translated, um, on a word document and then I read through them, um, just to help me get a better sense of context. And then I could see, for example, how her style and tone of language doesn't necessarily match the context. This they are talking about sincere stuff, but it sounds like, you know, she's angry. So, I think, no, you know, there I was the shortcoming if that makes sense."

5.2.3.3 High case volumes and working part-time. The counsellor supervisor worked on multiple research projects besides Project ASPIRE during her appointment as a supervisor on Project ASPIRE. Thus, she could only commit to working part-time instead of full-time. However, the high case volumes made it difficult for her to perform fidelity checks on all session recordings every week ahead of debriefing sessions. That made it challenging for her to prepare detailed and insightful feedback to give counsellors on their counselling sessions for the week, which, in turn, affected her ability to deliver adequate supervision and strengthen the quality of the supervisory relationships. As the supervisor said:

Supervisor: "And then also sometimes the caseloads can get overwhelming. I mean, at one stage, there were three counsellors and let's say they see two people a day, you know, um, it's like 15 sessions a week, and to listen to all of the recordings can be very tedious. It can be very time-consuming, and you also want to make sure that you're not fatigued, if that makes sense. So that when you listen, you're listening in a non-biased way. So, yeah, the caseloads, I would say sometimes, um … I think if I had enough time to read or listen to the cases before supervision. That would always help, but I

didn't always have time to listen to all of the sessions before the debriefing session. And then the counsellors had to spend a lot of time giving me context, or you know, I think I would have been [of] help a bit more had I had time to listen to all the recordings ahead of the debriefing sessions."

Additionally, the artefact of working part-time caught up with her as she could not necessarily have a flexible work schedule to fit in the time to schedule individual debriefing sessions whenever the counsellors needed them because she had other commitments. Also, she found it difficult to arrange a set time for the supervision sessions, so they were often unplanned. However, this was not only on the part of the supervisor. Some of the real-time demands because of the set-up of Project ASPIRE caused havoc with work schedules, such as the counsellors needing to locate adolescents in the communities on a day when they are supposed to have supervision.

Supervisor: "And I think the group setting that we had worked, but individual debriefing sessions were often needed, and maybe we couldn't squeeze it in or, um, so I think sometimes, just yeah, as flexible as we were, we still had some boundaries around that. Or challenges around that."

Counsellor 2: "Like she didn't set on a specific time we will have our session, or say our session starts from one to two, but she would tell us: 'You know what, at this specific time we will have a session from a certain time I will be there where you are, and this person will start, then this person will start, then this person will start". You, see?"

Interviewer: "Mm-mhm."

Counsellor 1: Because when we go out, we try to not only go out to track one client, but we try to do like two to three in order to pool resources, um, and that could ultimately fall on a supervision day which ultimately needs to also be rescheduled because why, um, you know, of us trying to locate the clients."

5.2.4 Counsellor-related factors

5.2.4.1 Patient tracking was disruptive to counsellors' work schedules and posed a safety threat. Counsellors wanted to conduct their sessions consistently each week at the same time and day of the week with their patients. However, South Africa is a low-resource

setting with many intersecting factors to adolescents' non-engagement in a mental health counselling programme such as Project ASPIRE, which gave rise to patient tracking being a part of the counsellor role. Patient tracking is an operational sustainability method to help maximize resources to locate some adolescents in a workday. Nevertheless, it sometimes disrupted counsellors from conducting their counselling sessions and attending supervision sessions as they had to track adolescents in their communities, sometimes resulting in constant rescheduling. As this counsellor said:

Counsellor 1: "… although we would like to see a client say, for instance, if they get recruited now, and we do the first session at 10 o'clock, we would like obviously to, in an ideal world, to have the counselling session every Thursday morning at 10 o'clock for the next few weeks until they are done with their sessions, but it doesn't always work out that way. Um, many times we need to reschedule sessions for whatever reasons and many times we need to go out in the community to track and in many cases that could take, you know, almost most of the working day, um, to try and track down clients, you know. Because when we go out, we try to not only go out to track one client, but we try to do like [track] two to three in order to pool resources, um, and that could ultimately fall on a supervision day which ultimately needs to also be rescheduled because why, um, you know, of us trying to locate the clients."

Additionally, patient tracking posed a safety risk as counsellors experienced direct exposure to community violence. To cope with witnessing community violence, counsellors dissociated from the traumatic experiences to continue with work, which could become detrimental to their mental health. Dissociation as a coping mechanism for exposure to violence can increase one's risk of developing post-traumatic stress disorder and other mental health problems such as depression, anxiety and substance use disorder (Alden et al., 2008; Johnson, 2009). Sadly, this can happen if one does not find ways to counteract the effects of violence exposure, for example, by receiving appropriate psychological assistance (van Horn & Lieberman, 2011)**.**

Dissociation is an altered state of consciousness, identity and perception that can disrupt the normal functioning of mental abilities, bodily movement, and behaviour (Bourget et al., 2017). People can experience negative or positive dissociative symptoms. Negative

dissociative symptoms result in retrieval failure of information from one's memory or impaired mental abilities, for example, memory loss. Conversely, positive dissociative symptoms are an awareness of intrusive thoughts or feelings that result in the mind detaching from the subjective experience, such as experiencing flashbacks (Bourget et al., 2017). The counsellor describes positive dissociative symptoms whereby he tells his mind to detach from the violence he was witnessing at a particular moment while doing his patient-tracking duties in the communities. His statements such as "you try to block it out somehow" to "get on" with his workday and his awareness that this is not ”the best way to cope” with it are evidence of this. As this counsellor said:

Counsellor 1: “Um, so, so, yeah, but perhaps what I would say maybe is sometimes the safety aspect in the community, um, we do, do quite a bit of tracking, um, in the communities, and you know sometimes you see stuff in the community. You come across, you know, things. You see people getting robbed. Uh, sometimes you have to turn around by a certain street because why there’s people maybe fighting or there’s maybe gang violence happening and stuff. Um, so, sometimes that does play a little at the back of your mind. But you try to block it out somehow and just get on. But obviously, I know that’s not always the best way to cope.”

5.2.4.2 Appointment availability issues. The scheduling of the counselling sessions sometimes clashed with school times and afterschool commitments such as playing sports or attending extra classes. In particular, when the counsellors would conduct the sessions after the adolescents returned from their afterschool extracurricular activities, the counsellors perceived the effectiveness of their intervention delivery might have been affected by meditating factors such as fatigue. That would have impaired adolescents’ concentration and lowered their engagement during the counselling sessions. As this counsellor said:

Interviewer: “So, what did you find was difficult with delivering the intervention?”

Counsellor 2: “So, what I found was difficult while I was doing counselling on ASPIRE project was working with children who attend schooling. So, … there were times you would schedule an interview with the child, but due to the time of attending school, then some would not be available, or you would be able to reach them after four or after five pm. Because they also have after classes and then when you get them, they are already tired, exhausted but we had to

do the counselling. That was the only thing that was difficult in delivering the intervention."

5.2.4.2.1 ***The stress of avoiding 'time outs.'*** From the counsellors' perspective, one could wonder whether the impact of scheduling might have caused some adolescents to make excuses for not attending the counselling sessions, even though most of them stated that nothing hindered their attendance. Exercising flexibility and conducting sessions whenever the adolescents were available made delivering the intervention difficult and played havoc with their schedules. As mentioned below:

Interviewer: "I'm just wondering if you had a participant coming to the program this week and not come to the [next session scheduled for the] following week. Did you experience something like that?"

Counsellor 3: "Yes, such a thing would happen whereby a participant would attend this week and not attend to the following week. Like even when we were tracking, they would tell stories about something they need to attend on the scheduled day. Like, for example, if we are having a session on Tuesday, the next session will be scheduled for the following Tuesday. So, when Tuesday comes, they tell stories and say they are not at home when you get there. So, you must be flexible enough to say if the participant did not attend the session on Tuesday, when I'm around their area, I must take them even if it's on Wednesday when they are available. So, in a way, you had to change sessions to accommodate their availability."'

Interviewer: "Was there anything that made you not able to attend your appointments?"

Adolescent 012: "No."

Furthermore, working around their availability caused inconsistent scheduling of counselling sessions and sometimes delays in conducting sessions. It was the only way to avoid 'time outs' (i.e., having them forfeit the remainder of their sessions). So, ensuring the adolescents completed their counselling sessions (or at least two sessions) within the allocated timeframe, typically six weeks, caused counsellors to stress about them forfeiting their sessions in Project ASPIRE for missing at least two sessions within those six weeks. As this counsellor said:

Counsellor 3: "Sometimes you could get that you scheduled for 10 am, and you arrive

> after nine am, and the adolescent says, “I haven’t bathed yet.” They will go take a bath. Then, you have to wait for them, and you find out that this takes away time from the next session because you must conduct a session. You have to be flexible enough to see them at their most available time to avoid them having a time-out. There is the issue of time-out.”

Chapter Summary

The categories identified within the data: Intervention, supervision and supervisor, counsellor, and adolescent-related factors reflected what worked and did not work in Project ASPIRE. Each category of factors revealed complexities of the adolescents’, counsellors’, and the counsellor supervisor's experiences in Project ASPIRE.

The adolescents began their journey toward mental wellness with the support and encouragement of their families, friends, and significant others. Also, they had access to nurturing and capable counsellors who gave them the necessary tools and relevant knowledge to build their autonomy and self-efficacy to achieve the desired change in their lives. The intervention made room for the counsellors to shift the sessions and their content to meet the mental health needs of the adolescents. The counsellors tried their best to be conscious of race, class, and gender relations that intersected with cultural, social, and economic factors that would have negatively influenced the mental health outcomes of the adolescents if they chose to ignore them. The adolescents benefitted from receiving appropriate counselling services in conducive community-based settings.

The patient-tracking duties the counsellors performed were a means to understand the reasons for adolescents' non-engagement, and these were often beyond the circumstances that the programme could control. When the counsellors performed these duties, it exposed them to incidents of direct violence in the communities which are difficult to avoid in our context. Exposure to violence can increase their risk of developing post-traumatic stress disorder and other mental health problems if they do not have healthy coping strategies or get mental health support.

Recently, the COVID-19 pandemic exacerbated adolescents' conditions of deprivation in their homes and mental health issues. Also, it forced the counsellors to utilize telephonic counselling sessions during the pandemic, which may not have been feasible without conducting the necessary formative research to prepare the adolescents for this shift by thinking of innovative approaches to managing their multiple deprivations and vulnerabilities.

There are considerations that the principal investigators need to make to strengthen their referral pathways to ensure continuous care and feedback between the primary healthcare system and the counsellors in the intervention. Reimagining ways to engage low cognitive functioning adolescents with the patient handbook, ensuring the supervisor and the counsellors have work schedule stability, cultural sensitivity training for the Xhosa population and regular mental health support. It will require the principal investigators to change the conditions, design, structure, and workforce of the ASPIRE counselling programme.

Chapter 4: Discussion

Investigating specific facilitators and barriers to effectively task-shifting mental health services is not new. Researchers have identified several facilitating factors to task-shifting psychological interventions. These include, but are not limited to (Crockett, 2012; Mendenhall et al., 2014; Munodawafa et al., 2017; Murphey et al., 2013):

a) content relevance,
b) extensive training,
c) appointing specialist mental health practitioners to provide adequate, ongoing, structured, emotionally supportive supervision sessions and referral support,
d) the use of a counselling manual to guide the sessions and
e) when counsellors can speak in the local language of the participants during counselling sessions, participants find it easier to connect, trust and understand them.

This study also found similar facilitating factors to those described in the literature. However, I found unique facilitating factors from exploring the views and experiences of the adolescents, counsellors, and the counsellor supervisor in their involvement in Project ASPIRE. Those included patient tracking and the value of upholding diversity, equity, and inclusion. Patient tracking was a sound retention strategy that the principal investigators used to control for the threat of attrition to the internal validity of the randomized controlled trial (Flannelly et al., 2018). Even though adding patient-tracking duties to the counsellor role might have added mental strain, it helped counsellors get a glimpse of the multiple deprivations that affect adolescents' motivation, commitment, engagement, and participation in the counselling process. An interpretive phenomenological study on the development of theoretical knowledge and skills in critical care nursing found that knowing a patient is essential for skilful clinical judgement (Tanner et al., 1993). In the context of Project ASPIRE, the significance of understanding the adolescents' vulnerabilities beyond the counselling environment through performing patient-tracking duties helped them with counselling with a raised consciousness which, in turn, strengthened their clinical judgement to improve treatment outcomes.

Furthermore, upholding diversity, equity, and inclusion in the intervention proved to help the counsellors to be aware of intersections of race, culture, and language by reflecting on potential barriers, such as language barriers. As indicated in the literature, employing racially and culturally diverse counsellors representing the patients' demographics can be

helpful in the relational process of receiving counselling. It can enhance the connection in the working alliance and deepen their trust and commitment in the relational process of receiving counselling as it centres on their positionality and mental health needs (Adames et al., 2018; Munodawafa et al., 2017; PettyJohn et al., 2020). In line with this, this study suggests that the prioritization of matching adolescents with counsellors based on race, culture, and language is essential when it is clinically relevant for the adolescent. Also, it may be a good idea to empower adolescents to decide whether they want their assigned counsellor to match them based on race, culture, and language before they are enrolled to begin their counselling sessions.

The empowering nature of the motivational interviewing and problem-solving counselling techniques laid a firm foundation for the counsellors to create affirming, humanizing, and client-centred therapeutic relationships with the adolescents in the counselling programme, which led to them better managing and understanding their feelings. It further supported the literature that suggests these counselling techniques can lead to reduced levels of depression and bring about positive behavioural changes in patients who suffer from alcohol and other substance use disorders and even those with comorbid depression (Naar & Safren, 2017; Riper et al., 2014; Sorsdahl et al., 2015).

The adolescents experienced these positive treatment outcomes after completing their counselling sessions and cited intrinsic motivations for participating in Project ASPIRE. Those included wanting to gain people, life, problem-solving, anger and stress management skills, improve their mental health and change their unhealthy behaviours. Conversely, there was little to no mention of cash vouchers as an intrinsic or extrinsic motivator for participating in the study. Researchers often use financial incentives to maximize recruitment (Zutlevics, 2016). In Project ASPIRE, the participants were offered financial incentives at three stages in the research process: When they joined the programme, after attending their counselling sessions and after completing their three-month post-intervention follow-up interview. Adolescents living in conditions of poverty face multiple deprivations that can lead to many unmet social and economic needs. It is reasonable to believe they might have regarded the financial incentive as an avenue of income to meet those needs and influenced their decision to join the programme. However, it would be interesting in future research to find out from the adolescents the impact the cash voucher had on their decision to join the programme and continue to participate in Project ASPIRE.

Nevertheless, the broader adolescent psychotherapy literature suggests that many adolescents are motivated by others to begin therapy (de Haan et al., 2013). It appeared that

extrinsic motivators such as the support of family members, friends, and significant others helped adolescents develop an investment in their mental healthcare and mental health practices. Further, having accessible, appropriate, and available counselling services and sites is an investment in adolescent mental healthcare that Project ASPIRE endorsed to meet the mental health needs of the adolescents in the study. Our national policies, such as the Child and Adolescent Mental Health Care Policy Framework (RSA DoH, 2003), support the capacity development of lay counsellors. However, they are silent on the need to appoint them to assist in delivering mental health services for adolescents in public healthcare clinics or mobile clinics to address the mental health service gap in the adolescent population of this country.

To address the mental health needs of adolescents within a structured intervention such as Project ASPIRE, the counsellors developed the adolescents' autonomy and perceived self-efficacy in the therapeutic process for successful treatment (Gibson & Cartwright, 2013; Lovgren et al., 2019). As the literature suggests, that can lead to adolescents conceptualizing positive therapeutic relationships with counsellors as sincere, caring, tolerant, trustworthy, supportive, attentive, and respectful, as was found in this study (Binder et al., 2011; Everall & Paulson, 2002; Gibson et al., 2016; Lavik et al., 2018; Lovgren et al., 2019; Sagen et al., 2013). Internalizing the overall intent of the intervention seems to be a reasonable condition to enable counsellors to meet adolescents' mental health needs. However, in reality, it necessitated them to remain devoted to delivering the targeted intervention, exercising flexibility and adaptability of the counselling sessions, and using their raised consciousness and clinical judgement to centre adolescents' mental health needs in each counselling session. Moreover, the value adolescents attached to the knowledge the counsellors imparted to them contributed to their receptivity towards that knowledge and leveraging the enlightenment they gained from the counselling sessions to strengthen their ability to improve their mental health (Liebowitz, 2000).

Another necessary condition in addressing the mental health needs of adolescents in a task-shifting psycho-social intervention, as indicated in the literature, is the provision of ongoing, structured, and emotionally supportive supervision sessions. It is beneficial in reducing counsellors' psychological distress and enhances the monitoring of their skills development post-training (Mendenhall et al., 2014). This study suggests that ongoing and structured formal and informal supervision sessions provide counsellors with adequate time in supervision with the supervisor. That helps them maintain the counselling skills taught in their training programme and encourages their participation, self-monitoring of skills

development, and enhances their personal growth. Additionally, the literature suggests that appointing specialist mental health practitioners can provide adequate supervision, strengthen monitoring and evaluation of quality assurance activities of the intervention, and offer referral support to counsellors (Mendenhall et al., 2014; Petersen et al., 2011). However, there are typically heavy case volumes in task-shifting psycho-social interventions, as evidenced by the supervisor, who had difficulty performing fidelity checks on all session recordings every week ahead of the debriefing sessions. So, including supervisors in the referral pathway may need further research on what is feasible and what is not in task-shifting psycho-social interventions.

Researchers have identified several barriers to task-shifting psychological interventions. These include, but are not limited to (Crockett, 2012; Heller et al., 2019; Mendenhall et al., 2014; Murphey et al., 2013):

1. heavy workloads,
2. the lack of infrastructure and office space for private consultations,
3. a lack of recognition of healthcare workers taking on new designated roles in the mental healthcare system,
4. long-distance travel to the facility,
5. long waiting times,
6. uneasiness about confidentiality and privacy,
7. dissatisfaction with health workers,
8. a shortage of a task-sharing workforce (i.e., lay counsellors, primary healthcare workers and specialists) with mental health training,
9. inadequate compensation of lay counsellors for training and delivery of services that can affect counsellor motivation, and
10. weak referral processes.

This study also found a few similar barriers to those described in the literature. However, from exploring the views and experiences of the adolescents, counsellors, and the counsellor supervisor, I found unique barriers to their involvement in Project ASPIRE. Those included the weak and non-responsive referral pathway, the impact of the COVID-19 pandemic and the lack of mental health support for staff. In Project ASPIRE, inefficient and non-responsive pathways were a crucial barrier to ensuring the adolescents continued to receive the mental healthcare they needed when they moved beyond the care the counselling

programme provided to healthcare facilities and non-governmental organizations for further follow-up. Also, the difficulty in accessing mental health services once referred adds to the multiple deprivations that disadvantage adolescents from underprivileged and marginalized communities. Hence, the literature suggests that establishing strong and functional links between the counsellors and health facilities in the primary healthcare system might help ensure continuity and efficiency of care for patients, which the principal investigators of Project ASPIRE must consider implementing in future trials (Give et al., 2019). However, if this is challenging to achieve, it will be worthwhile to consider intersectoral partnerships or innovative approaches. That will prevent the perpetuation of inaccessible mental health provisions based on race and class (Cluver, 2020), which needs the advancement of social justice to bring necessary change to this circumstance.

The COVID-19 pandemic induced fear, uncertainty, and concern for many people worldwide and presented unprecedented challenges to the counselling programme. The shift from face-to-face counselling to telephonic sessions affected the therapeutic alliance between counsellors and adolescents before the pandemic. The programme should have performed formative research to assess the feasibility of shifting to delivering the intervention over the phone for adolescents. On the one hand, having the counsellors carry out the intervention telephonically was the best ethical way to move forward during the pandemic since the principal investigators wanted to keep the therapeutic relationships going. However, on the other hand, the multiple deprivations that many adolescents face in their lives, such as living in overcrowded homes with no private space to talk openly or cell phone, caused the counsellors to encounter unforeseeable issues with delivering the intervention over the phone. This study suggests that, while this was a necessary and inevitable shift during the COVID-19 pandemic, future studies should do careful formative research to identify all the difficulties that may hinder interactive, engaging, and responsive therapeutic relationships if researchers contemplate a move to telephonic or online counselling.

In keeping with the topic of mental health, the counsellor supervisor exhibited these behaviours that were central features of her imposter syndrome: Persistent anxiety about professional standards, fear of failure, and masking (Clance & Imes, 1978; Pedler, 2011; Sakulku, 2011). The new transitions she experienced from taking on the supervisor role caused her to succumb to this pervasive psychological experience of perceived professional inadequacy, doubting her leadership capabilities and supervisor-worthy skill set. In Project ASPIRE, there was an open-door policy, and both the counsellors and the counsellor supervisor had access to a supervisor. This study suggests that the principal investigators of

Project ASPIRE must provide professional and regular mental health support for the counsellors and the counsellor supervisor to identify and manage their psychological experiences and meet the demands of their jobs with healthy mental states.

Limitations, Alternatives, and Future Research

In the context of the pandemic, conducting online interviews with the counsellors and the counsellor supervisor and then engaging the adolescents in telephone interviews was the only way to continue the study. However, under other circumstances, I would have done these in person. Generally, conducting online interviews with the counsellors and the counsellor supervisor is a possible limitation of the study. There were connectivity problems that resulted in the study interviews taking longer than expected. The transmission delays between the connectivity networks often made it difficult to follow what the participant was saying or what I was saying, which caused us to repeat what we said because we did not hear one another well. Since the interviews were audio-recorded, I experienced data loss whereby the last 20 minutes of the interviews were "cut off" as though the audio did not get recorded or saved appropriately on the system software, which caused a great inconvenience. Then, I needed to schedule a second set of interviews to make up for the lost data.

Generally, conducting the interviews with the adolescents over the phone was another possible limitation of the study because they tended to be shorter than the online interviews. The adolescents and I often experienced network connectivity issues that made communication difficult. As a result, some adolescents sounded slightly annoyed and would give short answers to the questions with little to no depth. Also, I found it difficult to use visual prompts during the telephone interviews to assist me in the interviewing, especially with questions of a complex nature that one would need to read to understand better.

Given that I conducted these interviews online and telephonically, I could not observe and adjust in real-based time to visual and contextual cues that would be present in an in-person interview (Gittings et al., 2021). Furthermore, I could not include the visual and contextual cues on participants' quotes, which could have added another layer of meaning to the narratives participants conveyed in the research encounter. In future studies, it will be better to conduct face-to-face interviews than online or telephonic interviews. Face-to-face interviews will make for more accessible communication, in-depth answers, and visual prompts to assist with the interviewing. Also, it would be easier to ensure the capturing of non-verbal communication and contextual cues on participants' quotes to add another layer of meaning to the participants' narratives conveyed in the research encounter.

Since I conducted the adolescent interviews three months post-intervention, reliance on retrospective recall was another possible limitation of the study. There is a possibility that adolescents may have unintentionally forgotten certain aspects of their counselling experience from when they completed their baseline assessment to their last counselling session because of a lapse in their recall accuracy over a couple of months. Reliance on retrospective recall affected the findings of this study because the adolescents' narrations were not rich with detailed descriptions of their feelings, fluctuations, and situations they experienced when they participated in the counselling programme (Day & Thatcher, 2009). In future studies, it will be better to conduct interviews with the adolescents as soon as they complete their counselling sessions to have them recall their experiences with greater detail and accuracy.

Furthermore, while conducting the interviews, I focussed on asking questions that appeared strictly on the interview schedule instead of using it as a guide and letting the conversation flow. That potentially affected my ability to be present in the room and delve deep into some of the things that participants shared. Future studies could use an unstructured approach to the research interviews to allow for a deep exploration of participants' responses shared in the research encounter.

Also, since this is qualitative research and a small sample, the findings are not generalizable to all adolescents, counsellors, and supervisors in mental health interventions that task shift adolescent mental healthcare. This study only used eight adolescents out of 100 who participated in Project ASPIRE. These adolescents suffered from common mental health problems and indicated that participating in Project ASPIRE made a difference in their lives. Even though the eight adolescent participants do not represent all the adolescents who participated in Project ASPIRE, this study data suggests that services such as those offered by Project ASPIRE could make a difference. Thus, the National Health Department could consider rolling it out more widely.

Future research could consider exploring this work through alternative research using a post-colonial feminist lens. It may help empower participants to challenge the dominant discourses and structural oppressions that limited their beliefs, feelings and views about their mental health issues, context, and the challenging circumstances of their experiences in the counselling programme (Collins, 2000). Thus, it would be fitting to use post-colonial feminist theory as the theoretical framework. Also, the ethics of the study would need to change to further humanize the research encounter by enabling the researcher to establish participant-centred relationships in the research context and reimagine participants as co-researchers.

Thus, avoiding the colonial way of thinking that the locus of knowledge production lies with the researcher (Anderson, 2002; Collins, 2000).

Decolonial approaches challenge researchers to think differently about doing research. The principles of post-colonial feminist research endeavours involve: Centring the researcher's positionality to challenge the limitations of objectivism, exploring how race, gender and class relations influence political, economic, social, and cultural factors that shape participants' experiences and advancing social justice and equality would increase the understanding and awareness of intersecting factors that affect the counsellors, supervisor and adolescents experiences at the margins (Anderson, 2002; Collins, 2000; Deutsch, 2004; Donnelly & McKellin, 2007). Centring critical reflexivity and participants' voices in every stage of the research process while using a post-colonial feminist theory to ground mental health research's methodological, ontological, and epistemic traditions could be a worthwhile endeavour in doing research about the mental healthcare experiences of underprivileged and marginalized adolescents, the demands of meeting their mental health needs from the counsellors' perspectives and the supervisor's experience in Project ASPIRE (Matutu, 2019).

In this study, I followed a structured approach to the institutional standard ethical protocols that I learned at the university level. That was a possible limitation of this study because it regulated and disciplined me in doing research in particular ways. Reimagining the following standard ethical protocol: *Do no harm, informed consent, privacy and confidentiality, and beneficence*, in the context of a post-colonial feminist praxis, would have enabled me to manage things differently to humanize the interview experience further and enhance the quality of the findings through affirming participants' agency and voices to advance social justice.

Do no harm

I attached a list of counselling services which my participants could contact if they needed counselling services. That did not showcase genuine care for participants' well-being after engaging them in their experiences. The ethical challenge posed here was the management of established relationships with participants after data collection. So, it would have been better to have considered notifying the principal investigators when the interviews were going to take place and kindly asked them to have at least one counsellor or the counsellor supervisor on standby. If any participants needed counselling services from well-trained mental health workers after the research encounter, they could provide counselling to them immediately. Also, part of the management of relationships with participants is challenging the exploitative history of the discipline by scheduling check-ins with the

participants to ask them if any negative emotions ensued after the research encounter by asking these questions to reflect:

1. How was your experience of sharing with me today?
2. Do you have any immediate negative emotions and experiences that you might have felt during the research encounter?
3. Can you tell me how I could have improved the experience for you?
4. Would it have been different for you if I were a mental health counsellor?

As mentioned earlier, I have no counselling experience besides completing a counselling theory course at the postgraduate honours level. In preparation to humanize the research encounter further, it would have been beneficial to the participants had I refreshed the counselling skills and knowledge I gained from this course. It would have helped me manage any immediate negative emotions they might have felt during the interviews with care while talking about their experiences of overcoming mental health struggles, deprivation, exposure to direct violence, and other social ills.

Also, I did not plan a self-care routine for myself after hearing the stories that shaped the participants' experiences. Having a researcher's journal would have assisted with centring critical reflexivity as a continuous process by documenting my feelings about hearing participants' stories after each interview and making notes about any shifts in the dynamic of all my various study interviews. Also, having a reflexive journal would have formed another triangulation strategy to validate my interpretations. Moreover, it would have helped me reflect on how I felt about those hours I spent collecting data when my mother fell severely sick before passing away instead of being by her side to take care of her, just like my younger sister was doing at the time. Adding excerpts from such personal reflections could have brought forward my sadness, regrets, shame, confusion, frustrations, stress, and curiosity that I experienced at different moments in the interviews and after data collection that I cannot accurately recall now.

Informed consent

When conducting qualitative research, I was taught at the university level that a researcher completes the informed consent process before the interviews occur. Extending the consent process is not considered to check in with participants. In keeping with the humanizing framing, continuous and ongoing verbal consent throughout the research process

allows the researcher to constantly negotiate informed consent with participants, especially when they begin to share sensitive and personal details about their experiences.

Privacy and confidentiality

In the academy, we often assume participants want to remain anonymous in the writing up of results. In the research encounter, I did not ask participants whether they wanted to have their identity disclosed or remain anonymous in the results section of this research to permit them to make that decision.

Beneficence

Since the counsellors and the supervisor did not benefit directly, it could have been insightful to ask them what they thought they would gain from participating in the research. It would have helped to know their motivations for participating in this study to derive their interest in working for Project ASPIRE.

Recommendations for Project ASPIRE

Several findings suggested ways to strengthen the intervention for future trials. At the referral level, the principal investigators must establish a clearly defined referral protocol for severe cases to assist the counsellors and the supervisor in helping adolescents gain access effectively and efficiently to health facilities for further follow-up. Also, in task-shifting environments, it is vital to establish a functional referral pathway to ensure continuity and efficiency of care. Creating an integrated care pathway is a core element of implementing two-way communication and coordination between counsellors and health facilities to have an effective referral system (Give et al., 2019).

Since the counsellors raised the point that the non-governmental organizations used to refer adolescents experienced considerable backlogs, considering intersectoral partnerships may be a viable solution to ensure the adolescents receive continuous and efficient care once referred and regular feedback between health facilities and the counsellors (Give et al., 2019).

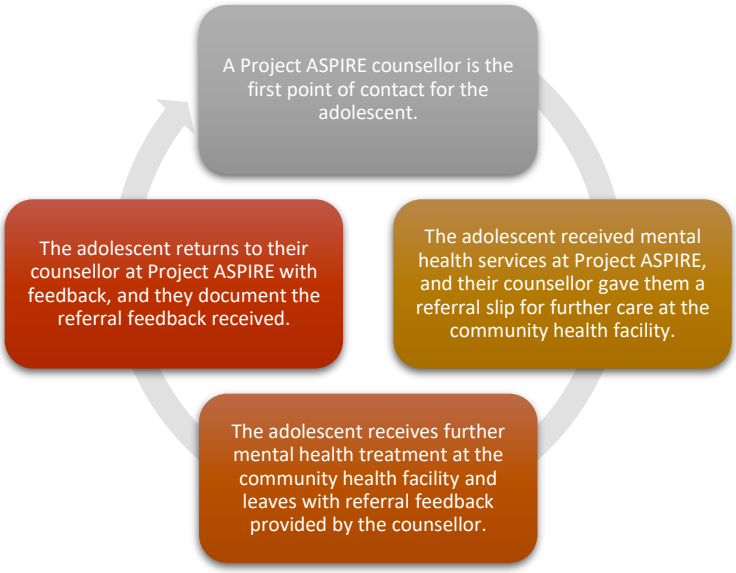
Multisectoral partnerships with organizations such as The South African College of Applied Psychology (SACAP) Foundation and the Trauma Clinic Foundation, among other mental health organizations in Cape Town, might be an opportunity to strengthen the referral pathway. It might enable the principal investigators to collaborate and negotiate to have access to their services to form part of the referral pathway of Project ASPIRE for future trials. The effectiveness of this referral system will depend on the capacity of their services and the framing of the dynamic relationships that will embed this referral network to facilitate a collaborative approach to enabling the adolescents, counsellors of Project ASPIRE and those of the partner organizations to work together (Give et al., 2019).

The suggested guidelines for establishing an integrated pathway of care for adolescents in Project ASPIRE are as follows: The counsellors of Project ASPIRE represent the first point of contact for the adolescents who participate in the trial. The adolescents receive mental health services provided by the registered counsellors of Project ASPIRE in their community-based settings and require further referral to healthcare facilities for further follow-up. Intersectoral partnerships with well-established mental health initiatives such as The SACAP Foundation and the Trauma Clinic Foundation might serve as an access point for further follow-up for adolescents with referrals. These organizations provide affordable and accessible mental health services at the community level (SACAP, 2022; The Trauma Clinic Foundation, n.d.). Therefore, forming intersectoral partnerships with these health facilities may promote the uptake of referrals to these health facilities through a community referral sub-system. Also, it will establish two-way communication and coordination between the counsellors and the health facilities to have an effective referral system (Give et al., 2019).

Below is a figure that represents how the interactions within the community referral sub-system might work:

Figure 3

Recommended Interactions of Key Stakeholders in the Referral Pathway



Ideally, when counsellors refer adolescents to social workers or other organizations for issues related to addressing the multiple deprivations they face in their lives, similar

interactions between the key stakeholders would be followed, as mentioned above. That will ensure the counsellors play an active role in helping the adolescents resolve these issues.

At the programme level, the adolescents revealed that the screening questions during the baseline assessment phase were triggering and uncomfortable to answer. To humanize the screening process, the principal investigators could introduce briefing sessions to give the adolescents relevant information and an immediate opportunity to ask questions about the contents the screening questions will cover beforehand and reiterate the purpose of the study. Also, the principal investigators could introduce debriefing sessions after completing the baseline assessment to mitigate the psychological distress adolescents might have felt answering the questions. Furthermore, the adolescents could be allowed to access counselling services from the counsellors or the supervisor if the debriefing sessions do not help reduce their psychological distress.

Further, it might be helpful to consider including trauma-informed counselling techniques alongside the MI-PST blended multicompetent counselling techniques because the counsellors revealed that adolescents face ongoing trauma exposure in their lives. Altering the focus of Project ASPIRE toward adding a trauma-informed approach to the counselling sessions will help to treat post-traumatic stress disorder or trauma-related symptoms of adolescents. There are many variations of trauma-informed therapies. Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a specific trauma-informed therapy that focuses on the emotional, behavioural, and cognitive functioning of children and adolescents between the ages of 3 and 18 (Cohen et al., 2010; Little & Akin-Little, 2019). The principal investigators would be able to adapt TF-CBT for the South African context as it is effective across different cultures (Allen & Johnson, 2012; Cohen et al., 2016; Weiner et al., 2009). Also, it is easy to individualize the counselling sessions using this approach as it considers the unique developmental needs of a child or adolescent in therapy. The primary goal of TF-CBT is to empower adolescents with the skills to manage the stress of being victimized and their reactions to reminders of traumatic events in their lives and help them move beyond those incidents (Cohen et al., 2010). TF-CBT is a multi-component-based model that uses psycho-education and teaches these adolescents relaxation techniques, emotional regulation skills, and cognitive coping strategies (Cohen et al., 2010). It would complement the empowering nature of the current use of the MI-PST counselling techniques in Project ASPIRE. Therapists Anthony Mannarino, Judith Cohen and Esther Deblinger initially developed TF-CBT for use with sexually abused children. However, in recent years, its scope

has expanded to effectively treat post-traumatic stress disorder symptoms, depression, anxiety and behavioural problems in children and adolescents (Cary & McMillen, 2012).

Although the patient handbook was a helpful counselling guide in the counselling sessions, it was unsuitable for adolescents with learning disabilities or low cognitive function, as the long texts led to them losing interest. Reimagining ways of engaging these adolescents in the patient handbook is necessary for future trials. Kim et al. (2017) conducted a research study on engaging adolescents with reading difficulties in a supplementary reading programme with many curricular activities to promote reading engagement and comprehension. Their study supported the hypothesis that behavioural engagement helps adolescents with learning disabilities or low cognitive function grow their reading skills (Kim et al., 2017).

Using this study as inspiration, the principal investigators can lean towards designing the counselling sessions to promote behavioural engagement instead of reading engagement. For example, the counsellors could use role-playing to foster competence in concepts and information in the handbook through contextualized scenarios with cartoon characterizations to draw their attention to it (Jamaludin et al., 2009). Also, the principal investigators could convert the content in the handbook to video or audio format to complement the role-plays. That will help the adolescents consume the information much quicker in digital format since adolescents nowadays spend less time reading books (van der Merwe, 2013). So, the handbook would then be supplementary to the counselling sessions. The idea would be to have the counsellors rely less on the patient handbook during the counselling sessions and instead rely more on role-plays and video formats to help adolescents consume the information better so that counsellors will not have to overextend themselves.

The majority of the adolescents expressed a preference to have longer durations of and more counselling sessions. The session lengths were four 45-minute counselling sessions for six weeks or a couple of months. Extending the session length to six hour-long counselling sessions over six weeks would be more or less appropriate for a brief psycho-social intervention, such as Project ASPIRE (American Psychological Association, 2017; Centre for Substance Abuse Treatment, 1999). That may allow the adolescents more time with the counsellors to delve deeper into the concepts and information in the handbook, achieve a more or less complete reduction of their mental health symptoms and build their self-efficacy in the skills needed to maintain treatment gains. Ideally, the colours used to identify the issues covered in each session would span over two sessions instead of one counselling session. So, the counsellors would cover a myriad of problems that the

adolescents are experiencing in their lives from the same colour group over two sessions. The counsellors would cover green group problems (i.e., day-to-day problems), purple group problems (i.e., troubling thoughts and feelings) and blue group problems (i.e., uncontrollable circumstances) for two sessions each in six weeks. In other words, participants in the intervention condition would have six MI-PST counselling sessions (or potentially six MI-PST and TF-CBT counselling sessions) to attend over six weeks. Also, this might alleviate the stress the counsellors had experienced because of 'time outs.' It would increase the number of sessions adolescents must complete within those six weeks to at least three sessions before their sessions are considered complete in the intervention.

The counsellors were exposed to violence in the communities while performing their patient-tracking duties, and the supervisor experienced imposter syndrome while working in Project ASPIRE. The provision of regular mental health support would have helped the counsellors and the supervisor to operate better under the exceptional circumstances, new transitions, and life events they experienced since the trial began in 2019. Moving forward, mental health support for the counsellors and the supervisor is needed to improve their mental health conditions and maintain good mental health throughout the trial (Presti et al., 2020).

Another solution to improve the mental health conditions of the counsellors and the supervisor would be to increase the workforce. The principal investigators can assign fieldworkers to perform the patient-tracking duties to eliminate this responsibility from the counsellor role since it disrupts their work schedules and exposes them to community violence. If this happens, the fieldworkers will need readily available mental health support when they begin to locate adolescents in the communities. That will help minimize their risk of gradually developing post-traumatic stress disorder and other mental health problems such as depression, anxiety and substance use disorder (Alden et al., 2008; Johnson, 2009) due to the exposure to community violence.

Furthermore, the supervisor suggested it would be helpful to appoint a native Xhosa-speaking supervisor full-time to work alongside her to reduce the high case volumes. Employing a supervisor bilingual in English and Xhosa would help to effectively perform fidelity checks on counselling sessions conducted in isiXhosa and provide constructive, detailed, and insightful feedback on those counselling sessions during supervision sessions. Also, it would mediate the current supervisor's limited understanding of the cultural context and expressions of sincerity and sensitivity towards adolescents' problems because of the language barrier and lack of cultural sensitivity training for the Xhosa population. If the principal investigators appoint the native Xhosa-speaking supervisor full-time, they may do

more work than the current appointed supervisor working part-time. So, the principal investigators would need to consider creating the same contractual appointments, whether full-time or part-time, so that they work the same number of hours and receive the same salary for the same amount of work completed to uphold equality. Upon this decision, the principal investigators would need to establish an induction programme for the supervisors to discuss protocols assigned for the role and get their input on them. Also, they would need to openly discuss their expectations and the format of the supervision sessions to help them settle into their new positions.

Lastly, there might be no other feasible solution to address the appointment availability issues the counsellors and adolescents experienced besides the counsellors would need to work around the adolescents' availability in future trials.

A way forward for adolescent mental healthcare at a national level and research endeavours

If our National Health Department is serious about adolescent mental healthcare, they need to appoint lay counsellors to deliver mental health services in the primary and mental healthcare systems. Mental health interventions such as Project ASPIRE help raise awareness and an understanding of the conditions to improve mental health services for adolescents. Project ASPIRE highlighted these conditions with the following considerations:

1. It is worthwhile moving mental health services beyond primary healthcare facilities to community-based settings to meet the mental health needs of adolescents.
2. It is beneficial to deploy registered and lay counsellors to meet the mental health needs of adolescents in community-based settings or public health facilities.
3. It is necessary to allocate an adequate budget to prioritize age-appropriate mental health services for adolescents to bridge the adolescent mental health service gap in South Africa (RSA DoH, 2022).

An agenda of advancing social justice is necessary to plan and implement age-appropriate mental health services for adolescents nationwide. In research endeavours, it is essential to incorporate the influence of race, class, gender, and historical, political, economic, social, and cultural relations in shaping adolescents' mental health conditions. Using a theoretical framework such as a post-colonial feminist perspective can help contextualize and conceptualize mental health research around adolescents' lived experiences (e.g., the multiple deprivations they face in their lives), beliefs and meanings of mental health

and illness. That will help mental health interventions to advance a decolonial social justice agenda to meet the mental health needs of adolescents.

Overall, there is still a long way toward reducing the number of adolescent mental health cases that go undiagnosed and untreated (Kessler et al., 2007) and the likelihood of adolescents developing mental disorders in adulthood and even in late adulthood (Kessler et al., 2005). It is "Not Yet Uhuru"[5] for marginalized Black adolescents. However, I believe there is still hope that they will have a sustainable future in South Africa by ensuring that service planners, researchers, policymakers, and healthcare providers take the right actions to meet their mental health needs.

Significance of Study

My research study drew from the ontological nature of investigating the delivery of adolescent mental health services by experienced, trained, and supervised counsellors to address the need for closing the mental health service gap for adolescents. I utilized a critical interpretivist view of the facilitators and barriers that shaped participants' experiences in Project ASPIRE by centring the narratives of the supervisor, counsellors, and adolescents to improve the conditions, structure, and design of the counselling programme for future trials. I hope that through doing this, my interpretation of the findings has produced a genuine representation of participants' experiences in Project ASPIRE. Also, I hope the recommendations have given direction for formulating a plan of action to promote social justice and equality.

All the factors in my analysis draw attention to the political, cultural, social, and economic conditions that influenced the outcomes of working and participating in Project ASPIRE for staff and adolescents. I hope that the principal investigators will consider the interconnectedness of these factors, their race, class and gender relations, and the participant's experiences, which gave rise to their circumstances.

Generally, my research study intended to support wide-ranging research and policy efforts to reduce the likelihood of mental health problems in adulthood and reduce the burden of disease in the country for a sustainable future. When it is published, my research study could inspire more studies by policymakers and researchers to increase knowledge production that focuses on the complexities of overcoming systemic barriers and inequities in the mental healthcare sector, especially in low-resource settings. Establishing public health

[5] "Not Yet Uhuru" is a song by Letta Mbulu written in 1998, Post-Apartheid South Africa, to describe how the emancipation of Black people has not come yet because of the many struggles they face in their lives despite the country being declared free.

forums for discussing the complex factors that influence adolescent mental health in low and middle-income countries can contribute to and influence considerations for implementation strategies with policymakers.

References

Adames, H. Y., Chavez-Dueñas, N. Y., Sharma, S., & La Roche, M. J. (2018). Intersectionality in psychotherapy: The experiences of an AfroLatinx queer immigrant. *Psychotherapy*, *55*(1), 73. https://doi.org/10.1037/pst0000152

Alden, L. E., Regambal, M. J., & Laposa, J. M. (2008). The effects of direct versus witnessed threat on emergency department healthcare workers: Implications for PTSD criterion A. *Journal of Anxiety Disorders*, *22*(8), 1337-1346. https://doi.org/10.1016/j.janxdis.2008.01.013

Allen, B., & Johnson, J. C. (2012). Utilization and implementation of trauma-focused cognitive–behavioural therapy for the treatment of maltreated children. *Child Maltreatment*, *17*(1), 80-85. https://doi.org/10.1177/1077559511418220

American Psychological Association. (2017). *How long will it take for treatment to work?* https://www.apa.org/ptsd-guideline/patients-and-families/length-treatment

Anderson, J. M. (2002). Toward a post-colonial feminist methodology in nursing research: Exploring the convergence of postcolonial and black feminist scholarship. *Nurse Researcher*, *9*, 7–27. https://doi.org/10.7748/nr2002.04.9.3.7.c6186

Asante, K. O., & Lentoor, A. G. (2017). Use of crystal methamphetamine among male adolescents in Cape Town, South Africa: Caregivers' experiences. *Substance Abuse Treatment, Prevention, and Policy*, *12*(1), 1-7. https://doi.org/10.1186/s13011-017-0102-9

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide*. Open University Press.

Baron, E. C., Davies, T., & Lund, C. (2017). Validation of the 10-item Centre for Epidemiological Studies Depression Scale (CES-D-10) in Zulu, Xhosa and Afrikaans populations in South Africa. *BioMedical Central Psychiatry*, *17*(1), 6. doi:10.1186/s12888-016-1178-x

Bateman, C. (2015). Mental health under-budgeting undermining SA's economy. *South African Medical Journal*, *105*(1), 7-8. doi: 10.7196/SAMJ.9166

Berrios, R., Totterdell, P., & Niven, K. (2015). Why do you make us feel good? Correlates and interpersonal consequences of affective presence in speed–dating. *European Journal of Personality*, *29*(1), 72-82. https://doi.org/10.1002/per.1944

Binder, P. E., Moltu, C., Hummelsund, D., Sagen, S. H., & Holgersen, H. (2011). Meeting an adult ally on the way out into the world: Adolescent patients' experiences of useful

psychotherapeutic ways of working at an age when independence really matters. *Psychotherapy Research, 21*(5), 554-566. https://doi.org/10.1080/10503307.2011.587471

Bourget, D., Gagné, P., & Wood, S. F. (2017). Dissociation: Defining the concept in criminal Forensic Psychiatry. *Journal of the American Academy of Psychiatry and the Law, 45*(2), 147–160.

Broom, A., & Willis, E. (2007). Competing paradigms and health research. In M. Saks & J. Allsop (Eds.), *Researching health: Qualitative, quantitative, and mixed methods* (pp. 16-30). Sage Publications.

Burns, J. K. (2011). The mental health gap in South Africa: A human rights issue. *The Equal Rights Review, 6*(99), 99-113.

Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioural therapy for use with children and youth. *Child and Youth Services Review, 34,* 748–757. doi:10.1016/j.childyouth.2012.01.003

Centre for Substance Abuse Treatment. (1999). "Brief interventions and brief therapies for substance abuse." *SAMHSA/CSAT Treatment Improvement Protocols.* Substance Abuse and Mental Health Services Administration.

Chibanda, D., Bowers, T., Verhey, R., Rusakaniko, S., Abas, M., Weiss, H. A., & Araya, R. (2015). The Friendship Bench programme: A cluster randomised controlled trial of a brief psychological intervention for common mental disorders delivered by lay health workers in Zimbabwe. *International Journal of Mental health Systems*, *9*(1), 21. https://doi.org/10.1186/s13033-015-0013-y

Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R., & Abas, M. A. (2011). Problem-solving therapy for depression and common mental disorders in Zimbabwe: Piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BioMedical Central Public Health, 11*(1), 828. https://doi.org/10.1186/1471-2458-11-828

Clance, P. R., & Imes, S. A. (1978). The imposter phenomenon in high achieving women: Dynamics and therapeutic intervention. *Psychotherapy: Theory, Research & Practice, 15*(3), 241. https://doi.org/10.1037/h0086006

Cluver, L. (2020). Solving the global challenge of adolescent mental ill-health. *The Lancet Child & Adolescent Health*, *4*(8), 556-557. https://doi.org/10.1016/S2352-4642(20)30205-4

Cluver, L., Boyes, M., Orkin, M., & Sherr, L. (2013). Poverty, AIDS, and child health: Identifying highest-risk children in South Africa. *South African Medical Journal*, *103*(12), 910-915. doi: 10.7196/SAMJ.7045

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2010). Trauma-focused cognitive-behavioural therapy for traumatized children. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 295–311). Guilford Press.

Cohen, J. A., Mannarino, A. P., Jankowski, K., Rosenberg, S., Kodya, S., & Wolford, G. L. (2016). A randomized implementation study of trauma-focused cognitive behavioural therapy for adjudicated teens in residential treatment facilities. *Child Maltreatment*, *21*(2), 156-167. https://doi.org/10.1177/1077559515624775

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the power of empowerment* (2nd ed.). Routledge.

Cope-Watson, G., & Betts, A. S. (2010). Confronting otherness: An e-conversation between doctoral students living with the imposter syndrome. *Canadian Journal for New Scholars in Education*, *3*(1).

Crawford, P., Brown, B., & Majomi, P. (2008). Education as an exit strategy for community mental health nurses: A thematic analysis of narratives. *Mental Health Review Journal*, *13*(3), 8 – 15. https://doi.org/10.1108/13619322200800017

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Crockett, J. (2012). There's nothing the*@#! wrong with me': Youth mental health and substance use in rural and remote Australia and the potential role of school-based interventions. *Youth Studies Australia*, *31*(1), 53-59.

Davison, K. G. (2007). Methodological instability and the disruption of masculinities. *Men and Masculinities*, *9*(3), 379-391. https://doi.org/10.1177/1097184X05284995

Dawes, A., Bray, R., & van der Merwe, A. (2007). *Monitoring child well-being: A South African rights-based approach*. Human Sciences Research Council Press.

Day, M., & Thatcher, J. (2009). “I'm really embarrassed that you're going to read this…”: Reflections on using diaries in qualitative research. *Qualitative Research in Psychology*, *6*(4), 249-259. https://doi.org/10.1080/14780880802070583

de Haan, A. M., Boon, A. E., de Jong, J. T., Hoeve, M., & Vermeiren, R. R. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health

care. *Clinical Psychology Review, 33*(5), 698–711. https://doi.org/10.1016/j.cpr.2013.04.005

Deutsch, N. (2004). Positionality and the pen: Reflections on the process of becoming a feminist researcher and writer. *Qualitative Inquiry, 10*(6), 885–902. https://doi.org/10.1177/1077800404265723

Diamond, G., Godley, S. H., Liddle, H. A., Sampl, S., Webb, C., Tims, F. M., & Meyers, R. (2002). Five outpatient treatment models for adolescent marijuana use: A description of the Cannabis Youth Treatment Interventions. *Addiction, 97,* 70-83. https://doi.org/10.1046/j.1360-0443.97.s01.3.x

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40,* 314-321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation, 35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Donnelly, T. T., & McKellin, W. (2007). Keeping healthy! Whose responsibility is it anyway? Vietnamese Canadian women and their healthcare providers' perspectives. *Nursing Inquiry, 14*(1), 2–12. https://doi.org/10.1111/j.1440-1800.2007.00347.x

Dowdall, N., Murray, L., Skeen, S., Marlow, M., De Pascalis, L., Gardner, F., Tomlinson, M., & Cooper, P. J. (2021). Book-sharing for parenting and child development in South Africa: A randomized controlled trial. *Child Development, 92*(6), 2252-2267. https://doi.org/10.1111/cdev.13619

Eisenkraft, N., & Elfenbein, H. A. (2010). The way you make me feel: Evidence for individual differences in affective presence. *Psychological Science, 21*(4), 505-510. https://doi.org/10.1177/0956797610364117

Ellen, M. E., Wilson, M. G., Vélez, M., Shach, R., Lavis, J. N., Grimshaw, J. M., Moat, K. A., & Synthesis Working Group. (2018). Addressing overuse of health services in health systems: A critical interpretive synthesis. *Health Research Policy and Systems, 16*(48), 1-14. https://doi.org/10.1186/s12961-018-0325-x

Enaifoghe, A., Dlelana, M., Durokifa, A. A., & Dlamini, N. P. (2021). The prevalence of gender-based violence against women in South Africa: A call for action. *African Journal of Gender, Society & Development, 10*(1), 117. https://hdl.handle.net/10520/ejc-aa_jgida1-v10-n1-a6

Etheridge, J. (2019, September 12). *Murder Stats: 6 out of 10 worst murder areas in Cape Town – and Nyanga remains murder capital.* News24.

https://www.news24.com/news24/SouthAfrica/News/murder-stats-6-out-of-10-worst-murder-areas-in-cape-town-and-nyanga-remains-murder-capital-20190912

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1-4. doi: 10.11648/j.ajtas.20160501.11

Everall, R. D., & Paulson, B. L. (2002). The therapeutic alliance: Adolescent perspectives. *Counselling and Psychotherapy Research, 2*(2), 78–87. doi: 10.1080/14733140212331384857

Flannelly, K. J., Flannelly, L. T., & Jankowski, K. R. (2018). Threats to the internal validity of experimental and quasi-experimental research in healthcare. *Journal of Health Care Chaplaincy*, *24*(3), 107-130. https://doi.org/10.1080/08854726.2017.1421019

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BioMedical Central Health Services Re search, 18*(1). https://doi.org/10.1186/s12913-018-2915-2

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framewor k method for the analysis of qualitative data in multi-disciplinary health research. *Bi oMedical Central Medical Research Methodology*, *13*(1), 1-8. https://doi.org/10.118 6/1471-2288-13-117

Gibson, K., & Cartwright, C. (2013). Agency in young clients' narratives of counselling: "It's whatever you want to make of it". *Journal of Counselling Psychology*, *60*(3), 340–352. https://doi.org/10.1037/a0033110

Gibson, K., Cartwright, C., Kerrisk, K., Campbell, J., & Seymour, F. (2016). What young people want: A qualitative study of adolescents' priorities for engagement across psychological services. *Journal of Child and Family Studies, 25*(4), 1057–1065. doi: 10.1007/s10826-015-0292-6

Gittings, L., Toska, E., Medley, S., Cluver, L., Logie, C. H., Ralayo, N., Chen, J., & Mbithi-Dikgole, J. (2021). 'Now my life is stuck!': Experiences of adolescents and young people during COVID-19 lockdown in South Africa. *Global Public Health*, *16*(6), 947-963. https://doi.org/10.1080/17441692.2021.1899262

Give, C., Ndima, S., Steege, R., Ormel, H., McCollum, R., Theobald, S., Taegtmeyer, M., Kok, M., & Sidat, M. (2019). Strengthening referral systems in community health programs: A qualitative study in two rural districts of Maputo Province,

Mozambique. *BioMedical Central Health Services Research, 19*(1), 1-11. https://doi.org/10.1186/s12913-019-4076-3

Gold, J. H. (2004). Reflections on psychodynamic psychotherapy supervision for psychiatrists in clinical practice. *Journal of Psychiatric Practice, 10*(3), 162-169. https://doi.org/10.1097/00131746-200405000-00004

Goodwin, J., Savage, E., & Horgan, A. (2016). Adolescents' and young Adults' beliefs about mental health services and care: A systematic review. *Archives of Psychiatric Nursing, 30*(5), 636-644. https://doi.org/10.1016/j.apnu.2016.04.004

Gore, F. M., Bloem, P. J., Patton, G. C., Ferguson, J., Joseph, V., Coffey, C., Sawyer, S. M., & Mathers, C. D. (2011). Global burden of disease in young people aged 10–24 years: A systematic analysis. *The Lancet, 377*(9783), 2093-2102. https://doi.org/10.1016/s0140-6736(11)60512-6

Govender, K., Cowden, R. G., Asante, K. O., George, G., & Reardon, C. (2019). Sexual risk behaviour: A multi-system model of risk and protective factors in South African adolescents. *Prevention Science, 20*(7), 1054-1065. https://doi.org/10.1007/s11121-019-01015-3

Guinta, M. R., & John, R. M. (2018). Social media and adolescent health. *Pediatric Nursing, 44*(4), 196-201.

Health Professionals Council of South Africa [HPCSA]. (2019). *Policy regarding registered counsellors: Framework for education, training, registration, and scope of registered counsellors.* https://www.hpcsa.co.za/Uploads/PSB_2019/Form%20258%20%20Registered%20Counsellor%20-%20Framework%20for%20Education%2CTraining%20%2CRegistration%20and%20Scope%20of%20Registered%20Counsellors%20.pdf

Heller, D. J., Kumar, A., Kishore, S. P., Horowitz, C. R., Joshi, R., & Vedanthan, R. (2019). Assessment of barriers and facilitators to the delivery of care for noncommunicable diseases by nonphysician health workers in low-and middle-income countries: a systematic review and qualitative analysis. *JAMA Network Open, 2*(12), e1916545-e1916545. doi:10.1001/jamanetworkopen.2019.16545

Humeniuk, R., Holmwood, C., Beshara, M., & Kambala, A. (2016). ASSIST-Y V1.0: First-stage development of the WHO Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and linked brief intervention for young people. *Journal of Child & Adolescent Substance Abuse, 25*(4), 384-390.

Hydén, M. (2014). The teller-focused interview: Interviewing as a relational practice. *Qualitative Social Work*, *13*(6), 795-812. https://doi.org/10.1177/1473325013506247

Ito, H. (2013). What should we do to improve patients' adherence? *Journal of Experimental & Clinical Medicine*, *5*(4), 127-130. https://doi.org/10.1016/j.jecm.2013.05.001

Jacobs, Y., Myers, B., van der Westhuizen, C., Brooke-Sumner, C., & Sorsdahl, K. (2021). Task sharing or task dumping: Counsellors experiences of delivering a psychosocial intervention for mental health problems in South Africa. *Community Mental Health Journal*, *57*(6), 1082-1093. https://doi.org/10.1007/s10597-020-00734-0

Jamaludin, A., San Chee, Y., & Ho, C. M. L. (2009). Fostering argumentative knowledge construction through enactive role play in Second Life. *Computers & Education*, *53*(2), 317-329. https://doi.org/10.1016/j.compedu.2009.02.009

Johnson, S. L. (2009). Assessing and diagnosing posttraumatic stress disorder. In S. L. Sharon (Ed.), *Therapist's guide to posttraumatic stress disorder intervention* (pp. 1 - 69). Academic Press. https://doi.org/10.1016/B978-0-12-374851-5.00001-9

Kessler, R. C., Angermeyer, M., Anthony, J. C., De Graaf, R., Demyttenaere, K., Gasquet, I., De Girolamo, G., Gluzman, S., Gureje, O., Haro, J. M., Kawakami, N., Karam, A., Levinson, D., Medina Mora, M. E., Oakley Browne, M. A., Posada-Villa, J., Stein, D. J., Adley Tsang, C. H., Aguilar-Gaxiola, S., … Ustün, T. B. (2007). Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*, *6*(3), 168.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 593-602. doi:10.1001/archpsyc.62.6.593

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Rohde, L. A., Srinath, S., Ulkuer, N., & Rahman, A. (2011). Child and adolescent mental health worldwide: Evidence for action. *The Lancet*, *378*(9801), 1515-1525. https://doi.org/10.1016/S0140-6736(11)60827-1

Kilpatrick, D. G., Acierno, R., Saunders, B., Resnick, H. S., Best, C. L., & Schnurr, P. P. (2000). Risk factors for adolescent substance abuse and dependence: Data from a national sample. *Journal of Consulting and Clinical Psychology, 68*(1), 19–30. https://doi.org/10.1037/0022-006X.68.1.19

Kim, J. S., Hemphill, L., Troyer, M., Thomson, J. M., Jones, S. M., LaRusso, M. D., & Donovan, S. (2017). Engaging struggling adolescent readers to improve reading skills. *Reading research quarterly*, *52*(3), 357-382. https://doi.org/10.1002/rrq.171

Kleintjes, S., Flisher, A. J., Fick, M., Railoun, A., Lund, C., Molteno, C., & Robertson, B. A. (2006). The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa. *African Journal of Psychiatry*, *9*(3), 157-160. http://dx.doi.org/10.4314/ajpsy.v9i3.30217

Kohrt, B. A., Jordans, M. J., Rai, S., Shrestha, P., Luitel, N. P., Ramaiya, M. K., Singla, D. R., & Patel, V. (2015). Therapist competence in global mental health: Development of the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale. *Behaviour Research and Therapy*, *69*, 11-21. doi: 10.1016/j.brat.2015.03.009

LaDonna, K. A., Ginsburg, S., & Watling, C. (2018). "Rising to the level of your incompetence": What physicians' self-assessment of their performance reveals about the imposter syndrome in medicine. *Academic Medicine*, *93*(5), 763-768. https://doi.org/10.1097/ACM.0000000000002046

Larson, L. M., & Daniels, J. A. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist*, *26*(2), 179-218. https://doi.org/10.1177/0011000098262001

Lavik, K. O., Veseth, M., Frøysa, H., Binder, P. E., & Moltu, C. (2018). What are "good outcomes" for adolescents in public mental health settings?. *International Journal of Mental Health Systems*, *12*(1), 1-10. https://doi.org/10.1186/s13033-018-0183-5

Liebowitz, J. (2000). Knowledge management receptivity at a major pharmaceutical company. *Journal of Knowledge Management*, *4*(3), 252–258. doi:10.1108/13673270010350057

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Program Evaluation*, *1986*(30), 73-84. https://doi.org/10.1002/ev.1427

Little, S. G., & Akin-Little, A. (2019). Trauma-focused cognitive behaviour therapy. In S. G. Little & A. Akin-Little (Eds.), *Behavioral interventions in schools: Evidence-based positive strategies* (2nd ed., pp. 393–402). American Psychological Association. https://doi.org/10.1037/0000126-021

Lovgren, A., Rossberg, J. I., Nilsen, L., Engebretsen, E., & Ulberg, R. (2019). How do adolescents with depression experience improvement in psychodynamic psychotherapy? A qualitative study. *BioMedical Central Psychiatry*, *19*, 95. doi: 10.1186/s12888-019-2080-0

Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., Swartz, L., & Patel, V. (2010a). Poverty and common mental disorders in low- and middle-income countries: A systematic review. *Social Science & Medicine*, *71*(3), 517-528. https://doi.org/10.1016/j.socscimed.2010.04.027

Lund, C., the MHaPP Research Programme Consortium. Kleintjes, S., Cooper, S., Petersen, I., Bhana, A., & Flisher, A. J. (2011). Challenges facing South Africa's mental health care system: Stakeholders' perceptions of causes and potential solutions. *International Journal of Culture and Mental Health*, *4*(1), 23-38. https://doi.org/10.1080/17542863.2010.503039

Lund, C., the MHaPP Research Programme Consortium. Kleintjes, S., Kakuma, R., & Flisher, A. J. (2010b). Public sector mental health systems in South Africa: Inter-provincial comparisons and policy implications. *Social Psychiatry and Psychiatric Epidemiology*, *45*(3), 393-404. doi: 10.1007/s00127-009-0078-5

Matutu, H. (2019). "On the way to Calvary, I lost my way": Navigating ethical quagmires in community psychology at the margins. In F. Boonzaier & T. van Niekerk (Eds.), *Decolonial feminist community psychology* (pp. 111-128). Springer, Cham. https://doi.org/10.1007/978-3-030-20001-5_8

McBain, R., Salhi, C., Morris, J. E., Salomon, J. A., & Betancourt, T. S. (2012). Disease burden and mental health system capacity: WHO Atlas study of 117 low-and middle-income countries. *The British Journal of Psychiatry*, *201*(6), 444-450. https://doi.org/10.1192/bjp.bp.112.112318

Mendenhall, E., De Silva, M. J., Hanlon, C., Petersen, I., Shidhaye, R., Jordans, M., Luitel, N., Ssebunnya, J., Fekadu, A., Patel, V., Tomlinson, M., & Lund, C. (2014). Acceptability and feasibility of using non-specialist health workers to deliver mental health care: Stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda. *Social Science & Medicine*, *118*, 33-42. https://doi.org/10.1016/j.socscimed.2014.07.057

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Sage Publications.

Miller, T., Birch, M., Mauthner, M., & Jessop, J. (2012). *Ethics in qualitative research.* Sage Publications.

Mokitimi, S., Schneider, M., & de Vries, P. J. (2022). A situational analysis of child and adolescent mental health services and systems in the Western Cape Province of South

Africa. *Child and Adolescent Psychiatry and Mental Health*, *16*(1), 1-22. https://doi.org/10.1186/s13034-022-00440-7

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research, 25*(9), 1212-1222. https://doi.org/10.1177/1049732315588501

Munodawafa, M., Lund, C., & Schneider, M. (2017). A process evaluation exploring the lay counsellor experience of delivering a task shared psycho-social intervention for perinatal depression in Khayelitsha, South Africa. *BioMedical Central Psychiatry*, *17*(1), 236. https://doi.org/10.1186/s12888-017-1397-9

Murphey, D., Vaughn, B., & Barry, M. (2013). Adolescent health highlight: Access to mental health care. *Child Trends, 21*(2), 1-5. https://doi.org/10.1037/e538172013-001

Musakwa, N. O., Bor, J., Nattey, C., Lönnermark, E., Nyasulu, P., Long, L., & Evans, D. (2021). Perceived barriers to the uptake of health services among first-year university students in Johannesburg, South Africa. *Public Library of Science One*, *16*(1), e0245427. https://doi.org/10.1371/journal.pone.0245427

Myers, B., Lund, C., Lombard, C., Joska, J., Levitt, N., Butler, C., Cleary, S., Naledi, T., Milligan, P., Stein, D. J., & Sorsdahl, K. (2018). Comparing dedicated and designated models of integrating mental health into chronic disease care: Study protocol for a cluster randomized controlled trial. *Trials*, *19*(1), 1-13. https://doi.org/10.1186/s13063-018-2568-9

Naar, S., & Safren, S. A. (2017). *Motivational interviewing and CBT: Combining strategies for maximum effectiveness*. Guilford Publications.

Ned, L., Tiwari, R., Buchanan, H., van Niekerk, L., Sherry, K., & Chikte, U. (2020). Changing demographic trends among South African occupational therapists: 2002 to 2018. *Human Resources for Health*, *18*(1), 1-12. https://doi.org/10.1186/s12960-020-0464-3

Nkhalamba, L., Rylance, S., Muula, A. S., Mortimer, K., & Limbani, F. (2021). Task-shifting to improve asthma education for Malawian children: A qualitative analysis. *Human Resources for Health*, *19*(1), 1-8. https://doi.org/10.1186/s12960-021-00576-1

O'Keeffe, S., Martin, P., Target, M., & Midgley, N. (2019). 'I just stopped going': A mixed methods investigation into types of therapy dropout in adolescents with depression. *Frontiers in Psychology, 10*, 75. doi: 10.3389/fpsyg.2019.00075

Okyere, E., Mwanri, L., & Ward, P. (2017). Is task-shifting a solution to the health workers' shortage in Northern Ghana?. *Public Library of Science One*, *12*(3), e0174631.

Padmanabhanunni, A., Jackson, K., Noordien, Z., Pretorius, T. B., & Bouchard, J. P. (2022). Characterizing the nature of professional training and practice of psychologists in South Africa. *Annales Médico-psychologiques, Revue Psychiatrique*, *180*(4), 360 – 365. https://doi.org/10.1016/j.amp.2022.02.012

Patel, V., Weiss, H. A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S., De Silva, M. J., Bhat, B., Araya, R., King, M., Simon, G., Verdeli, H., & Kirkwood, B. R. (2010). Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): A cluster randomised controlled trial. *The Lancet*, *376*(9758), 2086-2095. doi:10.1016/S0140-6736(10)61508-5

Pedler, M. (2011). Leadership, risk, and the imposter syndrome. *Action Learning: Research and Practice*, *8*(2), 89–91. doi: 10.1080/14767333.2011.581016

Petersen, I., Hancock, J. H., Bhana, A., & Govender, K. (2014). A group-based counselling intervention for depression comorbid with HIV/AIDS using a task-shifting approach in South Africa: A randomized controlled pilot study. *Journal of Affective Disorders, 158*, 78-84. doi: 10.1016/j.jad.2014.02.013 0165-0327

Petersen, I., Lund, C., & Stein, D. J. (2011). Optimizing mental health services in low-income and middle-income countries. *Current Opinion in Psychiatry*, *24*(4), 318-323. doi: 10.1097/YCO.0b013e3283477afb

Petersen, I., Swartz, L., Bhana, A., & Flisher, A. J. (2010). Mental health promotion initiatives for children and youth in contexts of poverty: The case of South Africa. *Health Promotion International*, *25*(3), 331-341. https://doi.org/10.1093/heapro/daq026

Petty, N. J., Thomson, O. P., & Stew, G. (2012). Ready for a paradigm shift? Part 2: Introducing qualitative research methodologies and methods. *Manual Therapy*, *17*(5), 378-384. https://doi.org/10.1016/j.math.2012.03.004

PettyJohn, M. E., Tseng, C. F., & Blow, A. J. (2020). Therapeutic utility of discussing therapist/client intersectionality in treatment: When and how? *Family Process*, *59*(2), 313-327. https://doi.org/10.1111/famp.12471

Presti, G., Dal Lago, B., Fattori, A., Mioli, G., Moderato, P., Sciaretta, L., & Costantino, M. A. (2020). Mental health support to staff in a major hospital in Milan (Italy) during the COVID-19 pandemic: A framework of actions. *General Psychiatry*, *33*(4). doi: 10.1136/gpsych-2020-100244

Qin, D. (2016). Positionality. In N. A. Naples (Ed.), *The Wiley Blackwell encyclopedia of gender and sexuality studies* (pp. 1-2). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781118663219.wbegss619

Ramaswamy, S., Sagar, J. V., & Seshadri, S. (2022). A transdisciplinary public health model for child and adolescent mental healthcare in low-and middle-income countries. *The Lancet Regional Health - Southeast Asia*, 100024. https://doi.org/10.1016/j.lansea.2022.100024.

Rehle, T., Shisana, O., Pillay, V., Zuma, K., Puren, A., & Parker, W. (2007). National HIV incidence measures - new insights into the South African epidemic. *South African Medical Journal, 97*(3), 194-199. https://doi.org/10.2989/16085906.2016.1153491

Republic of South Africa [RSA]. (2002). *Mental Health Care Act, No. 17 of 2002.* Government Printers.

Riessman, C. K. (2001). Analysis of personal narratives. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research* (pp. 168-191). Columbia University Press.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage Publications.

Riper, H., Andersson, G., Hunter, S. B., de Wit, J., Berking, M., & Cuijpers, P. (2014). Treatment of comorbid alcohol use disorders and depression with cognitive-behavioural therapy and motivational interviewing: A meta-analysis. *Addiction, 109*(3), 394-406. https://doi.org/10.1111/add.12441

Rocha, T. I. U., Aschar, S. C. D. A. L., Hidalgo-Padilla, L., Daley, K., Claro, H. G., Martins Castro, H. C., Dos Santos, D. V. C., Miranda, J. J., Araya, R., & Menezes, P. R. (2021). Recruitment, training and supervision of nurses and nurse assistants for a task-shifting depression intervention in two RCTs in Brazil and Peru. *Human Resources for Health, 19*(1), 1-7. https://doi.org/10.1186/s12960-021-00556-5

RSA Department of Health [DoH]. (2003). *Policy guidelines: Child and adolescent mental health.* Government Printer.

RSA Department of Justice and Constitutional Development. (1996). Chapter 2: Bill of Rights. *Constitution of the Republic of South Africa*. Government Printers.

RSA DoH. (2013). *National Mental Health Policy Framework and Strategic Plan (2013-2020).* Government Printers.

RSA DoH. (2019). *National Health Insurance Bill, No. 42598 of 26 July 2019.* Government Printers.

RSA DoH. (2020). *South African good clinical practice: Clinical trial guidelines.* Government Printers.

RSA DoH. (2022). *Minister Joe Phaahla: Health Department Budget Vote 2022/23.* https://www.gov.za/speeches/minister-joe-phaahla-health-dept-budget-vote-202223-10-may-2022-0000

Russell, M., Cupp, P. K., Jewkes, R. K., Gevers, A., Mathews, C., LeFleur-Bellerose, C., & Small, J. (2014). Intimate partner violence among adolescents in Cape Town, South Africa. *Prevention Science*, *15*(3), 283-295. https://doi.org/10.1007/s11121-013-0405-7

SACAP. (2022). *Social Impact.* https://www.sacap.edu.za/about/social-impact/

Sagen, S. H., Hummelslund, D., & Binder, P. E. (2013). Feeling accepted: A phenomenological exploration of adolescent patients' experiences of the relational qualities that enable them to express themselves freely. *European Journal of Psychotherapy & Counselling*, *15*(1), 53–75. doi: 10.1080/13642537.2013.763467

Sakulku, J. (2011). The impostor phenomenon. *The Journal of Behavioral Science*, *6*(1), 75–97. https://doi.org/10.14456/ijbs.2011.6

Salkind, N. J. (2010). *Encyclopedia of research design*. Sage Publications.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893-1907. https://doi.org/10.1007/s11135-017-0574-8

Savahl, S., Adams, S., Isaacs, S., September, R., Hendricks, G., & Noordien, Z. (2015). Subjective well-being amongst a sample of South African children: A descriptive study. *Child Indicators Research*, *8*(1), 211-226. https://doi.org/10.1007/s12187-014-9289-8

Schaaf, M., & Topp, S. M. (2019). A critical interpretive synthesis of informal payments in maternal health care. *Health Policy and Planning*, *34*(3), 216-229. https://doi.org/10.1093/heapol/czz003

Schou, L., Høstrup, H., Lyngsø, E. E., Larsen, S., & Poulsen, I. (2012). Validation of a new assessment tool for qualitative research articles. *Journal of Advanced Nursing*, *68*(9), 2086-2094. https://doi.org/10.1111/j.1365-2648.2011.05898.x

Seedat, M., van Niekerk, A., Jewkes, R., Suffla, S., & Ratele, K. (2009). Violence and injuries in South Africa: Prioritising an agenda for prevention. *The Lancet*, *374*(9694), 1011-1022. https://doi.org/10.1016/S0140-6736(09)60948-X

Skeen, S., Macedo, A., Tomlinson, M., Hensels, I. S., & Sherr, L. (2016). Exposure to violence and psychological well-being over time in children affected by HIV/AIDS in

South Africa and Malawi. *AIDS Care*, *28*(sup1), 16-25. https://doi.org/10.1080/09540121.2016.1146219

Sorsdahl, K., Myers, B., Ward, C. L., Matzopoulos, R., Mtukushe, B., Nicol, A., Cuijpers, P., & Stein, D. J. (2014). Adapting a blended motivational interviewing and problem-solving intervention to address risky substance use amongst South Africans. *Psychotherapy Research*, *25*(4), 435-444. https://doi.org/10.1080/10503307.2014.897770

Sorsdahl, K., Stein, D. J., Corrigall, J., Cuijpers, P., Smits, N., Naledi, T., & Myers, B. (2015). The efficacy of a blended motivational interviewing and problem solving therapy intervention to reduce substance use among patients presenting for emergency services in South Africa: A randomized controlled trial. *Substance Abuse Treatment, Prevention, and Policy*, *10*(1), 1-10. https://doi.org/10.1186/s13011-015-0042-1

Sorsdahl, K., van der Westhuizen, C., Neuman, M., Weiss, H. A., & Myers, B. (2021). Addressing the mental health needs of adolescents in South African communities: A protocol for a feasibility randomized controlled trial. *Pilot and Feasibility Studies*, *7*(1), 1-14. https://doi.org/10.1186/s40814-021-00803-5

South African Depression and Anxiety Group. (2020, February 11). *Curbing teen suicide in South Africa.* http://www.sadag.org/index.php?option=com_content&view=article&id=816:curbing-teen-suicide-in-south-africa&catid=94&Itemid=132

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *80*(4), 547. doi: 10.1037/a0028226

Tanner, C. A., Benner, P., Chesla, C., & Gordon, D. R. (1993). The phenomenology of knowing the patient. *Image: The Journal of Nursing Scholarship*, *25*(4), 273-280. https://doi.org/10.1111/j.1547-5069.1993.tb00259.x

Terre Blanche, M. T., Durrheim, K., & Painter, D. (Eds.). (2006). *Research in practice: Applied methods for the Social Sciences*. Juta and Company Ltd.

Tomlinson, M., Kleintjes, S., & Lake, L. (Eds.). (2022). *South African child gauge 2021/2022.* Children's Institute, University of Cape Town.

The Trauma Clinic Foundation. (n.d.). *About* [LinkedIn Page]. LinkedIn. Retrieved, 11 June 2022, from https://www.linkedin.com/company/the-traumaclinic-foundation/about/

U.S. Department of Health and Human Services. (2019). Chapter 1. *Clinical Supervision and Professional Development of the Substance Abuse Counselor, A Treatment Improvement Protocol (TIP) Series, No. 52.* Lulu Press.

van der Merwe, P. (2013). South Africa's adolescents in a wired world. *International Journal of Criminology and Sociology*, *2*, 348-361. https://doi.org/10.6000/1929-4409.2013.02.33

van Horn, P., & Lieberman, A. F. (2011). Psychological impact on and treatment of children who witness domestic violence. In C. Jenny (Ed.), *Child Abuse and Neglect* (pp. 501-515). W. B. Saunders. https://doi.org/10.1016/B978-1-4160-6393-3.00052-X

van Niekerk, T. J., & Boonzaier, F. A. (2019). An intersectional analysis of responses to intimate partner violence in two marginalised South African communities. *International Journal of Child, Youth and Family Studies*, *10*(1), 26-48. doi: 10.18357/ijcyfs101201918805

Vasquez, M. J. (1992). Psychologist as clinical supervisor: Promoting ethical practice. *Professional Psychology: Research and Practice, 23*(3), 196 - 202. https://doi.org/10.1037/0735-7028.23.3.196

Ward, C., & Dawes, A. (2012). *Youth Violence: Sources and Solutions in South Africa*. University of Cape Town Press.

Ward, C. L., Artz, L., Leoschut, L., Kassanjee, R., & Burton, P. (2018). Sexual violence against children in South Africa: A nationally representative cross-sectional study of prevalence and correlates. *The Lancet Global Health*, *6*(4), e460-e468. https://doi.org/10.1016/S2214-109X(18)30060-3

Wassenaar, D. (2006). Ethical issues in Social Science research. In M. Terre Blanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the Social Sciences* (pp. 60-79). Juta & Company Ltd.

Weiner, D. A., Schneider, A., & Lyons, J. S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review, 31,* 1199–1205. doi:10.1016/j.childyouth.2009.08.013

Wheeler, R. L., & Gabbert, F. (2017). Using self-generated cues to facilitate recall: A narrative review. *Frontiers in Psychology*, *8*, 1830. https://doi.org/10.3389/fpsyg.2017.01830

WHO. (2007a). *WHO-Assessment Instrument for Mental Health Systems report on mental health system in South Africa*.

https://www.who.int/mental_health/evidence/south_africa_who_aims_report.pdf?ua=1

WHO. (2007b). Task shifting: Rational redistribution of tasks among health workforce teams: Global recommendations and guidelines. WHO Press.

WHO. (2013). Mental Health Action Plan 2013–2020. WHO Press.

WHO. (2014). *Adolescence: A period needing special attention.* https://apps.who.int/adolescent/second-decade/section2/page1/recognizing-adolescence.html

WHO. (2016). *mhGAP intervention guide version 2.0. for mental, neurological and substance use disorders in non-specialized health care settings.* https://www.who.int/publications/i/item/9789241549790

WHO. (2017). *Mental health ATLAS 2017 member state profile.* https://www.who.int/mental_health/evidence/atlas/profiles-2017/ZAF.pdf?ua=1

World Health Organization [WHO]. (2019). *Adolescent mental health.* https://apps.who.int/adolescent/second-decade/section2/page1/recognizing-adolescence.html

World Medical Association. (2013). World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. *Jama*, *310*(20), 2191-2194. doi: 10.1001/jama.2013.281053

Yasamy, M. T., Maulik, P. K., Tomlinson, M., Lund, C., Van Ommeren, M., & Saxena, S. (2011). Responsible governance for mental health research in low resource countries. *Public Library of Science Medicine*, *8*(11). https://doi.org/10.1371/journal.pmed.1001126

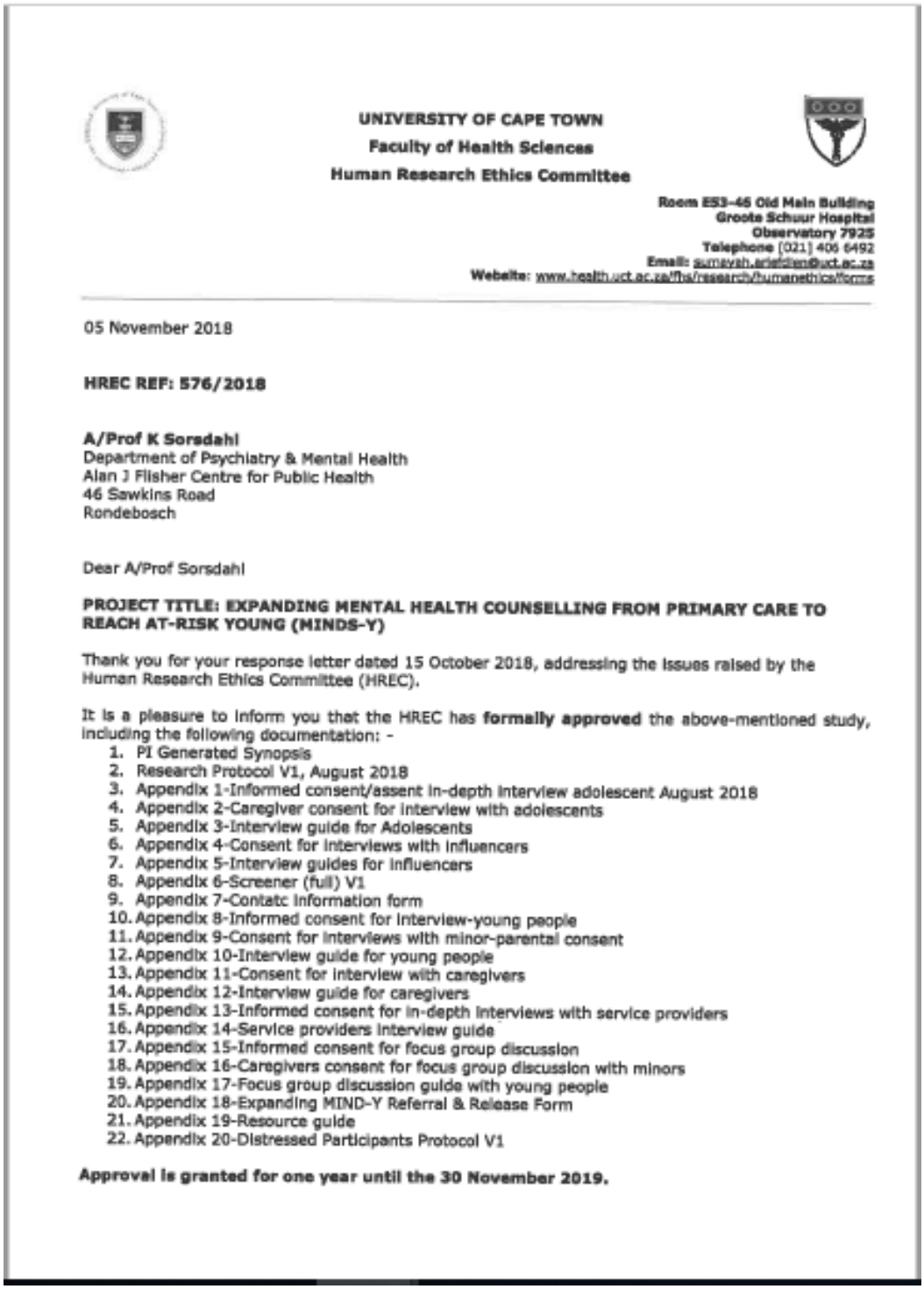
Young, V. (2011). *The secret thoughts of successful women: Why capable people suffer from the imposter syndrome and how to thrive in spite of it.* Crown Publishing Group.

Zeegers, I., Rabie, H., Swanevelder, S., Edson, C., Cotton, M., & Van Toorn, R. (2010). Attention deficit hyperactivity and oppositional defiance disorder in HIV-infected South African children. *Journal of Tropical Pediatrics*, *56*(2), 97-102. https://doi.org/10.1093/tropej/fmp072

Zimbardo, P. G., Haney, C., Banks, W. C., & Jaffe, D. (1971). *The Stanford prison experiment*. Zimbardo, Incorporated.

Zutlevics, T. L. (2016). Could providing financial incentives to research participants be ultimately self-defeating? *Research Ethics*, *12*(3), 137-148. https://doi.org/10.1177/1747016115626756

Appendix A: Project ASPIRE Ethical and Amendment Approval from the HREC



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: sumayah.arieff@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

05 November 2018

HREC REF: 576/2018

A/Prof K Sorsdahl
Department of Psychiatry & Mental Health
Alan J Flisher Centre for Public Health
46 Sawkins Road
Rondebosch

Dear A/Prof Sorsdahl

PROJECT TITLE: EXPANDING MENTAL HEALTH COUNSELLING FROM PRIMARY CARE TO REACH AT-RISK YOUNG (MINDS-Y)

Thank you for your response letter dated 15 October 2018, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study, including the following documentation: -

1. PI Generated Synopsis
2. Research Protocol V1, August 2018
3. Appendix 1-Informed consent/assent in-depth interview adolescent August 2018
4. Appendix 2-Caregiver consent for interview with adolescents
5. Appendix 3-Interview guide for Adolescents
6. Appendix 4-Consent for interviews with influencers
7. Appendix 5-Interview guides for influencers
8. Appendix 6-Screener (full) V1
9. Appendix 7-Contatc information form
10. Appendix 8-Informed consent for interview-young people
11. Appendix 9-Consent for interviews with minor-parental consent
12. Appendix 10-Interview guide for young people
13. Appendix 11-Consent for interview with caregivers
14. Appendix 12-Interview guide for caregivers
15. Appendix 13-Informed consent for in-depth interviews with service providers
16. Appendix 14-Service providers interview guide
17. Appendix 15-Informed consent for focus group discussion
18. Appendix 16-Caregivers consent for focus group discussion with minors
19. Appendix 17-Focus group discussion guide with young people
20. Appendix 18-Expanding MIND-Y Referral & Release Form
21. Appendix 19-Resource guide
22. Appendix 20-Distressed Participants Protocol V1

Approval is granted for one year until the 30 November 2019.

Please submit a progress form, using the standardised Annual Report Form if the study continue beyond the approval period. Please submit a Standard Closure form if the study is completed within th approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principa investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate Institutional approval, where necessary, before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines.
The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

HUMAN RESEARCH ETHICS COMMITTEE
18 SEP 2019
UNIVERSITY OF CAPE TOWN

UNIVERSITY OF CAPE TOWN HEALTH SCIENCES FACULTY OF HEALTH SCIENCES
UNIVERSITY OF CAPE TOWN Human Research Ethics Committee

Form FHS006: Protocol Amendment

HREC office use only (FWA00001637; IRB00001938)			
☑ Approved	☑ Type of review: Expedited	☐ Full committee	
This serves as notification that all changes and documentation described below are approved.			
Signature Chairperson of the HREC		Date	17/9/19

Note: All major amendments must include a local **PI Synopsis** justifying the changes for the amendment. Please note that incomplete amendment submissions will not be reviewed.

Comments from the HREC to the Principal Investigator:
Participant Information Sheet (p.161):"If you have any questions, please ask the project team,: "Project team" is not a clear term and the person may be confused whom to speak to. Please indicate who the person should ask, e.g." please ask me."
Note: The approval of this protocol amendment does not grant annual approval. Please complete the FHS018 / FHS017 form for annual approval at least one month before study expiration.

Principal Investigator to complete the following:

1. Protocol Information

Date (when submitting this form)	20/08/2019		
HRBC REP Number	576/2018		
Protocol title	Expanding mental health counselling from primary care to reach at-risk youth. (MINDS-Y)		
Protocol number (if applicable)			
Principal Investigator	A/Prof Katherine Sorsdahl		
Department / Office Internal Mail Address	Alan J Flisher Centre for Public Mental Health, Sawkins Road Rondebosch		
1.1 Is this a major or a minor amendment? (see FHS005(a)) Major (tick box) Minor (tick box)		✓ Major	☐ Minor
1.2 Does this protocol receive US Federal funding?		☐ Yes	✓ No
1.3 If the amendment is a major amendment and receives US Federal Funding, does the amendment require full committee approval? **Note: Any protocol amendments for Full Committee review MUST be submitted on the monthly HREC submission dates.** (Please email an electronic copy to hrec-enquiries@uct.ac.za)		☐ Yes	✓ No

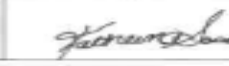
UNIVERSITY OF CAPE TOWN

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

Sponsor's name	
Contact person	
Address	
Telephone number	
Email Address	

7. Signature

My signature certifies that I will maintain the anonymity and/ or confidentiality of information collected in this research. If at any time I want to share or re-use the information for purposes other than those disclosed in the original approval, I will seek further approval from the HREC.

Signature of PI		Date	20/08/2019

☐	Other. Please specify:

4.1 In your opinion, will there be any **increase** in risk, discomfort or inconvenience to participants?	✓ Yes	☐ No

If yes, please provide a detailed justification/explanation:

We do not believe that there will be a significant increase in risk or discomfort since the measures used in screening and assessment in Phase Two are similar to the measures used for screening in Phase One of this study (already approved).

We are now requesting approval for Phase Two, the feasibility study, which was mentioned in the first version of this protocol but not described in detail. There may be a slight increase in discomfort for some participants as they will be receiving an individual counselling intervention. However, the counselling approaches used have been used in other adolescent populations with good results, but have not yet been adapted for the South African context. Additionally, we will be using experienced lay counsellors to deliver the intervention, who will be supervised by registered counsellors. All members of the study team and counsellors will receive training to recognize signs of mental discomfort and to provide counselling and referrals when appropriate. Staff will also receive regular supervision and debriefing to help them deal with distressed participants.

There will be a slight increase in inconvenience for the participants in the intervention arm as we are asking them to: (i) complete a baseline assessment and counselling session on the day of enrolment, (ii) attend an additional three counselling sessions delivered at least five days apart,, which last between 45 and 60 minutes and (iii) complete a three-month post-enrolment follow-up assessment visit. Participants in the comparison arm will be asked to: (i) complete a baseline assessment and counselling session on the day of enrolment and (ii) complete a three-month post-enrolment follow-up assessment visit.

	4.2 What follow-up action do you propose for participants who are already enrolled in the study?
☐	Inform current participants as soon as possible
☐	Re-consent current participants with revised consent/assent forms (append)
✓	No action required
☐	Other. Please describe:

5. Detailed description of the change(s)

Please attach, for each amendment, a summary of all changes which clearly indicates:

i. Old wording (e.g. ~~strikethrough~~ text, CHANGED FROM and CHANGED TO)

ii. New wording (e.g. *italicized*, **bold**, tracked)

iii. Detailed rationale/ justification/ explanation for each change

6. Ethics Review Levy – cost including vat

Cost for Major Amendments - R3 691.20

(Protocols funded by UCT (e.g. departmental funding / student research) and by certain grant funding organizations (e.g. MRC, NRF, CANSA,) are exempt from charges)

For invoicing purposes, please provide:

Appendix B: Current Study Ethical Approval

UNIVERSITY OF CAPE TOWN

Department of Psychology

University of Cape Town Rondebosch 7701 South Africa
Telephone (021) 650 3417
Fax No. (021) 650 4104

27 October 2020

Nqabisa Faku
Department of Psychology
University of Cape Town
Rondebosch 7701

Dear Nqabisa

I am pleased to inform you that ethical clearance has been given by an Ethics Review Committee of the Faculty of Humanities for your study, *Creating a sustainable future: Task-shifting for adolescent mental health care*. The reference number is PSY2020-045.

I wish you all the best for your study.

Yours sincerely

Debbie Kaminer
A /Professor
Acting Chair: Ethics Review Committee

Appendix C: Informed Consent Form for Parents of Adolescent Minors

Please note that this informed consent form was approved as part of Project ASPIRE, and no changes were made to it.

PARTICIPANT INFORMATION SHEET AND GENERAL INFORMED CONSENT FOR TRIAL PARTICIPATION – Parent Consent

Introduction:

Hello. My name is_____. I am from the South African Medical Research Council (SAMRC). We are asking you to agree for your child to take part in a study that involves provision of mental health counselling. Before you agree for your child to take part you should understand what it involves. This pamphlet is to help you decide if you want your child to take part in this study. If you have any questions, please ask the project team. You should not agree to this request unless you are happy about all that is involved.

The goal of the MIND-Y project is to adapt a counselling programme designed for adults to meet the needs of younger people. We would like to invite your child to participate in a research study. In this study, we want to know whether young people like our counselling programme and find it helpful. Your child qualifies for this study as she/he is between 15 and 18 years old and may benefit from counselling. If you allow your child to participate, they will be one of 100 young people in the study.

What We're Asking of You.

Your child has participated in Project ASPIRE. It's been 3 months since they first took part.

Today: We will ask your child to take part in another interview in which we will ask the same questions as well as questions about how they experienced the counselling and whether they found it helpful. The appointment will last about an hour. Your child is also asked to take part in a more in-depth interview after the main study. This interview will ask your child for feedback on the counselling sessions they received. If they are chosen and agree to take part in this interview, we will ask you to sign another parental consent form.

Potential Risks or Discomforts: There are some risks to your child taking part in this study. Answering some of our questions may make your child feel uncomfortable. It is okay if your child does not want to talk about certain topics. Your child can also take a break at any time.

If your child is distressed by any topic during counselling, we will ensure that your child is able to access services to help them cope with these experiences. Participation is fully voluntary.

Potential Benefits of Taking Part in The Study: If you allow your child to take part in this study, the counselling they receive may help them develop better coping skills and may improve their well-being and quality of life. Their feedback will also help us improve this new counselling programme, which could help other children.

Confidentiality and Privacy: Any information obtained will remain confidential. It will be disclosed only as required by law in the following instances: 1) If your child tells us that they are about to hurt themselves or someone else, 2) if your child is being abused or neglected, or 3) if they are involved in the neglect and/or abuse of a child. In these cases, we will report that information to the appropriate authorities.

We will not share your child's information with anyone. None of the questionnaires will have your child's name on them. The only confidential information will be on the consent and locator forms which will be stored in locked filing cabinets. The consent forms will be destroyed after 5 years of completing the study. The SAMRC ethics committee will however have access to all data. We will use the information your child provides to write and publish papers in academic journals, but this data will be anonymized (it won't have your child's name). Your child's name will not appear in any published material.

Participation and Withdrawal: Participation is voluntary. You can choose for your child not to participate in this study. Your child may also choose not to participate. If he/she decides to participate, they may choose to stop their participation at any time. There will be no consequences. They may also refuse to answer any questions they do not want to answer.

Who is funding the study?

The study is being conducted by the South African Medical Research Council and the University of Cape Town. It is being funded by the Joint Global Health Trials Initiative through the United Kingdom's Research Initiative.

Reimbursement

Today- For your time today will give your child a virtual voucher of R100.

Future Contact.

In the future, we may contact you to ask if you want your child to participate in additional study activities. You will complete a separate consent form if you agree to participate.

I consent to be contacted about future study activities (Please check the appropriate box).

Yes ☐ No ☐

Who to Contact with Questions.

This study has been approved by the South African MRC Ethics Committee (EC 012-8-2018), the University of Cape Town's Ethics Committee (576/2018). The study will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki, and the South African Guidelines for Good Clinical Practice.

If you have any questions or concerns about the research, please contact Dr. Bronwyn Myers (Principal Investigator) at +021 938 0993 or write to bmyers@mrc.ac.za, or South African Medical Research Council (MRC) P.O. Box 19070, Tygerberg 7505, South Africa.

Rights of Research Participants.

You can decide you do not want to participate at any time. If you have any questions about your rights as a participant, you can contact the chairperson of the MRC ethics committee, Prof D. du Toit at 021 938 0687 or email: adri.labuschagne@mrc.ac.za.

What if Something Goes Wrong?

The University of Cape Town (UCT) undertakes that in the event of your child suffers any significant deterioration in health or well-being that is caused by their participation in the study, it will provide immediate medical care. UCT has appropriate insurance cover to provide prompt payment of compensation for any trial-related injury according to the guidelines outlined by the Association of the British Pharmaceutical Industry, ABPI 1991. An injury is considered trial-related if, and to the extent that, it is caused by study activities. You must notify the study doctor immediately of any side effects and/or injuries during the trial, whether they are research-related or other related complications. UCT reserves the right not to provide compensation if, and to the extent that, your child's injury came about because they did not follow the instructions given while taking part in the study. Your right in law to

claim compensation for injury where you prove negligence is not affected. Copies of these guidelines are available on request.

Indicating Consent.

Please let us know if you have any questions before signing this consent form. Please initial next to each item to show that you agree to what is required:

	Agree	**What We're Asking of You**
1		I agree for my child to continue in the study, which has been fully described to me. This means that I agree for my child to answer questions today and to receive a first counselling session.
2		I agree for my child to provide contact information
3		I agree for study staff to contact friends and relatives if I cannot be reached by telephone
4		I understand that my child may receive additional counselling sessions
5		I understand that in 6 weeks time, my child will asked to return for a follow up interview
6		I understand that in 3 months from now my child will be asked to return for a follow up interview
7		I understand that my child's participation in this study is completely voluntary, and there will be no penalty if I choose for my child not to participate.

Please also provide a full signature to show whether you agree to counselling sessions being audio-taped to check for staff quality. (This is not a study requirement).

Agree	
	I agree to my child's counselling sessions being audio-taped for quality control purposes.

By signing this consent form, I indicate that I have read this consent form (or have had it read to me), my questions have been answered to my satisfaction, and I voluntarily agree for my child

_____(Full name of child) to participate in this research study. You will receive a copy of this signed consent form.

Parent (Signature and Printed Name) Date

Person Obtaining Consent (Signature and Printed Name) Date

Witness (Signature and Printed Name) Date

**A witness is required if the research patient or legal representative cannot read (e.g. blind or illiterate) or if it is required by the study plan. The witness should participate in all of the discussions with regards to the participant research during the consent process. By signing this consent term, the witness guarantees that all the information within the consent has been explained to the participant, and that the consent seemed to have been understood and given by free will.*

Appendix D: Assent or Informed Consent Form for Adolescents

Please note that this assent or informed consent form was approved as part of Project ASPIRE, and no changes were made to it.

PARTICIPANT INFORMATION SHEET AND GENERAL INFORMED CONSENT FOR TRIAL PARTICIPATION – Adolescent Assent/Consent

Introduction:

Hello. My name is_____. I am from the South African Medical Research Council (SAMRC). We are asking you to take part in a study that involves mental health counselling. Before you agree to take part, you should understand what it involves. This pamphlet is to help you decide if you want to take part in this study. If you have any questions, please ask the project team. You should not agree to this request unless you are happy about all that is involved.

The goal of the MIND-Y project is to adapt a counselling programme designed for adults to meet the needs of younger people. We would like you to take part in this study. In this study, we want to know whether young people like our counselling programme and find it helpful. You qualify for this study as you are between 15 and 18 years old and may benefit from counselling. If you decide to participate, you will be one of 100 young people in the study.

What We're Asking of You.

We are asking if you would like to participate in our study. If you are younger than 18 years old, we need your parent or legal guardian's permission for you to participate in the study. If you do not want us to contact your parent/guardian, we will not do so, but we will not be able to include you in the study. We will not share any of the information you give us with them. More specifically:

You have participated in Project ASPIRE. It has been 3 months since you first took part.

Today: We will ask you to take part in another interview in which we will ask the same questions as well as questions about how you experienced the counselling and whether you found it helpful. The appointment will last about an hour. This interview will ask you for feedback on the counselling sessions receive.

Potential Risks or Discomforts: There are some risks to you taking part in this study. Answering some of our questions may make you feel uncomfortable. It is okay if you do not want to talk about certain topics. You can also take a break at any time. If you are distressed by any topic during counselling, we will ensure that you can access services to help you cope with these experiences. Participation is fully voluntary.

Potential Benefits of Taking Part in The Study: If you choose to take part in this study, the counselling you receive may help you improve your coping skills, well-being, and quality of life. Your feedback will also help us improve this new counselling programme, which could help other young people.

Confidentiality and Privacy: Any information obtained will remain confidential. It will be disclosed only as required by law in the following instances: 1) If you tell us that you are about to hurt yourself or someone else, 2) if you are a child and are being abused or neglected, or 3) if you are involved in the neglect and/or abuse of a child. In these cases, we will report that information to the appropriate authorities.

We will not share your information with anyone. None of the questionnaires will have your name on them. The only confidential information will be on the consent and locator forms which will be stored in locked filing cabinets. The consent forms will be destroyed after 5 years of completing the study. The SAMRC ethics committee will however have access to all data. We will use the information you provide to write and publish papers in academic journals, but this data will be anonymized (it won't have your name). Your name will not appear in any published material.

Participation and Withdrawal: Participation is voluntary. You can choose not to participate in this study. You may choose to stop your participation at any time. There will be no consequences. You may also refuse to answer any questions you do not want to answer.

Who is funding the study?

The study is being conducted by the South African Medical Research Council and the University of Cape Town. It is being funded by the Joint Global Health Trials Initiative through the United Kingdom's Research Initiative.

Reimbursement

Today- For your time today will give you a voucher of
R100.

Future Contact.

In the future, we may contact you to ask if you want to participate in additional study activities. You will complete a separate consent form if you agree to participate.

I consent to be contacted about future study activities (Please check the appropriate box).

Yes □ No □

Who to Contact with Questions.

This study has been approved by the South African MRC Ethics Committee (EC 012-8-2018), the University of Cape Town's Ethics Committee (576/2018). The study will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki, and the South African Guidelines for Good Clinical Practice.

If you have any questions or concerns about the research, please contact Dr. Bronwyn Myers (Principal Investigator) at +021 938 0993 or write to bmyers@mrc.ac.za, or South African Medical Research Council (MRC) P.O. Box 19070, Tygerberg 7505, South Africa.

Rights of Research Participants.

You can decide you do not want to participate at any time. If you have any questions about your rights as a participant, you can contact the chairperson of the MRC ethics committee, Prof D. du Toit at 021 938 0687 or email: adri.labuschagne@mrc.ac.za.

What if Something Goes Wrong?

The University of Cape Town (UCT) undertakes that in the event you suffer any significant deterioration in health or well-being that is caused by participation in the study, it will provide immediate medical care. UCT has appropriate insurance cover to provide prompt payment of compensation for any trial-related injury according to the guidelines outlined by the Association of the British Pharmaceutical Industry, ABPI 1991. An injury is considered trial-related if, and to the extent that, it is caused by study activities. You must notify the study doctor immediately of any side effects and/or injuries during the trial, whether they are research-related or other related complications. UCT reserves the right not to provide compensation if, and to the extent that, your injury came about because you did not follow

the instructions given while taking part in the study. Your right in law to claim compensation for injury where you prove negligence is not affected. Copies of these guidelines are available on request.

Indicating Consent.

Please let us know if you have any questions before signing this consent form. Please initial next to each item to show that you agree to what is required:

	Agree	**What We're Asking of You**
1		I agree to continue in the study, which has been fully described to me. This means that I agree to answer questions today and to receive a first counselling session.
2		If younger than 18, I agree to my parent or guardian being contacted to request permission for me to participate in this group
3		I agree to provide contact information
4		I agree for study staff to contact friends and relatives if I cannot be reached by telephone
5		I understand that I may receive additional counselling sessions
6		I understand that in 6 weeks time, I will be asked to return for a follow up interview
7		I understand that in 3 months from now I will be asked to return for a follow up interview.
8		I understand that my participation in this study is completely voluntary, and there will be no penalty if I choose not to participate.

Please also provide a full signature to show whether you agree to counselling sessions being audio-taped to check for staff quality. (This is not a study requirement).

Agree	
	I agree to my counselling sessions being audio-taped for quality control purposes.

Signing this consent form indicates that you have read this consent form (or have had it read to you), that your questions have been answered to your satisfaction, and that you voluntarily agree to participate in this research study. You will receive a copy of this signed consent form.

Participant (Signature and Printed Name) Date

Person Obtaining Consent (Signature and Printed Name) Date

Witness (Signature and Printed Name) Date

**A witness is required if the research patient or legal representative cannot read (e.g. blind or illiterate) or if it is required by the study plan. The witness should participate in all of the discussions with regards to the participant research during the consent process. By signing this consent term, the witness guarantees that all the information within the consent has been explained to the participant, and that the consent seemed to have been understood and given by free will.*

Appendix E: Informed Consent Form for the Counsellors and the Supervisor

Please note that this informed consent form was approved as part of my master's study, and I wrote it.

Consent to participate in a research study:

Creating a sustainable future: Task-shifting for adolescent mental health care

Hello. My name is Nqabisa Faku. I am a master's student in the Department of Psychology at the University of Cape Town. I am an independent researcher trying to explore your views and experiences of working in the ASPIRE counselling programme. I am inviting you to take part in a study today. Before you can take part in this study, you need to know what it involves.

The study aims to explore the facilitators and barriers of delivering adolescent mental healthcare within the ASPIRE counselling programme. You qualify for this study as you have worked as either a lay counsellor or counsellor supervisor on Project ASPIRE. If you decide to participate, I will ask you some questions on your views and experiences of delivering the ASPIRE counselling programme to adolescents in community settings. The interview will take about an hour.

Potential Risks or Discomforts: Answering some of my questions may make you feel uncomfortable. The interview questions might bring to mind, for example, challenging experiences during counselling, supervision and training. At the end of this form, I have provided a list of places you can access counselling services for free if you feel you need it to help you cope with these experiences.

Potential Benefits of Taking Part in The Study: If you choose to take part in this study, your feedback will help to improve the ASPIRE counselling programme, which will contribute to our knowledge of how to improve adolescent mental health services.

Confidentiality and Privacy: All identifying information obtained will be anonymized. However, I am required by law to disclose if you are at risk of causing harm to yourself or someone else. In that case, I will work with you to report this to people who can help.

Other than that, I will not share your identifying information with anyone.

If you agree to participate in this study, the interview will be recorded. The recording of the interview will make it easier for me to be sure that I have correctly captured what you have told me. The transcriptions of the consent process will be saved with your name. However, the transcriptions of the actual interview will be saved separately, without your name. I will store the consent forms, recordings and transcriptions on a password-protected computer, and these files will be kept in separate folders with encrypted passwords. I will send the consent forms and study data to the principal investigator to store for at least five years after completing the study. The Faculty of Humanities Research Ethics Committee will, however, have access to all data. Any reports or publications about the research study will not identify your name.

Participation and Withdrawal: Participation is voluntary. You can decide to not participate in this study. You may also choose to withdraw your participation at any time with no consequences. You may also refuse to answer any questions you do not feel comfortable answering.

Who to Contact with Questions: The Research Ethics Committee of the Faculty of Humanities at the University of Cape Town has approved this study.

If you have any questions or concerns about the research, you can contact the following persons: Nqabisa Faku (researcher) at 071 489 2691 or on email to fkxnqa001@myuct.ac.za. Alternatively, you can contact Professor Catherine Ward (supervisor) at 021 650 3422 or send email to catherine.ward@uct.ac.za. Or, you can contact Professor Crick Lund (co-supervisor) at 021 6850120 or on email to crick.lund@uct.ac.za.

Rights of Research Participants: You can decide if you do not want to participate at any time. If you have any questions about your rights as a participant, you can contact the Ethics Review Committee of the Faculty of Humanities via Mrs Rosalind Adams (rosalind.adams@uct.ac.za or 021 650 3417).

Indicating Verbal Consent

Please let me know if you have any questions before giving your consent. I will now read out statements to find out whether you consent to participate in the study. I will ask you to please say "yes" or "no" after each statement to indicate your consent to what is stipulated:

	Agree	**What the Researcher is Asking of You**
1		I agree to continue in the study, which the researcher has fully described to me. I agree to answer questions today.
2		I understand that my participation in this study is voluntary, and there will be no penalty if I choose not to participate.

I will now read out a statement to find out whether you consent to have the interview audio-taped for research purposes. Please say "yes" or "no" after this statement to indicate your consent to what is stipulated:

Agree	
	I agree to have my interview audio-taped for research purposes.

Resources you might find helpful:

South African Depression and Anxiety Group (SADAG)

SADAG offers free telephonic counselling between 08h00 and 20h00 every day of the week. To contact a counsellor, you can call 011 234 4837. Alternatively, you can contact their 24-hour helpline service on 0800 456 789.

Lifeline Cape Town

Lifeline offers confidential and anonymous counselling services. You can call to speak to a counsellor on 021 813 6878 between 09h30 and 22h00. The cost of the call is the only charge.

You can give them a WhatsApp call between 10h00 and 14h00 on 063 709 2620.

Appendix F: Interview Schedule for Adolescents

Please note that this interview schedule was approved as part of Project ASPIRE and no changes were made to it.

INTERVIEW SCHEDULE FOR PATIENT FEEDBACK

- End of Study Interview
Project MIND

PARTICIPANT ID: …… |__|__|__|__|
SITE ID: …… |__|__|__|__|
STAFF ID: …… |__|__|
DATE: …….. |__|__| / |__|__| / |__|__|__|__|
DD MM YYYY

READ: Thank you for agreeing to talk with me about your experience with the Project ASPIRE programme. Now that you have completed the counselling sessions, we want to ask you some questions about your experiences about the service you received. The information you provide us with will help us improve the intervention.

Study Experience

A. What did you think about the questions that the counsellor asked you before starting the counselling (that is the screening questions about your feelings or emotions??)

Probe:

1. What about the number of questions?
2. Were there any questions that were difficult to answer?

B. From what the counsellor explained to you, how much do you think your _____ (*interviewer to fill in from what is known about participant: depression and/or alcohol use*) is making problems for you?

C. Why did you agree to participate in the programme?

D. What would you like to tell us about your experience of the counselling?

Probe:

1. What did you like most about the counselling programme?

2. What did you not like about the programme?
3. Were their parts that were difficult to understand or did not work well?

E. What did you learn from the counselling programme?

Probe:

1. Were there any new skills that you learned?
2. What new information did you learn?

F. Since you completed the counselling programme, what (if any) changes have you been able to make in your life?

Probe:

1. Can you describe anything that you are doing differently in your life?
2. How has the counselling made a difference in your life?

G. Remember when we asked you to think of problems you were experiencing in your life? How did you use what you learned during counselling to address these problems?

Probe:

1. What were these problems?
2. How did you go about trying to solve these problems? Were you successful?
3. How have you continued to use the skills you learned in your daily life?

I. Were there any parts of the counselling programme that were less helpful to your life?

Probe:

1. In which ways could the intervention have been more helpful to you?

J. How do you feel about the counsellor who provided the programme?

Probe:

1. How much did you feel the counsellor understood you?
2. Do you think the counsellor cared about your situation? (If yes or no, please explain.)
3. Was there anything that frustrated or upset you about the counsellor?

K. How comfortable do you feel during the sessions? What, if anything could we change to make you feel more comfortable?

L. What did you think about the number of sessions? Would you have liked more or fewer sessions with your counsellor?

M. (*Show booklet*). What did you think of the patient handouts? What did you like the most? Is there anything you would have like to see changed?

N. How easy was it to attend the counselling sessions?

Probe:

1. Was there anything that made it difficult for you to keep your appointments with the counsellor?
2. Is there anything we can do to help people keep their appointments?

O. Where do you think the counselling should ideally take place?

Probe:

1. Was coming to the Delft site OK? Would you have preferred another location?

P. How useful do you think this programme would be for your friends and other adolescents you know?

Probe:

a) Would you recommend the programme to your friends?

Q. What did your family think of you attending counselling?

R. Do you have anything else to tell me about your experience of the counselling programme?

Ending Questions

Our time is about up. You have provided us with a lot of information in this short amount of time. Thanks again for your time—we really appreciate all of your help.

[Give a short oral summary of the key ideas that emerged from the discussion.]

A. Is this an adequate summary of the things that we have discussed today?

B. Do you have any questions for us?

C. Do you have anything to add that we may have missed? _____

_____

Appendix G: Interview Schedule for the Counsellors

Please note that this interview schedule was approved as part of my master's study, and I wrote it.

Interview Schedule for Counsellor Feedback

PARTICIPANT ID: …… |__|__|__|__|
DATE: …….. |__|__| / |__|__| / |_2_|0__|2__|0__|

READ: Thank you for agreeing to talk with me about your experience with the Project ASPIRE programme. Now that you have delivered the counselling sessions, I want to ask you some questions about your experiences of the training and supervision you received. The information you provide me with will help to improve the intervention.

Introductory question

What experience do you have with counselling patients before you worked as a counsellor in Project ASPIRE? Where did you perform your counselling (e.g. in primary healthcare facilities, schools or other settings)?

Counselling Experience

---

1. What did you find was difficult about delivering the intervention?
2. What made it easier to deliver the intervention?
3. What did you think about the patient handbook that you used for the counselling?

Probe:

1) Is there anything you would have liked to see changed or added to it?
2) Would you have preferred to have a separate counselling manual to the patient handbook?

4. How easy was it to connect with the participants?

Probe:

a. Was there anything that made it difficult for them to build rapport with you?

5. How effective do you think the Motivational interviewing and problem-solving counselling techniques were for the adolescents?

Probe:

I. What other counselling techniques do you think could have been incorporated to address the problems the participants were facing?

6. What did you think about the structure of the counselling sessions?

Probe:

a) What, if anything, could the programme change to the structure of each counselling session?

b) How much did you feel you were able to be flexible and adapt the structure of the counselling sessions to meet the participants' needs?

7. How did you refer severe cases?

8. What did you think about the community settings that the counselling took place?

9. Were you adequately compensated for the delivery of the intervention?

10. How do you suggest we can improve the adaptability of the counselling intervention for adolescents?

Supervision Experience

---

11. How did you experience supervision?

Probe:

i. How supportive was it?

ii. Did supervision help to develop your skills further?

iii. Were you comfortable in group supervision? Or, would you had preferred individual supervision?

iv. What things did you find most difficult to resolve during debriefing sessions?

v. Was there any assistance you required to deliver the intervention that was difficult for the supervisor to provide?

12. What did you think about the supervisor who provided supervision?

Probe:

a) Did you feel the supervisor adequately supported you emotionally?

13. What did you think about the number of supervision sessions? How many supervision sessions did you have? Or, how frequent was it?

Probe:

a. Would you have preferred longer or shorter durations of the sessions with the supervisor?

b. Alternatively, would you have preferred more or fewer sessions with the supervisor?

14. How useful did you find the training log?

Probe:

A. Do you think it helped with accountability?

15. How did you experience the quality assurance activities (i.e. monitoring of your skills development) during supervision?

Probe:

I. Did you feel the quality assurance activities gave an accurate perception and judgement about your capabilities to deliver the intervention?

II. Do you think the quality assurance activities helped to improve your delivery of the intervention?

16. What do you think about the participant's commitment to attending the counselling programme?

Probe:

A. What do you think encouraged participants' commitment to the counselling programme?

B. What do you think affected participant's attendance to the counselling programme?

Training Experience

---

17. What did you think about the content of the training programme before you began counselling the adolescents?

Probe:

a) Was there any material you felt was missing in the content of the training programme?

18. What did you think about the format of the training?

19. What do you think about the number of hours dedicated to the training? Would you have preferred more or fewer hours devoted to training?

20. What did you learn from the training programme that was new to you?

Probe:

I. What new knowledge did you learn about counselling common mental disorders?

II. Were there new practices about assisting participants with common mental disorders that you learned?

21. After completing the training, did you feel competent to deliver the intervention?

Probe:

a. Did you feel like you needed more training?
b. Did you feel confident to begin counselling?

22. Do you have anything else to tell me about your counselling, supervision and training experience in Project ASPIRE?

Ending Questions

We have come to the end of the interview. You have provided me with plenty of information in this short amount of time. Thanks again for your time—I appreciate all of your help.

[Give a short oral summary of the key ideas that emerged from the discussion.]

A. Is this an adequate summary of the things that we have discussed today?

B. Do you have any questions for me?

C. Do you have anything to add that I may have missed?

Appendix H: Interview Schedule for the Counsellor Supervisor

Please note that this interview schedule was approved as part of my master's study, and I wrote it.

Interview Schedule for Counsellor Supervisor Feedback

PARTICIPANT ID: …… |_#_|_0_|_0_|_1_|
DATE: …….. |__|__| / |__|__| / |_2_|0__|2__|0__|

READ: Thank you for agreeing to talk with me about your experience with the Project ASPIRE programme. Now that you have supervised the counsellors, I want to ask you some questions about your experiences about the supervision sessions and the counsellors' performance. The information you provide me with will help to improve the intervention.

Introductory question

What experience do you have with providing supervision before you worked as a counsellor supervisor in Project ASPIRE? What kind of settings did you supervise counsellors (e.g., in primary healthcare facilities, schools or other work environments)?

Supervisor Experience

---

1. What did you find was difficult about providing the supervision sessions?
2. What made it easier to provide the supervision sessions?
3. In general, how was your experience of providing supervision?
4. What difficulties did you experience during debriefing sessions?

Probe:

i. What things did you find were beyond your expertise during debriefing sessions?
ii. Was there any assistance that you found difficult to provide to help the counsellors deliver the targeted intervention?

5. How comfortable did you feel with providing the supervision sessions? What, if anything, could have been changed to make you feel more comfortable with holding the supervision sessions?
6. Do you feel you adequately supported the counsellors emotionally?

Probe:

A. If no, then who could the counsellors see if they were experiencing psychological distress?

7. Do you think the number of supervision sessions was adequate?

Probe:

a) Would you have preferred more or fewer supervision sessions?

8. How did you run the supervision sessions?

Probe:

I. What did you think about the topics that you covered during supervision sessions?

II. Was there anything that made it difficult for you to perform your supervisor duties?

III. Is there anything the project team could have done differently to help you with your supervision duties?

9. Who reviewed the quality of your supervision sessions?

Probe:

1. What feedback did you receive about the quality of the supervision sessions?

10. What did you learn from the quality assurance activities that improved the quality of your supervision sessions?

Probe:

1) Did you learn any new skills?

2) Did you gain new knowledge?

11. When you reviewed the counsellors' clinical note-taking of each counselling session, what did those reveal?

12. What did you find out from the various training logs?

Probe:

A. Do you think it helped with accountability or something else, perhaps?

13. What did your monitoring and evaluation assessments of counsellor's delivery of the intervention entail? How did you perform these assessments?

Probe:

i. What did the feedback from monitoring and evaluating the counsellors' delivery of the intervention reveal?

ii. Do you think the counsellors maintained the use of a motivational interviewing counselling style?

iii. How did the delivery of the intervention improve after the evaluation of the counsellor's skills?

iv. What skills and knowledge did the counsellors need more training based on the feedback from the monitoring and evaluation procedures of the counsellors' delivery of the intervention?

v. Was there any feedback you received that you could not provide help or more training?

14. Do you think the counsellors delivered the objectives of the targeted intervention during counselling sessions? If yes, please explain.

15. What did you think about the counsellors' motivation to deliver the counselling programme?

Probe:

A. What do you think encouraged counsellors' commitment to the counselling programme?

B. What do you think affected counsellors' commitment to the counselling programme?

16. Based on the counsellors' report back, how do you think the participants' progressed?

Probe:

I. What other counselling techniques do you think could have been incorporated to address the problems the participants were facing?

17. What did you think about the counsellors using the patient handbook for the counselling sessions?

Probe:

1. Do you think they should have had a separate counselling manual?

18. What did you think about the structure of the counselling sessions?

Probe:

a) Do you think the structure of the counselling sessions enabled the counsellors to be flexible and adapt the counselling sessions to meet the participants' needs?

19. What did you think about the referral system?

Probe:

i. Do you think the referral path was efficient?

20. Where did the supervision sessions take place?

Probe:

1) Was the building or location ideal for the supervision?

2) Would you have preferred another location?

21. Were you adequately compensated for the supervisory role you provided in the intervention?

22. Do you have anything else to tell me about your supervisory experience in Project ASPIRE?

Ending Questions

We have come to the end of the interview. You have provided me with plenty of information in this short amount of time. Thanks again for your time—I appreciate all of your help.

[Give a short oral summary of the key ideas that emerged from the discussion.]

A. Is this an adequate summary of the things that we have discussed today?

B. Do you have any questions for me?

C. Do you have anything to add that I may have missed?
