THE EXPERIENCES OF FACILITY-BASED COUNSELLORS WHO PROVIDE A PSYCHOSOCIAL INTERVENTION FOR MENTAL ILLNESS IN PRIMARY HEALTHCARE FACILITIES IN THE WESTERN CAPE

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Declaration

I, *Yuche Andy Jacobs*, hereby declare that this thesis is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Abstract

Background: Despite the movement in global mental health that advocates for task-sharing, few studies have investigated the experiences of facility-based counsellors (FBCs) who provide a psychosocial intervention for mental illness in primary healthcare. Project MIND, a cluster-randomized controlled trial at 24 primary healthcare facilities in the Western Cape, trained FBCs to deliver a three-session evidence-based intervention for patients with a common mental disorder. Therefore, project MIND presents an opportunity to address a gap in the literature by exploring the experiences and needs of FBCs delivering a psychosocial intervention.

Aims & Objectives: The overall aim of this study is to explore the experiences of FBCs working on Project MIND in the dedicated (training and adding a counsellor to the chronic disease team) and designated (training and using existing counsellor from the chronic disease team) intervention arms. Specific objectives included: (1) exploring the barriers and challenges that FBCs experienced while delivering a psychosocial intervention; (2) exploring FBCs' perceptions of regular structured supervision, debriefing and in-service training for improving micro-counselling skills; and (3) eliciting suggestions from the FBCs for future scale up of counselling services in primary healthcare settings.

Methods: A qualitative study was conducted among FBCs delivering the project MIND psychosocial intervention (N=18). All interviews were conducted by an independent qualitative interviewer in a private room at the primary healthcare facilities. Interviews were audio-recorded and transcribed verbatim. NVivo 12 was used to store data and facilitate analysis using the Framework Approach.

Results: Findings of the study were grouped according to four main themes. The first theme focused on FBCs' perceptions of the benefits of the project MIND training. Several perceived benefits were reported such as having a better understanding about mental illness particularly depression, enhanced counselling skills and transferability of skills to other daily duties in the healthcare facility. Role-playing stood out as a key training component to assess counselling readiness. The second theme focused on barriers and facilitators related to the implementation of the project MIND intervention. Designated FBCs reported competing task demands as a barrier to implementing the MIND intervention compared to designated FBCs. Further, most designated counsellors reported feeling marginalized in the facility due to their lowly status. Other barriers reported which impacted on their motivation to implement the MIND intervention by both dedicated and designated FBCs were low remuneration, a lack of counselling space, and a lack of privacy and confidentiality. Regarding facilitators to implementing the MIND intervention, experiencing first-hand how well patients were able to solve some of their problems using the problem-solving method and taking responsibility for their health motivated FBCs to implement the MIND intervention. In addition, the MIND intervention aided

FCBs with solving their own problems which enhanced their belief in the effectiveness of the intervention. The third theme dealt with how FBCs perceive the clinical supervision and debriefing provided by project MIND. Regular structured supervision, debriefing and in-service training delivered by a registered psychological counsellor, a novel approach, was perceived as beneficial to all FBCs as it provided them with a means to reassess and improve their counselling skills. Further, role-playing was reported as an effective method for rehearsing their counselling skills and enhancing quality of intervention delivery. Fidelity feedback through audio-recorded counselling sessions was highlighted as feasible. Considerations around space, location (distance), a lack of privacy, and scheduling were mentioned. The fourth and final theme focused on FBCs' recommendations for improving the project MIND training, supervision and debriefing model, and implementation. FBCs recommended that more time should be allocated for role-playing and skills rehearsal exercises during training to test their counselling skills and readiness. There were some suggestions that the amount of training hours per day should be reduced as it might aid FBCs to remain focused and retain information. Regarding supervision, a few FBCs recommended incorporating occasional peer group supervision and debriefing to benefit from shared experienced. Other recommendations were adding content related to substance use to the intervention and including management in training.

Conclusion: Regular structured supervision, debriefing and in-service training provided by a Registered Counsellor are both feasible and beneficial for improving micro-counselling skills and the quality of intervention delivery among FBCs delivering a psychosocial intervention. Considerations for scaling up FBC-led psychosocial interventions should involve addressing barriers such as limited counselling space, remuneration, and marginalization.

List of abbreviations

SASH	South African Stress and Health study
LMICs	Low-and middle income countries
CMDs	Common mental disorders
SAMHP	South African Mental Health Policy Framework and Strategic Plan
WHO	World Health Organization's
FBCs	Facility-based counsellors
PHC	Primary healthcare
TB	Tuberculosis
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
GBD	Global Burden of Disease
SSA	Sub-Saharan Africa
NCDs	Non-communicable disease
DALYs	Disability adjusted life years
PLWH	People living with Human Immunodeficiency Virus
mhGAP	Mental Health Gap Action Programme
mhGAP-IG	Mental Health Gap Action Programme Intervention Guide
CHWs	Community health workers
PRIME	Programme for Improving Mental Healthcare
MI-PST	Motivational Interviewing and Problem-Solving Therapy
PST	Problem-Solving Therapy
HPCSA	Health Professions Council of South Africa
SAMRC	South African Medical Research Council
WCDoH	Western Cape Department of Health
COREQ	Consolidated Criteria for Reporting Qualitative Research

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CHAPTER 1: INTRODUCTION

Untreated mental disorders are highly prevalent in South Africa. The South African Stress and Health study (SASH), a nationally representative study, found that the 12-month prevalence of any mental disorder was 16.7% (Williams et al., 2008), with a life-time prevalence of 30.3% (Stein et al., 2008). Anxiety disorders had the highest lifetime prevalence (15.8%), followed by alcohol use disorders (11.4%) and mood disorder (9.8%) (Stein et al., 2008). Despite this high prevalence of common mental disorders (CMDs), only 25% of those meeting criteria for a 12-month mental disorder received treatment (Seedat et al., 2008). This large treatment gap is similar to that found in other low-and middle-income countries (LMICs) (Demyttenaere & Bruffaerts, 2004).

Several factors contribute to this treatment gap in South Africa. These include structural and financing barriers, low perceived need for treatment, low mental health literacy, stigma, and systemic barriers (Ameh et al., 2017; Bruwer et al., 2011; Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003; Mendenhall et al., 2014). A key system constraint is the limited availability of mental healthcare providers. Nationally, the average number of psychiatrists working in the public sector is 0.31 per 100 000 people with 0.97 psychologists per 100 000 people (Docrat, Besada, Cleary, Daviaud, & Lund, 2019). Consequently, few mental health services are provided on the primary care platform: services that are available focus on medication provision for people with severe mental illness, with little provision of mental health counselling for individuals with common mental disorders (CMDs) (Docrat et al., 2019).

Given the human resource constraints, South Africa through its Mental Health Policy Framework and Strategic plan (SAMHP), has endorsed the World Health Organization's (WHO) recommendation of "task sharing" mental health counselling to non-specialist providers, including facility-based counsellors (FBCs) who work within primary healthcare (PHC) facilities (Department of Health Replublic of South Africa, 2013). One of the aims set forth by the SAMHP is to integrate mental health into all aspects of general healthcare with a particular focus and priority on chronic disease care (tuberculosis (TB), human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS) (Department of Health Replublic of South Africa, 2013). In the South African setting, FBCs are a specific cadre of community health workers trained to deliver health promotion and HIV adherence counselling services. Within this task-sharing framework, the WHO has identified two approaches: either mobilizing the human resources currently available within PHC services (such as FBCs) by expanding their current roles to include counselling (termed the "*designated approach*") or re-distributing funding to allow for the employment of additional counsellors (termed the "*dedicated approach*") (WHO, 2007b).

In South Africa, and other LMICs, it remains to be shown which human resource configuration is effective, feasible, and acceptable for delivering counselling. Project MIND is investigating the relative effectiveness of the designated and dedicated approaches to integrating a FBC-delivered intervention for depression and alcohol use disorders into chronic disease services (Myers et al., 2018b). In addition to the clinical outcomes of this trial, information on the experiences of both dedicated and designated FBCs is needed to guide health planners' decision making. FBCs are likely to be the frontline workers tasked with the delivery of these services; ensuring that their training, supervision, and support needs are met will help support delivery of a high-quality service.

Concerns regarding the high levels of responsibility placed on FBCs with no formal mental health training, the degree to which they are supported in this new role, and the potential negative impact that insufficient support and training may have on both counselling outcomes and their own well-being are highlighted in the literature (Agyapong, Osei, McLoughlin, & McAuliffe, 2016; Shahmalak, Blakemore, Waheed, & Waheed, 2019). For instance, in the absence of adequate training and regular supervision, FBCs are at risk of experiencing compassion fatigue, burnout, and depression which could negatively impact the quality of counselling (Peltzer, Matseke, & Louw, 2014; Visser & Mabota, 2015). FBCs also face common challenges in PHC settings, including lack of private spaces in which to provide counselling, feeling unwelcome and marginalised from the rest of the PHC team, lack of confidence in their role, and lack of clarity on role functions (Petersen et al., 2016). Further, although counsellors may have the skills to deliver the technical content of the counselling interventions, the more nuanced micro skills such as reflecting on feelings and interpreting clients' responses may require intensive training (Kagee, 2013).

Several studies in LMICs, including South Africa, have investigated the acceptability, feasibility, and potential effectiveness of using dedicated FBCs to deliver mental health counselling at PHC facilities (Mendenhall et al., 2014; Padmanathan & Silva, 2013; Singla et al., 2017; Spedding, Stein, & Sorsdahl, 2014), including the Friendship Bench in Zimbabwe (Chibanda et al., 2016), the MANAS trial in India (Patel et al., 2010), and project STRIVE in South Africa (Sorsdahl et al., 2015b). However, only a handful of studies from LMICs have explored the experiences of counsellors responsible for the delivery of these interventions (Shahmalak et al., 2019). These studies suggest that counsellors are generally highly motivated, experience growth from training and supervision, and apply concepts from the intervention to address difficulties in their own lives (Munodawafa, Lund, & Schneider, 2017; Shahmalak et al., 2019). FBCs also face common challenges in PHC settings, including lack of private spaces in which to provide counselling, feeling unwelcome and marginalised from the rest of the PHC team, lack of confidence in their role, and lack of clarity on role functions (Petersen et al., 2016). These studies have conducted an in-depth exploration of the FBCs' experiences of training

and supervision (Barnett, Lau, & Miranda, 2018). In addition, the potential differences in the experiences of *designated* or *dedicated* counsellors remains unknown. FBCs' perceptions on the most beneficial aspects of training and supervision (e.g. content, intensity, duration) can guide the development of training and supervision models for the scale up of mental health counselling in these settings. Comparing the experiences of designated and dedicated counsellors is also relevant since they are likely to face different systemic challenges to delivering counselling. Implementation strategies required to support the scale up of dedicated versus dedicated approaches may therefore need to vary.

This paper helps provide this information through exploring the experiences of both dedicated and designated FBCs tasked with delivering the project MIND counselling intervention within primary care chronic disease services in the Western Cape Province of South Africa.

1.1 Aim

The proposed qualitative study aims to explore the experiences of FBCs working on Project MIND who provide psychosocial counselling to individuals with a common mental disorder in primary healthcare settings in the Western Cape.

1.2 Objectives

1. To explore the barriers and challenges that dedicated and designated FBCs experience when delivering the psychosocial intervention.

2. To explore dedicated and designated FBCs' perceptions of regular structured supervision, debriefing and in-service training for improving micro-counselling skills.

3. To elicit suggestions from the FBCs for future scale up of counselling services in primary healthcare settings.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

This section starts by discussing the prevalence of CMDs including their burden and the large unmet treatment need for these conditions. It then discusses the WHO's optimal mix of mental health services and the Mental Health Gap Action Programme (mhGAP). Thereafter, brief evidence-based treatments are described, followed by a discussion on the barriers to the provision of task- sharing. It concludes by discussing the experiences of FBCs within the context of task-sharing and provides a rationale for why the experiences of these counsellors require further investigation.

2.2. Prevalence and burden of common mental disorders

Globally, CMDs such as depression, anxiety, and alcohol use disorders are highly prevalent (Steel et al., 2014). A systematic review and meta-analysis revealed that about 1 in 5 people (17.6%) experienced a CMD within a 12-month period while 1 in 3 people experienced a CMD within their life-time (29.2%) (Steel et al., 2014). More specifically, mood disorders such as depression affected 1 in 20 people (5.4%) annually, followed by anxiety disorders (1 in 15 people ; 6.7%), and substance use disorders (1 in 25 people ; 3.8%) (Steel et al., 2014). Consistent with this high 12-month prevalence, the life-time prevalence for each respective CMD was 9.6% for mood, 12.9% for anxiety and 10.7% for substance use disorders (Steel et al., 2014). Furthermore, during the decade between 2005 and 2015, the global prevalence of depression increased by 18.4%, overtaking iron-deficiency anaemia to become the third leading cause of disability (Vos et al., 2016). The prevalence of anxiety disorders also increased by 14.9% during this time period (Vos et al., 2016).

In South Africa, a middle-income country there is a dearth of representative studies on the prevalence of CMDs. In 2008, the first nationally representative study conducted in South Africa found a 12-month prevalence for mental disorders to be 16.7% (Williams et al., 2008) with a life-time prevalence of 30.3% (Stein et al., 2008). Furthermore, the lifetime prevalence estimates for any mood, anxiety and alcohol use disorder were found to be 9.8%, 15,8% and 11,4%, respectively (Herman et al., 2009; Stein et al., 2008). Despite the high prevalence of CMDs in South Africa, modelled estimates from a recent nationally representative study showed that a mere 0.89% and 7.5% of the population requiring care but who are unable to afford private mental health care received some form of inpatient and outpatient mental health care at a public

healthcare facility (Docrat et al., 2019). These modelled estimates suggest that South Africa has a large treatment gap closer to 92% (Docrat et al., 2019).

For the past two decades, the annual global burden of disease (GBD) studies which comprises the most comprehensive global observational epidemiological study, have recorded the morbidity and mortality associated with a range of health conditions. Chronic-communicable disease such as HIV have been the main driver of disease burden in many LMICs, particularly in Sub-Saharan Africa (SSA). Recent GBD studies revealed that many LMICs in SSA are experiencing an epidemiological transition from chronic communicable- to non-communicable disease (NCDs) (Iburg, 2017). Disability adjusted life years (DALYs), which is a metric used to describe the health of a population, showed a decrease in communicable, maternal, neonatal, and nutritional disorders during 1990 – 2016. In contrast, an increased number of DALYs for NCDs was evident during the same period (Iburg, 2017). This means that as people live longer, non-fatal health outcomes become an increasing burden which may increase the risk of developing other comorbidities. This is a concern particularly for South Africa's under-resourced health system as the country is challenged by what is known as a quadruple burden of disease including chronic communicable and NCDs, injury, and mental disorders (Mayosi et al., 2012).

2.3. Comorbidity of mental health and other non-communicable disease

Not surprisingly, there are high rates of comorbidity of mental disorders with other non-communicable diseases. A systematic review found CMDs such as depression and alcohol use disorder to be more common among people living with HIV (PLWH) globally compared to non-infected persons (Nakimuli-Mpungu et al., 2012). This is supported by a number of other studies which have been conducted in LMICs (Breuer, Myer, Struthers, & Joska, 2011; Chibanda, Benjamin, Weiss, & Abas, 2014; Kagee, Saal, & Bantjes, 2017) and have shown that CMDs are more prevalent among PLWH than in non-HIV infected persons. Similarly, CMDs are more common among people living with diabetes (Ali, Stone, Peters, Davies, & Khunti, 2006) and have been shown to be a strong predictor of diabetes onset (De Jonge et al., 2014).

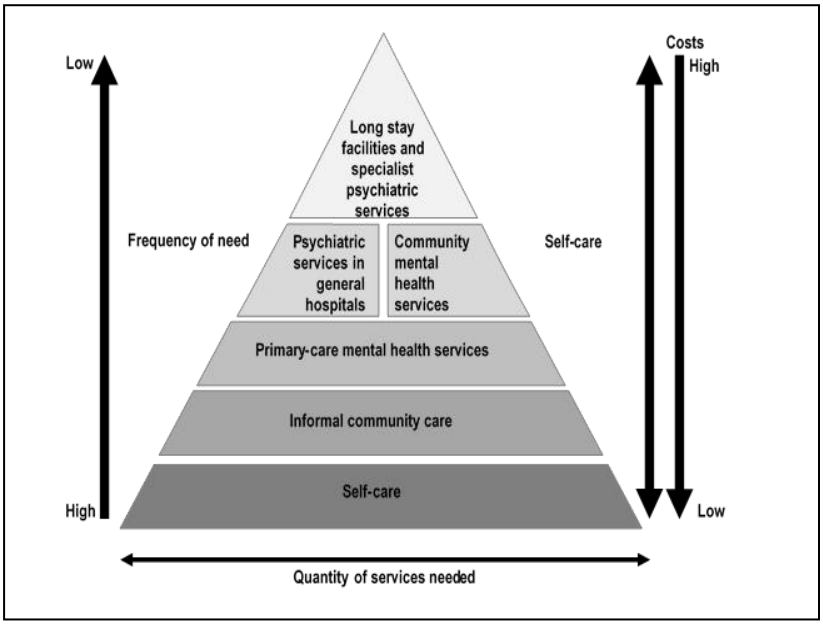
Several important reasons exist to address comorbid CMDs, HIV and diabetes. In particular, this is true for two major chronic diseases: HIV and diabetes. Studies indicated that leaving CMDs untreated is associated with poor treatment adherence, which in turn exacerbates disease progression and thus treatment failure (Mayosi et al., 2012). CMDs often go undetected and untreated which negatively affects treatment outcomes of coexisting diseases such as HIV, AIDS and/or diabetes (Lin, Von Korff, & Consortium, 2008; Neuman, Schneider, Nanau, & Parry, 2012). Conversely, those living with HIV, AIDS and/or diabetes are at higher risk of developing a CMD

due to the stresses and strains of living with chronic health conditions (Lindeman et al., 2000). The implications for mental healthcare service provision in LMICs, including South Africa, are therefore further concerning considering the existing large treatment gap (Seedat et al., 2008). As people live longer and their quality of life better due to the epidemiological transition mentioned earlier, more people are at risk of developing these comorbid NCDs, which in turn means even more human resources will be required to address the unmet need of mental health care.

2.4. Optimal mix of services for mental health

As part of the WHO's strategy to address the mental health treatment gap in LMICs, they have developed a framework to guide countries in establishing an optimal mix of mental health services. This framework, as illustrated in Figure 2, recommends that an optimal functioning mental healthcare system would include self-care (level 1); informal community care (level 2); primary-care mental health services (level 3); psychiatric services in general hospitals, and community mental health services (level 4); and long stay facilities and specialist psychiatric services (level 5). This framework suggests that at levels 1 and 2, which are overlapping and nested within the community, people should be empowered to manage their own psychosocial problems including receiving help from families, friends and non-governmental organisations. Empowerment at this level may include awareness campaigns about mental health by means of posters and digital media. Additionally, services leveraged from other sectors such as teachers, traditional healers or community groups for example should educate and teach people basic skills necessary to identify, cope and manage psychosocial problems successfully. Where mental health problems become more complex or more severe, additional expertise should be sought by means of "upward referral" at levels 3 to 5 in ascending order.

Figure 1. WHO optimal mix of services pyramid



Source: (WHO, 2007a)

Despite these recommendations, current mental health services in South Africa are fragmented and unequally distributed (Lund, Kleintjes, Kakuma, & Flisher, 2010). South Africa's mental health services remain focused on providing services within general hospitals and psychiatric facilities (levels 4 and 5) (Lund & Flisher, 2003; Vergunst, 2018). This means that more money and services are allocated at levels 4 and 5 where the need for mental health service provision is low, and the costs are high. Furthermore, severe mental illness remains the focus of treatment while service provision to address CMDs is neglected. One of the recommendations to address this issue is by means of expanding mental health services to include early identification through screening for CMDs and providing brief psychosocial interventions as treatment within level 3 (Sorsdahl, Stein, & Lund, 2012). In addition, linkages between these levels need to be established for both "upward" and "downward" referral as part of prevention and treatment strategies.

2.5 Mental Health Gap Action Programme (mhGAP)

The mhGAP, developed by the WHO, was launched in 2008 to assist, particularly LMICs, to address the large treatment gap (WHO, 2008). The WHO recognised that where mental health resources were available, it was insufficient, unequally distributed, and used inefficiently (Saxena, Thornicroft, Knapp, & Whiteford, 2007). Therefore, one of the key tenets of the mhGAP in addressing these limitations was recognising the need to scale up resources by upskilling non-specialist health workers and lay persons to provide mental health treatment packages beyond the confines of mental hospitals and

increasing service coverage into primary healthcare and the broader community (WHO, 2008). Extending on this earlier work, the WHO released the Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) in 2010; a second edition was published in 2016. The mhGAP-IG provides a set of recommendations on how to manage mental, neurological and substance use disorders, which are considered priority health conditions due to their high burden (Wang, 2016). Simply put, it provides non-specialists with the necessary tools to effectively treat, manage and prevent disease progression. The mhGAP-IG has been successfully adapted and utilized for treating mental illness in several LMICs under a research umbrella, however its full-scale implementation has been hampered by a range of barriers to the uptake and provision of these services.

2.6. Barriers to accessing available mental health care in South Africa

Several barriers have been identified which continue to hinder people accessing mental healthcare treatment in South Africa. These include, but are not limited to, structural and financing barriers, low perceived need for treatment, low mental health literacy, stigma, and systemic barriers (Bruwer et al., 2011; Hugo et al., 2003; Mendenhall et al., 2014). These barriers are discussed below.

2.6.1 Knowledge, attitudes and beliefs related to mental health

Several studies have documented the reluctance of those living with a mental disorder to seek treatment (Andrade et al., 2014; Bruwer et al., 2011; Edlund, Unützer, & Curran, 2006). For example, results from the WHO's World Mental Health surveys revealed that a low perceived need for treatment was reported in more than half (56.4%) of all respondents that needed treatment (Andrade et al., 2014). This is in accordance with results from a South African study that revealed a low perceived need to seek treatment to be one of the main reasons among those that did not access treatment (Bruwer et al., 2011). This supports findings from the SASH study discussed earlier whereby only 1 in 4 persons who needed it, sought treatment (Seedat et al., 2008). Several other reasons have been documented that contribute to people who are living with a mental illness not recognising the need for treatment. Barriers such as wanting to deal with a mental disorder on one's own (Andrade et al., 2014; Bruwer et al., 2011), stigma and discrimination by the general public and healthcare professionals (Ross & Goldner, 2009), and low mental health literacy (Sorsdahl & Stein, 2010) are some of the main reasons documented in the literature.

Mental health literacy is considered a key factor when it comes to people's treatment seeking behaviour. This is evident from its definition where Jorm et al. (1997) first defined it as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (p. 182).

This means that someone with knowledge about mental health will be able to identify a mental health problem in either themselves or others, know where and by whom to seek help, and know how to prevent disease progression (Jorm et al., 2006; Jorm et al., 1997). Unfortunately, studies have shown that people lack accurate knowledge about mental illness resulting in them being unable to recognize a mental disorder (Hugo et al., 2003; Sorsdahl & Stein, 2010; Thornicroft, Rose, Kassam, & Sartorius, 2007).

A study conducted in South Africa, a middle income country, showed that only about a third (31%) of the general public were able to identify the presence of a CMD correctly (Sorsdahl & Stein, 2010). Even healthcare professionals, such as nurses and general physicians, struggle to identify CMDs which further exacerbates the issue of low mental health literacy (Ross & Goldner, 2009). Furthermore, it is unlikely that a CMD will be detected unless patients explicitly communicate their concerns about a potential CMD to a general practitioner (Jacob, Bhugra, Lloyd, & Mann, 1998). It follows that a non-systematic review about mental health literacy in developing countries stressed the need for those working in primary healthcare to improve their knowledge on mental health (Ganasen et al., 2008).

The implications of low mental health literacy are that people will, in all likelihood, not be able to identify whether they have a CMD (Jorm et al., 2006; Sorsdahl & Stein, 2010). If patients are not able to identify and communicate symptoms of their potential CMD to a healthcare provider, the CMD will most likely go undetected and untreated resulting in a missed opportunity to provide appropriate mental health treatment (Jacob et al., 1998; Sorsdahl et al., 2010). This delays early treatment of CMDs, which could otherwise have prevented disease progression especially in individuals with comorbid diseases (both communicable and non-communicable) (Kakuma et al., 2011). Moreover, if CMDs are left untreated, the progression to more severe symptoms may become pronounced and increase the likelihood of individuals experiencing mental health stigma, another key barrier to mental health treatment.

For decades, the issue of stigma has impacted the lives of those living with a mental illness negatively. People living with a mental illness are discriminated against by being viewed by their communities as dirty, worthless and a nuisance (Ross & Goldner, 2009). In some African cultures, people living with a mental illness are viewed by their community as being possessed by evil spirits, violent and dangerous (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005; Mbanga et al., 2002). These negative perceptions are further reinforced by the film and media industry by portraying individuals living with a mental illness as violent and animalistic (Babic, 2010; Sartorius & Schulze, 2005). Despite stigma being a negative concept, it is pervasive and extends to primary healthcare providers as well.

Healthcare professionals, such as nurses for instance, play an important role in providing PHC, including mental health care. Despite this, studies have shown that they contribute to the stigmatizing burden of those living with a mental disorder who seek healthcare treatment (Ross & Goldner, 2009). Globally, a literature review conducted by Ross and Goldner (2009) regarding stigma, negative attitudes and discrimination towards mental illness revealed several concerning findings, namely; 1) nurses were fearful of those with a mental illness and treated them with caution, fearing that they could become violent in an instant; 2) nurses held the beliefs that mental illness was due to a lack of will-power, laziness and weakness of morals; and 3) patients who inflicted self-harmed were seen to be wasting resources and treated with a hostile attitude. These findings are concerning because a) if you are mental health literate, visiting a PHC facility will not help if healthcare staff are not supportive; and, b) healthcare staff will be less likely to identify those in need of mental health treatment.

A number of stigma-related consequences have been identified in the literature (Corrigan et al., 2014; Sharac, Mccrone, Clement, & Thornicroft, 2010; Sorsdahl & Stein, 2010). For instance, a study conducted in South Africa by Sorsdahl, Kakuma, Wilson, and Stein (2012) revealed that respondents living with a mental illness felt rejected by the general public, which increased the likelihood of them experiencing discrimination and thus withdrawing themselves socially. Second, research has found that individuals who disclose their mental disorder at their place of work experience difficulty with their supervisor, are treated differently by their colleagues, and may lose out on job opportunities when seeking formal employment (Sharac et al., 2010). Third, those who experience stigma from healthcare professionals reported feelings of alienation with the healthcare system due to feeling discriminated against and being treated without dignity (Ross & Goldner, 2009). These barriers influence a patient's initiation and retention in mental health services.

2.6.2 Availability and accessibility of mental health services

LMICs including South Africa continue to face the difficult task of addressing the lack of resources required for providing mental healthcare services (Saxena et al., 2007). This is evident by the large disparities in human resource allocation in LMICs compared to higher-income countries (Kakuma et al., 2011; Saxena et al., 2007; WHO, 2018). For instance, more psychiatrists per population (12.7 per 100 000 people) are found in higher-income countries compared to LMICs (0.1 lower-income; 0.5 lower-middle; 2.1 upper-middle per 100 000 people) (WHO, 2018). Moreover, the proportion of nurses per population in higher-income countries (23.5 per 100 000) far outweigh those in LMICs (0.3 lower-income; 1.4 lower-middle; 6.8 upper-middle) (WHO, 2018).

In South Africa, despite the country's democratic status since 1994, mental health service provision still remains unequally distributed within and between provinces (Docrat et al., 2019; Petersen et al., 2009). Reasons for these disparities include mental health professionals moving from rural to urban areas in search of better working conditions, career development and financial incentives (Kakuma et al., 2011). Other studies (Friedman, 2004; Gureje et al., 2009; Hamilton & Yau, 2004) showed that these are similar reasons for emigration to higher income countries which further exacerbates the issue of unequally distributed health resources. Findings from a recent study, which is the first nationally representative study to investigate public health expenditure on mental health service provision in South Africa revealed several key findings (Docrat et al., 2019). First, mental health treatment predominantly occurs as inpatient care accounting for 86% of all mental health expenses, with only 14% spent on outpatient care. Secondly, the majority of provinces in the country spend fewer than 5% of their health budgets towards mental health services which is below the recommended minimum level of expenditure (5%) (Chisholm, Saxena, & Van Ommeren, 2006); Third, there are on average 0.31 psychiatrists and 0.97 psychologists working in the public sector per 100 000 people. Further, other healthcare providers such as occupational therapists and social workers which offer important support services are equally low at 1.53 and 1.83 per 100 000 people. Despite professional and specialised nurses showing good coverage of 80 and 27.5 per 100 000 people respectively, there is no indicator on how many are psychiatric nurses (Docrat et al., 2019).

Given South Africa's limited availability of mental health professionals, the provision of mental health treatment services at primary healthcare level, if/when available remains questionable. Most mental health services at PHC are focused on people living with severe mental illness, with PHC nurses lacking confidence in their skills to adequately assist these patients (Petersen et al., 2009). Further, nurses struggle to identify and treat CMDs due to insufficient time and viewing the assessment of someone with a possible CMD as taking too long (Petersen et al., 2009). This is in accordance with other findings where nurses were unable to recognize CMDs such as depression and anxiety, resulting in missed opportunities for providing mental health treatment and thus failing to address the large mental health treatment gap (Dirwayi, 2002; Sorsdahl et al., 2010).

When mental health services are available at primary care, the organizational culture often hinders the provision of high-quality mental healthcare. A systematic review has shown that PHC facilities are still dominated by a task-oriented biomedical care approach which focuses on giving advice despite evidence to the contrary recommending a patient-centred collaborative care approach (Petersen, Fairall, Egbe, & Bhana, 2014a). Further, the dominant biomedical care approach has perpetuated the lack of attention given to creating an environment conducive to patient-centred mental health counselling such as providing adequate counselling space, sufficient time for counselling, adequate referral pathways and patient follow-up (Petersen et al., 2014a). More recently, a study found that one

quarter of the 26 PHC facilities in the Western Cape lack a person-orientated care approach to health services which is underpinned by weak management, a lack of teamwork and staff shortages (Myers et al., 2019a). Moreover, within these facilities patients are often treated harshly with staff appearing disinterested in their patients' needs (Myers et al., 2019a). Research has shown that patients prefer having a caring and safe therapeutic environment and are more likely to take up mental health counselling in the absence of these barriers (Myers et al., 2018a).

In addition to the dominant biomedical culture found in PHC facilities, there is a mismatch between the ethnic and cultural diversity of the population needing mental health treatment and the number of culturally diverse mental healthcare providers (Kazdin, 2019). This mismatch has contributed to the limited treatment-uptake and retention of people within mental health treatment programmes (Kazdin, 2019). Patients feel misunderstood and less motivated to continue mental health treatment. Research has shown that mental health interventions that are culturally appropriate, such as being delivered in the patients' own language and by someone with an intimate knowledge of the community, is often more effective (Rathod et al., 2018). One such example is found in a recent study in which community health workers (CHWs) recognised the need to use culturally sensitive language to facilitate better rapport and understanding among patients attending the counselling programme (Chibanda et al., 2017).

Other barriers which continue to hinder the provision of quality mental healthcare is systemic barriers (Padmanathan & Silva, 2013). These barriers include aspects such as excessive task demands, inadequate training and ongoing supportive supervision, and poor remuneration (Padmanathan & Silva, 2013). Further, excessive task demands in the absence of adequate training and supportive supervision while also being poorly remunerated could lead to poor job satisfaction, compassion fatigue and burnout, which has been shown to compromise quality of care (Khamisa, Oldenburg, Peltzer, & Ilic, 2015). A large multi-site study which formed part of the Programme for Improving Mental Healthcare (PRIME) described additional systemic barriers such as a lack of private space for counselling, poorly defined roles, and education and training impacting delivery of quality mental health services (Mendenhall et al., 2014). For instance, concerns were raised regarding who should provide mental health training as specialists such as psychiatrists had limited community experience compared to non-specialist staff. Moreover, factors such as poorly defined roles could lead to staff being overburdened with work and impact negatively on their ability to deliver quality mental healthcare (Mendenhall et al., 2014).

2.7 Task-sharing mental health counselling

Task-sharing is an approach to addressing health provider shortages (Spedding et al., 2014). Over the last few years, task-sharing mental health counselling to FBCs or lay health workers in LMICs has gained considerable attention with regards to its feasibility and acceptability. For instance, systematic reviews have shown that using FBCs or lay health workers who are trained to deliver counselling packages of care in LMICs, particularly in South Africa, are indeed acceptable and feasible (Padmanathan & Silva, 2013; Petersen et al., 2014a; Spedding et al., 2014). Although these studies have found task-sharing to be feasible and acceptable, key challenges such as a lack of resources, adequate remuneration, acceptance among healthcare providers and supervision and training need to be addressed for the model to be successful and sustainable (Padmanathan & Silva, 2013; Petersen et al., 2014a; Spedding et al., 2014).

Building on these reviews, a multi-site qualitative study which formed part of the PRIME project examined stakeholder perceptions on the acceptability and feasibility of task-sharing mental healthcare in LMICs (Mendenhall et al., 2014). Stakeholders across the various sites described that task-sharing in mental healthcare is acceptable and feasible provided key requirements are met such as: 1) increasing the number of human resources and improving access to medications; 2) providing health workers with adequate training and compensation for adopting additional tasks; and 3) supporting health workers through regular structured supervision at the community and primary healthcare level (Mendenhall et al., 2014).

In addition to the evidence on the acceptability and feasibility of task-sharing, there is growing evidence on the effectiveness of task-sharing in LMICs. Project “Strive” conducted in South Africa using peer counsellors to deliver a blended motivational interviewing and problem solving therapy (MI-PST) intervention to patients attending emergency settings showed promising outcomes for reducing risk of substance abuse and depression (Sorsdahl et al., 2015c). Elsewhere, the “Friendship Bench” study conducted in Zimbabwe showed that lay health workers who are trained to provide problem solving therapy (PST) to patients with a CMD was effective in reducing symptoms of their mental illness (Chibanda et al., 2015; Chibanda et al., 2016). Further support of task-sharing is found with the “MANAS” trial in India where lay health workers provided treatment for depression and anxiety disorders with positive results (Patel et al., 2010), and in Pakistan where a community health worker-led Cognitive-Behavioural Intervention yielded positive results for mothers living with depression (Rahman, Malik, Sikander, Roberts, & Creed, 2008).

A recent systematic review (Singla et al., 2017) described key elements which aid the effectiveness of task-sharing in mental health interventions. Important treatment-specific elements included eliciting

or identifying support (85.2%); problem-solving engagement (80.8%); identifying or eliciting affect (76.9%); or both; linking affect to events (76.9%); and identifying thoughts (63.0%) were among the five most common elements used by non-specialist providers delivering effective interventions. In addition, important non-specific elements included empathy (88.9%); collaboration (85.2%); active listening (77.8%); normalization of treatment or aspects related to the illness (70.4%), or both; and the involvement of family members or significant other (63.0%). Non-specialist providers delivering these elements require competencies which need to be reinforced among non-specialist providers as the foundation for providing effective mental health treatment. It is no surprise that there remains a need to provide non-specialist providers with regular training, ongoing supervision and debriefing to ensure maintenance of these elements and therefore effective counselling (Mendenhall et al., 2014).

2.8 Experiences of facility-based counsellors

A number of studies have investigated the experiences of FBCs (also known as HIV adherence counsellors) working in PHC settings in South Africa to address HIV and AIDS (Malema, Malaka, & Mothiba, 2010; Mwisongo et al., 2015; Peltzer & Davids, 2011; Rohleder & Swartz, 2005). For instance, Peltzer and Davids (2011) explored the experiences of FBCs providing HIV counselling in the Cacadu district of the Eastern Cape Province to identify potential needs for HIV counselling; and Malema et al. (2010) investigated the experiences of FBCs who provide voluntary counselling and testing for the prevention of mother to child transmission of HIV and AIDS in the Capricorn District of Limpopo Province; 3) Mwisongo et al. (2015) evaluated the HIV lay counselling and testing profession in South Africa by exploring the experiences of FBCs who provide HIV testing in the context of task shifting; and 4) Rohleder and Swartz (2005) investigated the experiences of FBCs working in a task-orientated healthcare system.

In general, although these studies were conducted in different contexts, they reported similar barriers to the successful delivery of adherence counselling for people living with HIV and AIDS in South Africa. These barriers include: structural barriers such as the lack of private counselling space, a lack of regular supervision and training, not feeling recognized as an integral part of the facility, and lack of professional registration of their trade (Malema et al., 2010; Mwisongo et al., 2015; Peltzer & Davids, 2011; Rohleder & Swartz, 2005). Given the increased prominence of utilising FBCs and the number of tasks that have shifted to this cadre of staff working in primary health care, regular supervision, in-service training and support is crucial for its successful implementation.

However, despite the movement in global mental health advocating for task-sharing as a means to address the scarcity of specialized mental health professionals, few studies have investigated the

experiences of FBCs who provide a psychosocial intervention for mental illness in PHC. To the best of my knowledge, a total of two studies have investigated this issue in South Africa. First, Munodawafa et al. (2017) explored the experiences of FBCs who delivered a task-sharing psychosocial intervention for perinatal depression in Khayelitsha, South Africa. This served as a sub-study of the Africa Focus on Intervention Research for Mental health South Africa (AFFIRM-SA) (Lund et al., 2015). Several important findings emerged from their qualitative interviews regarding the counsellor's experience with delivering the psycho-social intervention. These include lacking private space to conduct counselling sessions, not feeling welcome in the facility, and experiencing personal difficulties. Despite these challenges, counsellors also provided positive feedback such as feeling motivated and altruistic, experiencing growth from supervision, and using concepts from the intervention to address problems in their own lives.

Second, Petersen et al. (2015) sought to develop a district mental healthcare plan by integrating mental health treatment into chronic disease care. Although the study had its advantages such as providing holistic care for patients, many bottle necks were reported on the part of the FBCs delivering the psychosocial intervention. FBCs felt that they were marginalised in the facility, private space to conduct counselling sessions were an issue which limited confidentiality, and their confidence was low with no clear roles of their duties (Petersen et al., 2015). Unsurprisingly, interviews with nurses revealed that they had no confidence in FBCs' abilities to deliver the psychosocial intervention which further reinforced the FBCs' poor experiences (Petersen et al., 2015).

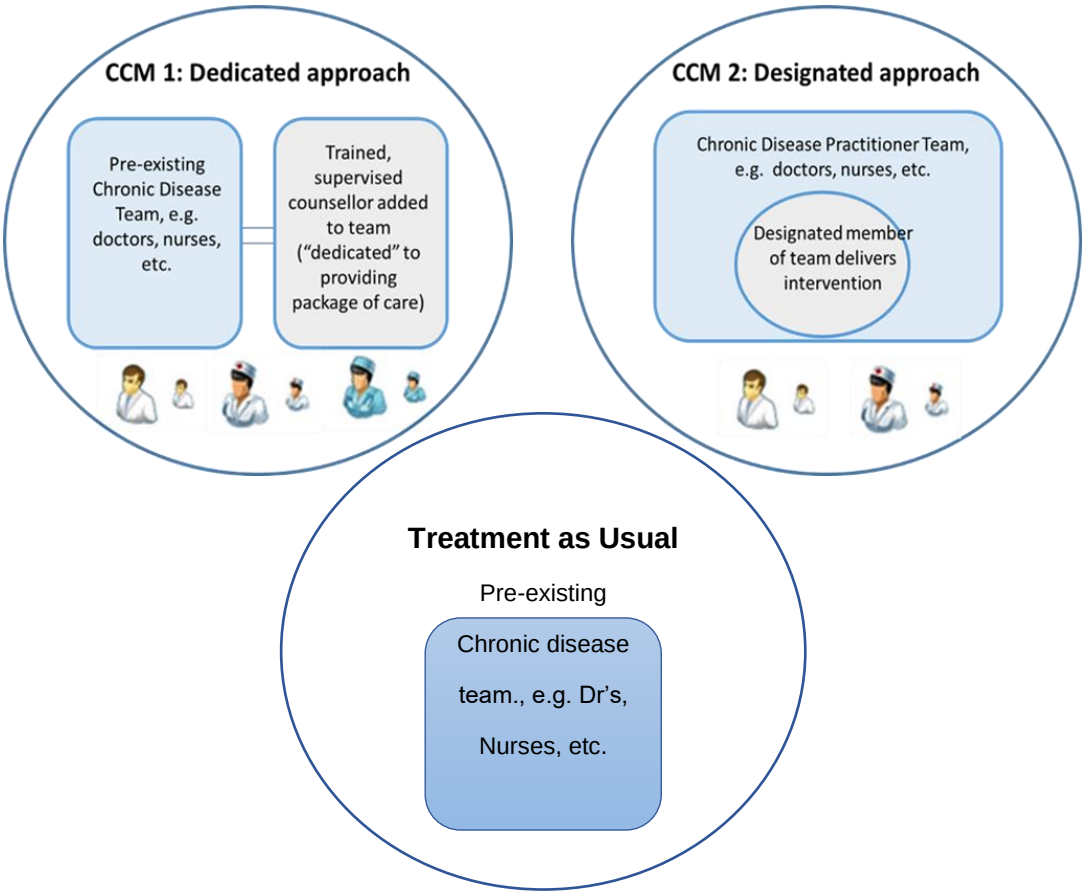
Interestingly, these studies all reported similar themes despite the psychosocial interventions being conducted in different contexts and delivering different interventions. Considering these overlapping themes, it is no surprise that a recent systematic review emphasised the need for reporting on aspects concerning training and supervision of FBCs, fidelity checking and components of the intervention (Petersen et al., 2014a). South Africa, unlike most other LMICs, is in the unique position to possess a cadre of staff that can address the training and supervision challenges. Registered counsellors, despite being under-utilised, are professionally trained psychological counsellors with a University Honours-level qualification. The Health Professions Council of South Africa (HPCSA) through the Professional Board for Psychology introduced this middle-level category of psychological counsellors to address the lack of mental health treatment capacity at PHC level. Moreover, their scope of practice allows for the training and supervision of other equally or lessor qualified mental healthcare practitioners. Therefore, registered counsellors are perfectly positioned to address the need to provide regular training, supervision and debriefing to FBCs working in PHC in a way that is cost effective and sustainable (Petersen, 2004).

Project MIND is utilizing a registered counsellor to conduct training, supervision and debriefing to FBCs providing a brief psychosocial intervention. This novel approach is important for mental health research in South Africa as, to my knowledge, no other studies exist utilizing a registered counsellor to provide training, supervision and debriefing of FBCs working within the dedicated and designated approaches in PHC facilities. The few studies gleaned from the literature which involves registered counsellors working in South Africa focus on aspects such as the state of the registered counsellors profession (Abel & Louw, 2009), employment patterns of registered counsellors (Elkonin & Sandison, 2006; Kotze & Carolissen, 2005) and the perceived role of registered counsellors as mental healthcare providers (Elkonin & Sandison, 2010; Rouillard, Wilson, & Weideman, 2016). One of the suggestions put forward to advance the role of registered counsellors is to look at innovative ways, such as project MIND, of utilizing registered counsellors within the South African context in order to better contribute to mental health services (Rouillard et al., 2016).

2.9 Project MIND

Project MIND, a cluster-randomized controlled trial currently being conducted by the South African Medical Research Council (SAMRC) in collaboration with the University of Cape Town (UCT), University of Oxford, and the Western Cape Department of Health (WCDoH), is testing models for integrating a brief psychosocial intervention into chronic disease services (specifically HIV and diabetes) at 24 primary healthcare facilities in the Western Cape (Myers et al., 2018c). This study has three research arms (see Figure 2): 1) control group (treatment as usual), which involves referring patients to the services normally provided when providers suspect a patient receiving HIV or diabetes treatment has a CMD; 2) "dedicated" approach in which a trained FBC is added to the chronic disease team to provide a three-session blended MI-PST intervention for patients who screen at-risk for a CMD; and 3) "designated" approach, which involves identifying an existing FBC within the chronic disease team and training this person to provide the MI-PST intervention in addition to their usual adherence counselling duties. Both "dedicated", and "designated" FBCs receive regular supervision, debriefing, and in-service training by a registered psychological counsellor.

Figure 2: Collaborative care models compared to treatment as usual



2.9.1 Description of the project MIND intervention delivered by facility-based counsellors

Project MIND is using a brief evidence-based MI-PST intervention consisting of three sessions which are based on the coping theory by Lazarus and Folkman (1984) (see table 1 below for summary of these sessions). This intervention was adapted for the South African context (Sorsdahl et al., 2015a) and has shown to be effective and cost effective for treating CMDs such as depression and alcohol use disorder in adults (Dwommoh et al., 2018; Sorsdahl et al., 2015c; van der Westhuizen et al., 2019). The goal of the intervention is to enhance intrinsic motivation to bring about change in risky behaviour and to teach problem-solving coping skills for mutable and non-mutable problems (Lazarus & Folkman, 1984).

FBCs in both the dedicated and designated arms deliver this brief MI-PST intervention to patients attending chronic care and who are presenting with symptoms of depression and/or risky alcohol use. Each counselling session is generally between 40 to 60 minutes in length and consists of

psychoeducation, motivational enhancement, and teaching patients how to cope and address everyday problems using the structured PST approach. FBCs collaborate with the patient using the project MIND patient handout to guide the sessions in one of the official languages of the Western Cape (English, Afrikaans, and isiXhosa). Each session presents patients with an opportunity to practice and implement their newly acquired problem-solving skills by means of a take-home activity. The take-home activity is discussed at the start of the following session to assess whether the patient was able to implement the problem-solving skills effectively. All counselling sessions are delivered within an office in the PHC facility. In general, FBCs in the dedicated arm must arrange with facility staff for a space to deliver counselling whereas FBCs in the designated arm have their own assigned offices.

Table 1: Summary of blended MI-PST sessions

Session 1	• Conduct screening/assessment of mental health
	• Provide feedback on results of screening/assessment
	• Increase knowledge of how depression and/or alcohol use impacts on course of HIV and diabetes
	• Use MI to build rapport and develop readiness to change
	  ○ Assess readiness to change (using readiness ruler)
	  ○ Assess pros and cons of change
	  ○ Use MI to elicit a commitment to change

Session 2	• Patient check-in using MI
	• Build the rationale for PST
	  ○ Explain the structure and rationale for PST
	  ○ Establish positive problem orientation
	• Teach the steps of PST
	• First problem-solving exercise with facility-based counsellor and take-home activity

Session 3	• Patient check-in using MI
	• Review practice exercises from session 2 and discuss challenges
	  ○ Elicit positive change talk and affirm commitment to change using MI techniques
	  ○ Review PST steps
	  ○ Establish positive problem orientation
	• *Coping with negative thoughts*: Explain how to cope with problems that are not important
	• Second problem-solving exercise with facility-based counsellor and an exercise
	• *Advance process of acceptance*: teach how to deal with problems that are important and cannot be solved
	• Third problem-solving exercise with facility-based counsellor and recap
	• Elicit positive change talk and affirm commitment to change using MI

2.9.2 Training, supervision and debriefing

All dedicated and designated counsellors received approximately 40 hours of formal training delivered by a registered counsellor. The project MIND training included: 1) understanding CMDs and chronic disease such as diabetes and HIV; 2) screening for depression and hazardous/harmful alcohol use; 3) delivering brief MI-PST using a structured three-session guidebook; and 4) responding to distressed participants. These were presented as a mixture of didactic teaching and experiential group processes including role plays and group exercises. Prior to the training, the FBCs completed a brief assessment of their knowledge, attitudes, beliefs and practices around counselling for CMDs, which

was also done at completion of training. The structure and format of supervision was consistent across all sites. This included: debriefing, discussing patient progress, addressing challenges, and providing feedback from their counselling sessions. Audio recorded counselling sessions were listened to by the counselling supervisor using a fidelity checklist. The fidelity checklist was used to assess whether the intervention was being delivered as intended. When fidelity to the intervention was found to be high, feedback was given to FBCs as a means of positive reinforcement. When fidelity to some areas of the intervention was found to be low, corrective steps were discussed and, on many occasions, role-played. FBCs were accessed through a blend of either weekly visits at the primary healthcare facilities or by means of telephonic sessions. Between these scheduled supervision and debriefing sessions, brief communication also occurred via text or WhatsApp messaging to address challenges in real-time.

CHAPTER 3: METHODS

3.1. Study design

This study adopted a qualitative study design comprising in-depth semi-structured interviews with facility-based counsellors (FBCs). This design was shown to be appropriate for gaining insight and understanding of people's lived experiences (Gill, Stewart, Treasure, & Chadwick, 2008). The reporting complies with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong, Sainsbury, & Craig, 2007).

3.2 Theoretical Framework

Constructs described in the Consolidated Framework for Implementation Research (CFIR) were used to guide the qualitative data collection, analysis and reporting of the findings. The CFIR was developed to guide implementation science research, such as identifying barriers related to implementing healthcare interventions (Damschroder et al., 2009). This framework comprises of 37 constructs within five domains namely: i) intervention characteristics; ii) outer setting (e.g. financing of services, community attitudes towards mental health); iii) inner setting (e.g. leadership engagement); iv) characteristics of individuals involved in implementation (e.g. experiences of lay counsellors, knowledge and belief about the intervention and dedication to work); and v) the process of implementing interventions (Damschroder et al., 2009). These domains are not necessarily mutually exclusive, but are cross-cutting and influences the effectiveness of implementing interventions (Damschroder et al., 2009). This framework provides us with a structure to discuss the multi-level barriers in the context of mental health service provision in primary healthcare.

3.3 Study setting

This study interviewed FBCs working on Project MIND from the 16 primary healthcare facilities in the Western Cape assigned to the experimental arms ("dedicated" and "designated"). Each facility has a chronic disease unit offering free anti-retroviral treatment and diabetes management. These units are usually staffed by at least one medical doctor, a professional nurse and an HIV counsellor who provides adherence counselling and/or lifestyle advice.

3.4 Participants

A total of 29 FBCs who conducted the psychosocial intervention on project MIND were invited to participate in this qualitative study after they had been conducting the psychosocial intervention for at least 3-months. All dedicated and designated counsellors were eligible for the study. A total of 18 FBCs were interviewed, and 11 refused due to work responsibilities. FBCs who refused participation included eight designated counsellors who viewed their job as more important and an interview as a luxury, whereas three dedicated counsellors found a permanent job and was unable to get time off due to job demands.

3.5 Study procedure

Due to the nature of my relationship with the FBCs as their counsellor supervisor, a qualitative interviewer independent of project MIND conducted the qualitative interviews to minimise response bias. The qualitative interviewer is a registered psychological counsellor with a master's degree qualification in public mental health and has experience in conducting qualitative interviews. FBCs were approached by the qualitative interviewer after their weekly supervision session and asked to participate in a qualitative study. The purpose and aims of the study were described including potential risks and benefits, privacy and confidentiality, and the rights of participants. Written informed consent was obtained from those willing to participate (See Appendix A). A mutually beneficial time was scheduled to conduct each interview.

An interview guide (see Appendix B) was developed and used to guide the discussions and interviews which lasted approximately 45 minutes to an hour. Considering all FBCs working on Project MIND were trained using English as the medium of instruction, all interviews were conducted in English. All Interviews were conducted in the FBC counselling room in the PHC facility where they worked. All interviews were digitally recorded using two recording devices simultaneously. Participants were issued a R150 grocery voucher to compensate them for their time. Recordings were transcribed verbatim by a professional transcriber, who also signed a confidentiality agreement form. To minimise bias, all transcriptions were anonymized and the identities of those who refused participation withheld.

3.6 Data analysis

Qualitative data analyses were conducted using the Framework Approach. This approach involved five main steps (Pope, Ziebland, & Mays, 2000). These steps include: (1) familiarization – immersing oneself in the data by reading the data thoroughly more than once; (2) identifying a thematic

framework - specific themes are identified and the data is coded by using numerical values; (3) Indexing – the data that emerges are indexed and used to generate a thematic matrix, which in turn are numbered and labelled; (4) charting – different themes are organized into charts whereby each participant response is organised under the appropriate chart; and (5) mapping and interpretation – creating linkages with the data in order to generate a broader understanding of the data. Initially, interview transcripts were read several times to identify emergent themes and in turn coded. Each lay counsellor was allocated a code from ID01 to ID18 in order to distinguish them. To ensure validity of the categories, a second researcher coded the first 5 interviews independently. Both coders met regularly to review the codes for consensus. A code breaker was not needed to resolve coding stalemate as consensus were reached after reviewing the codes. After the themes were identified from the data, member checks were done. FBCs were revisited to check whether the data and the interpretation thereof were accurately captured (Babbie, Mouton, PayzeVorster, & Prozesky, 2011). To facilitate analysis of the data, qualitative analysis computer software Nvivo 12 was used.

3.7 Reflexivity and methodological quality

Reflexivity and methodological quality of the study was guided by the Consolidated criteria for reporting qualitative research (COREQ). The COREQ is a 32-item checklist to assess and guide methodological rigour in qualitative research (Tong et al., 2007). Reflexivity refers to how one's background and experiences influence, intentionally or unintentionally, the qualitative research process (Jootun, McGhee, & Marland, 2009). In line with the above mentioned, several steps were taken to mitigate against bias namely, i) due to the nature of my relationship as counselling supervisor with the FBCs, a qualitative interviewer independent of project MIND approached FBCs for participation; ii) the qualitative interviewer conducted all interviews, which likely mitigated potential response bias from FBCs; iii) interview recordings were transcribed and anonymized with unique identifiers, and iv) the identities of those who refused participation was withheld. Despite these steps to mitigate bias, I do not completely discount the possibility of response bias by FBCs due to the nature of the questions about the counsellor supervisor. I was also aware of my own potential bias while analysing the results. For this reason, I regularly consulted with my supervisors while analysing the results in an attempt to remain objective.

3.8 Ethical considerations

Ethical approval was obtained from the University of Cape Town human research ethics committee. Informed consent was obtained from each participant prior to enrolment in the study. Each participant was informed that his/her participation is completely voluntary and had the right to withdraw at any

time without concern of it affecting their employment or involvement with project MIND. Considering this study was nested within a larger study (project MIND), approval to conduct the research study at primary healthcare facilities had already been granted (ethics reference number 753/2017).

3.8.1 Description of risks and benefits

The study involved minimal risks to participants. Some of the questions and discussions might have made them feel uncomfortable, but they were not pressured to answer any questions.

3.8.2 Privacy and confidentiality

Digital recordings of the interviews were encrypted and stored on a password protected computer for the duration of the research study and then destroyed at completion. Transcriptions of the digital recordings and consent forms were stored in a double-locked filing cabinet in a locked office at a security-controlled premises at the SAMRC. Transcriptions and consent forms are kept for 15 years as part of the South African Good Clinical Practice requirements.

CHAPTER 4: RESULTS

This chapter starts by describing the characteristics of the counsellors who participated in this study. Thereafter, the research results are presented according to the four major themes that emerged from the data analysis: These are: 1) counsellors' perceptions of the benefits of the project MIND training; 2) barriers and facilitators related to the implementation of the project MIND intervention; 3) counsellor perceptions of the clinical supervision & debriefing provided by project MIND; and 4) counsellor recommendations for improving the project MIND training, supervision and debriefing model, and implementation. The theme relating to barriers and facilitators is structured according to the two domains of the Consolidated Framework for Implementation Research (CFIR): 1) intervention characteristics e.g. perceived complexity of the intervention and relative advantage; and 2) inner setting e.g. compatibility, organizational incentives and rewards, available resources, and culture. This framework helps in recognising the multi-level barriers in the context of mental health service provision in primary healthcare (PHC) facilities.

4.1. Characteristics of study participants

From a total of 29 FBCs who were invited to participate, 18 FBCs agreed and completed the interviews, while 11 FBCs initially agreed but struggled to be available due to work responsibilities. Among the counsellors who participated, eight (44.4%) were from the dedicated arm and 10 (55.6%) from the designated arm. More than half of the FBCs were female (72.2%). This higher proportion of female FBCs reflects the staffing profile working in primary healthcare facilities in the Western Cape. The age of the FBCs ranged from 28 to 55 years old (mean=40; SD=9.05). Most FBCs had received previous HIV counselling training through the Western Cape Department of Health's (WCDoH) Aids Training, Information & Counselling Centre (ATICC). Furthermore, four (22.2%) FBCs described having received HIV counselling training through Non-Government Organisations (NGOs) affiliated with the WCDoH. Three (16.7%) FBCs (one dedicated and two designated) indicated that they had completed a two-year part-time counselling course in the past. This course, offered by the University of Cape Town, focused on general counselling skills to support patients attending public health facilities. Only one (5.6%) FBC completed the final year of a four-year university degree while working on project MIND. In terms of previous work experience, the majority of designated FBCs started working as either home-based carers or community care workers before progressing to work as HIV FBCs in PHC facilities. Dedicated FBCs had similar work experience but were unemployed at the point of recruitment from the community. All socio-demographic and counselling characteristics of FBCs are presented in table 2 below.

Table 2: Socio-demographics and counselling characteristics of FBCs (N=18)

	Intervention arms		
	Dedicated (N=8)	**Designated (N=10)**	**Both**
Gender N (%)			
Male	3 (37.5%)	2 (20%)	5 (27.8%)
Female	5 (62.5%)	8 (80%)	13 (72.2%)
Age			
Mean (Std. deviation)	41.1 (8.8)	39.1 (7.0)	40 (9.0)
Education N (%)			
Completed school	6 (75%)	8 (80%)	14 (77.8%)
University degree/diploma	2 (25%)	2 (20%)	4 (22.2%)
Counselling experience (years)			
Mean (Std. deviation)	9.1 (5.9)	7.0 (5.6)	7.9 (5.6)

4.2. Counsellors' perceptions of the benefits of the project MIND training

Generally, training was well received among all FBCs who perceived several benefits from participating in the training. Most FBCs reflected that the content and delivery method of the MI-PST training was new to them and differed from the counselling training they had received previously from the ATICC. Almost all of the participants regardless of whether they were in the designated or dedicated arm had been an HIV counsellor in PHCs previously and had received the ATICC training. Their previous training focused on information sharing and providing adherence support, while the MI-PST training received through project MIND was psychosocial in nature and equipped them with skills to improve the therapeutic relationship with patients and work effectively to address psychosocial issues.

> *"…it* (Project MIND training) *was different because mainly at ATICC you talk about HIV and so, it has nothing with a person's psychological state…this one is psychological all the way because it is a person's problems, all the way. So that is the difference."* (ID06, designated counsellor)

> *"…I have been in the field of HIV counselling for the past seven years, but this is another model of counselling…"* (ID15, dedicated counsellor)

In particular, designated counsellors highlighted how these newly acquired skills benefitted their counselling practice through improving the counselling relationship they had with other patients receiving chronic care. Communication skills such as active listening, asking open-ended questions,

and using reflections learnt from the MI component of the training were considered highly beneficial for their interactions with all patients, irrespective of whether they were participants in project MIND.

> *"…if we have a defaulter* [patient who stopped taking ARV's] *we can ask them what is the reason, why did you not come, what made you feel that way…which I did not do before because we did not go on the* [project MIND] *training…we did not know about this…"* (ID11, designated counsellor)

Designated counsellors also emphasised how, through the transfer of these newly acquired counselling skills to their other daily activities, they felt more confident and empowered to probe for psychosocial issues impacting on the patient's ability to stay adherent to their chronic medication. Previously, these mental health concerns would have gone unnoticed.

> *"The experiences was for me very good, very empowering, because I always -like I say, I use some of this in my day to day work* [HIV counselling] *and you get to know the other side of doing counselling* [mental health counselling]*"* (ID13, designated counsellor)

Role-playing stood out as one of the key training aspects that most FBCs thought was beneficial for assessing their new counselling skills and their readiness to implement them into practice. It provided them with opportunities to rehearse their new counselling skills while simultaneously familiarising themselves with the manualised nature of the intervention.

> *"I learned so much [through] role plays so that we can familiarise…how the intervention should be like…from session one to session three."* (ID08, dedicated counsellor)

> *"…the role play really, really helps a lot. It is good to understand content, but role play that is what matters when you do this counselling intervention."* (ID15, dedicated counsellor)

In addition to acquiring skills to assist clients with psychosocial issues, the FBCs reported improvements in their mental health literacy as a result of this training. Regardless of designation, most FBCs indicated that they had experienced a shift in their knowledge and understanding of mental health problems, particularly for depression. Previously, when conceptualizing mental illness, most of the FBCs referred to severe mental disorders such as people experiencing psychosis. As a result, stigmatizing terms such as "asithati kakhle" ("there is nobody home" or "it is not right upstairs") and "pambeni" ("the rocks get inside the ears") were used to describe people living with a mental disorder. However, after training, FBCs reported improvements in their mental health literacy, and described having more insight into CMDs, potential contributing factors to these disorders, and the consequences of leaving these problems untreated.

> *"…after I went on [the] training and as I was doing the sessions, I found out it is not about that* [referring to severe mental illness]. *It is about people's lives and what they go through in*

life, like maybe they lost someone, depression, like daily stresses of life." (ID11, designated counsellor)

Most of the FBCs also highlighted how they applied their newly acquired counselling skills and knowledge about CMDs and chronic illnesses in their personal lives. These FBCs indicated that they were confronted with many personal problems at home such as family members drinking or making unhealthy food choices. After experiencing how the application of the problem-solving method helped their patients resolve their problems, they were motivated to apply this method to resolve their own challenges.

"…It benefited me because my husband also drinks [alcohol]*, so some of the things -I have given him my book. And then it was very helpful, and he was interested…"* (ID01, designated counsellor)

"…my husband takes diabetes medication. So, from the start he was [drinking] Coke every day. Almost every day, he buys 2 litres of Coke, because he [does] not [drink] alcohol. So now, because of this counselling session, I can just say to him, no, you do not [drink] Coke like this…because Coca Cola is not good for the people that have diabetes. And if you go to the clinic, your diabetes is always going to be [high] because you are [eating] bad food. But now, I do not want to lie to you, my husband is not drinking Coca Cola anymore. He just drinks eight glasses of water and eat veg and fruit, not even any Coca Cola." (ID14, dedicated counsellor)

4.3 Barriers and facilitators related to the implementation of the project MIND intervention

A number of barriers and facilitators related to the project MIND intervention were identified that can be categorized according to two domains within the consolidated framework for implementation research (CFIR): 1) intervention characteristics; and 2) inner setting. The CFIR was developed to guide implementation science research, such as identifying barriers related to implementing healthcare interventions (Damschroder et al., 2009). The first domain refers to how well the characteristics of an intervention is implemented within an organization, including its essential components which can not be changed (e.g. problem-solving method) and other elements which can be adapted (e.g. language). The Inner setting refers to how the intervention is received within the organization (e.g. organizational culture). These are described below.

4.3.1 Intervention Characteristics

Both perceived complexity of the intervention and relative advantage of the intervention compared to usual care were highlighted by FBCs as barriers and facilitators to implementing the MIND intervention in the PHC facilities. With regards to the perceived complexity of the intervention, a barrier to implementing the project MIND intervention that was highlighted by most designated counsellors related to the length of the counselling sessions. Compared to their adherence counselling sessions, they felt that the project MIND counselling sessions were too long despite the benefits. These FBCs felt concerned about the many other adherence patients waiting to be seen while they were spending up to an hour counselling one of the project MIND patients.

> *"…It is programmed very well. It is very helpful, but it is too long."* (ID01, designated counsellor)

Most dedicated and designated FBCs recommended simplifying the format of the patient handout to make it more accessible to patients. These FBCs indicated that the language and grammar was too formal compared to the local spoken languages in the communities. Some patients therefore struggled to understand some of the information initially. As a result, and contrary to expectation, many patients whose first language was isiXhosa for instance, requested to have their sessions in English as it was easier to understand.

> *"There is some of them…they do not understand because some of the Afrikaans words is just...too formal…"* (ID03, designated counsellor)

> *"…I will find with that some of the youth, they will say "no man, we want English… Xhosa* [language] *is too long for us".* (ID07, dedicated counsellor)

In addition, half of the group (both dedicated and designated counsellors) indicated that many of their patients struggled to complete the take-home activity part of the intervention and that it could be simplified further. According to this group of FBCs, these patients were challenged by poor literacy and time constraints.

> *"Some of them, they do not have time, to do homework in their home because of some many things like, there are -maybe, the funerals, or they are busy with their own things."* (ID05, designated counsellor)

> *"Most of them to be honest do not do their homework…because I have picked up that –some of our patients, like I said most of them is illiterate…"* (ID15, dedicated counsellor)

All of the FBCs highlighted how the MIND intervention was of benefit to their patients (relative advantage) and extended beyond what was currently available as part of chronic disease services.

This belief in the effectiveness of the intervention through seeing changes in their patients' circumstances reinforced the counsellors' willingness and motivation to provide counselling. Moreover, a few FBCs described how some patients appeared withdrawn and hesitant during the first session, which they ascribed to being the patients' first counselling experience. However, the FBCs reported that this changed with patients engaging more as counselling progressed.

> *"…On the first session yes, they do* [participate] *but not much, but on the second session they have got stories…"* (ID01, designated counsellor)

All the FBCs described how many patients generally avoided solving the important problems in their lives prior to joining the MIND counselling programme. These FBCs reported that the project MIND intervention enabled them to empower patients by guiding them through a process of problem-solving using their existing problems. This enabled patients to return home and implement their problem-solving strategies. By working with patients from different backgrounds and having the opportunity to relate to them over time, counsellors reported observing how the counselling sessions benefitted their patients.

> *"It* [project MIND] *is a good intervention because people do not know always how to handle situations…they do not listen so when they come here to the intervention they learn how to listen and think about the negativity… how that situation will impact them negatively and positively."* (ID03, designated counsellor)

> *"There is another client that I met, what, on Sunday? And then she saw me I was not at work. She says, 'you know what; I have a good relationship with my daughter, and I have a good relationship with my mother, but my mother just died. But before she died, I feel that we just had a good time'… because she was not talking to her mother or the daughter, because of some family problems. But once she came to project MIND, she was able to resolve it in three weeks. So, it is good."* (ID06, designated counsellor)

In addition, fewer than half of the FBCs reported witnessing an improvement in self-care among their patients, potentially signifying that their symptoms of depression were abating. When patients arrived for the follow-up counselling sessions, visible improvements were evident in their outward appearance such as wearing new clothing or having a new hairstyle.

> *"On the second visit, it is a week after…they come in feeling much better…looking more happier and more light in the face. I had this one patient that came in with new hair[style], new dress and makeup."* (ID02, designated counsellor)

Furthermore, most FBCs observed that patients seemed to have taken increased responsibility for their health after completing the project MIND counselling programme. According to the FBCs, one of

the ways in which patients demonstrated this was through improved adherence to their chronic medication while also reducing their alcohol intake.

> *"…I am working with the clients and they come back to me and they say, "I am no longer that kind of person now, I am not drinking now, I quit drinking".* (ID07, dedicated counsellor)

> *"What I like about this, implementing this intervention is that it –for the patient that was not compliant, is compliant now. I think our rate of defaulters, the patients that we have seen has decreased."* (ID18, designated counsellor)

FBCs' beliefs in the benefits of this counselling were also based on their observations of some patients becoming employed. Most of the FBCs reported how some patients, by means of applying the PST skills, were able to find employment or start their own small business to earn an income.

> *"One client she even got a job…that was one of the problems that she had, and she wanted a job in the retail, and she got a job."* (ID13, designated counsellor)

All FBCs indicated how most of their patients seemed better able to address their current problems by means of applying the problem-solving skills. Experiencing first-hand how well their patients progressed provided counsellors with positive reinforcement and the motivation to continue delivering the intervention.

> *"It was like I am getting the blessings. I am getting the blessings because I did help those people* [patients]*."* (ID05, designated counsellor)

> *"Because helping other people, it learns* [teaches] *me, it is helping myself also, it makes me strong and being positive in future and in life."* (ID10, dedicated counsellor)

> *"The nicest part is when you can see -when the patient comes back for the follow-up and you can see the difference before and now after."* (ID13, designated counsellor)

4.3.2 Inner Setting

Several inner setting constructs were described by FBCs as barriers and facilitators to implementing the project MIND intervention. These include: i) implementation climate (compatibility, organizational incentives and rewards); 2) readiness for implementation (available resources); and 3) culture.

Compatibility is defined as "the degree of tangible fit between meaning and values attached to the intervention by involved individuals, how those align with individuals' own norms, values, and perceived risks and needs, and how the intervention fits with existing workflows and systems" (Damschroder et al., 2009). Successfully implementing an intervention is therefore likely to occur in a

work climate where the meaning ascribed to the intervention by FBCs and their needs align with the current PHC system. Designated counsellors expressed competing task demands (misalignment) as a barrier to implementing the project MIND intervention. These FBCs described having to oversee several chronic clubs, perform HIV testing and counselling, and complete their administration duties as some of their core duties. As delivering the project MIND intervention was an addition to their daily duties, these FBCs felt that the task demands were often too much to perform all their duties optimally.

> *"At the beginning it was fine but as time went by it was such a lot of people we had to see and we had to see our work as well. So, it was tiring because an hour to sit with a person is a lot when you know my colleagues need to see now maybe 20 or 30 more people because I am busy in this project."* (ID11, designated counsellor)

> *"…say for example we are three and the one is being booked for Project MIND, the pressure is on the other two to work for that one."* (ID13, designated counsellor)

On the other hand, dedicated counsellors did not report compatibility as a barrier. They did not report any concerns for implementing the project MIND intervention as this was their main duty. Dedicated counsellors reported enjoying their work and being able to focus on delivering counselling without feeling pressured to perform other tasks (alignment). During times when they were not busy counselling patients, they offered their assistance to other areas in the facility such as helping healthcare staff or administrative personnel.

> *"…On Wednesdays I am busy with mental illness* [psychiatric clinic] *with the psychiatrist and doctor…whereby I do not focus on Project MIND alone, but I also participate and assist also on the psychiatrist and doctor that is here."* (ID08, dedicated counsellor)

> *"As long as I do not have any clients, I go to the reception to help them with the folders." and "…if there is the doctor or the nurse that need a translator, then I translate for them."* (ID14, dedicated counsellor)

Organizational incentives and rewards such as how well individuals are recognised and rewarded for their work either through promotions, salary increases, status and respect (Damschroder et al., 2009), was reported by most FBCs as lacking. In particular, most designated FBCs described feeling marginalised and having a lowly status within the healthcare facilities. Most dedicated and designated FBCs are not professionally skilled staff and do not possess professional qualifications such as a diploma or degree compared to professional nurses for instance. Generally, the FBCs started working as home-based carers or community care workers and afterwards attained a training certificate to work as FBCs for NGO's. This lowly status impacted their ability to negotiate space or advocate for privacy to deliver the project MIND counselling. Therefore, the FBCs felt that they were disrespected and treated as outsiders by some of the healthcare staff in the facilities. They also felt marginalised

in the facility with no credence given to the important work they performed. Their views on the matter is accurately captured with the following quotes.

> *"Sometimes I feel like…I do not know whether I am not accepted. I do not know. I do not know how can I put it, because sometimes I am doing counselling saying, "Eish* [Sigh]*, I am not happy,* [after being asked for the space by nurses]*."* (ID05, designated counsellor)

> *"…Sometimes they* [nurses] *just say, 'oh, this is the lay counsellor', you know, you are just* [irrelevant]*".* (ID18, designated counsellor)

A subgroup comprising of dedicated and designated counsellors described how low remuneration impacted their motivation to implementing the project MIND intervention. According to these FBCs, inner setting constraints such as low remuneration decreased their motivation to provide this counselling service. Designated counsellors in particular cited this as a frustration due to their scope of work increasing without their salaries increasing. As a result, the FBCs felt that they are not recognised and appropriately rewarded for the work they do.

> *"…I like this job but because of the money that I get, I have too many responsibilities."* (ID05, designated counsellor)

> *"…I am going to be honest with you…I felt that the money that I was earning at least would have* [been more] *–even if it was more than with R1,000 then I will be happy".* (ID07, dedicated counsellor)

> *"…we do not want to sound like* [we] *always wants recognition in the form of finance, but that would also help, because I mean, your load is increasing, your targets is increasing but money wise it is not increasing."* (ID13, designated counsellor)

Second, the inner setting construct of readiness for implementation, in the form of lack of resources, was described as a barrier to implementing the project MIND intervention into PHC facilities. For instance, most of the FBCs identified a lack of space as one of the main resource constraints. On several occasions, when counselling sessions were due, FBCs had to search for a room to deliver the counselling. Moreover, there were certain days in the week where no counselling could take place due to additional healthcare staff such as optometrists and psychiatrists visiting the facility and occupying the rooms.

> *"It is the space that we do not have, and you find that sometimes the nurses are demanding the room."* (ID05, designated counsellor)

> *"…on Thursdays we normally do not have sessions…what happens is there is an eye clinic…They visit this side, yes. So that makes it a little bit hard for us to work."* (ID17, dedicated counsellor)

Finally, the majority of FBCs identified culture (norms, values, and basic assumptions of a given organization) as a barrier. Counselling requires that privacy and confidentiality be maintained at all times which is in line with basic principles of client-centred care (Lamont-Mills, Christensen, & Moses, 2018). A lack of privacy and confidentiality was described by many FBCs as a challenge to providing client-centred counselling in these settings. During counselling sessions, healthcare staff would often enter the room to collect facility-related supplies such as files or medical supplies. During these interruptions, the counsellors had no choice but to pause the session in order to accommodate the staff. Despite designated counsellors having their own office in the facility compared to dedicated counsellors, counselling interruptions were consistent for both approaches. Counsellors felt that this interruption of the counselling sessions might have had an impact on the patient's willingness to disclose personal information and fully engage in the counselling process. Moreover, not recognizing and prioritizing patients' need for privacy by healthcare staff demonstrated the cross-cutting impact this had on the inner setting context (interruption of counselling sessions).

> *"I do not have my privacy with my patients. So, there is that in and out happening."* (ID05, designated counsellor)

> *"…when you are in the session and now the patient is like, does not want to open up. And the patient has opened-up before but now you have so many distractions. Everyone is entering the room…there is people sitting on the side, so you can see, it is not that the patient does not want to open-up to you. There are too many distractions."* (ID18, designated counsellor)

4.4 Counsellor perceptions of the clinical supervision & debriefing provided by Project MIND

All FBCs received supervision and debriefing once a week, either in-person or telephonically, for between one to two hours. This included: debriefing, discussing patient progress, addressing challenges, and providing feedback from their counselling sessions. Audio recorded counselling sessions were listened to by the counselling supervisor using a fidelity checklist. The fidelity checklist was used to assess whether the intervention was being delivered as intended. When fidelity to the intervention was found to be high, feedback was given to FBCs as a means of positive reinforcement. When fidelity to some areas of the intervention was found to be low, corrective steps were discussed and, on many occasions, role-played. FBCs were accessed through a blend of either weekly visits at the primary healthcare facilities or by means of telephonic sessions. Between these scheduled supervision and debriefing sessions, brief communication also occurred via text or WhatsApp messaging to address challenges in real-time. Several themes emerged that related to FBCs'

perceptions of the project MIND clinical supervision and debriefing which formed part of the intervention package. These factors included: the perceived benefits of supervision and debriefing; perceptions of the content and format of supervision and debriefing; the logistics of supervision and debriefing; counsellors' perceptions of challenges to the uptake of supervision and debriefing; and characteristics of the counsellor supervisor. These factors are described below.

4.4.1 Perceived benefits of supervision and debriefing

Counsellors participating in project MIND viewed receiving regular supervision as highly important for their professional development and for ensuring quality of counselling. According to the majority of counsellors, this supervision provided them with an opportunity to discuss patient progress, assess counselling performance, and identify ways of improving their practice.

> *"I think for me supervision is important because you can get help with whatever case or any difficult situations that we are facing and also to know where to work on. It is also nice to hear that, oh, you are doing good or you can work on that or maybe do not use that and so on. So that really, really, really helps a person."* (ID03, designated counsellor)

The majority of FBCs found the role-playing exercises conducted during supervision as particularly beneficial. The FBCs indicated that at times they would get stuck during a counselling session while not knowing what to say or how to proceed. However, during supervision the counsellors would assume the role of the patient and role-play challenging counselling scenarios with the counsellor supervisor. This facilitated experiential learning. By means of role-playing such scenarios, it enabled the FBCs to reflect on past situations and practice managing them differently while simultaneously preparing them to deal with such scenarios more effectively thereafter. This also enabled the FBCs to, in a figurative sense, walk in the shoes of their patients to gain an insider's perspective from their patients.

> *"…we do a bit role-play also…so that is the one thing that stands out for me…when you put yourself maybe in a client's position…or you change roles, so that gives you a bit of an idea of what you must do."* (ID03, designated counsellor)

In addition to receiving project MIND supervision, all FBCs emphasised the importance of receiving regular debriefing at least once as part of their weekly supervision. The FBCs had to listen and help patients work through their problems daily while dealing with their own personal problems. The FBCs expressed an understanding that these problems impact on them if self-care is not practiced. Furthermore, they felt that the regular opportunities for debriefing created a safe space to discuss personal issues, adopt new selfcare habits and develop coping strategies. FBCs stressed the

importance of regular debriefing and self-care for functioning optimally when counselling patients. This is evidenced by the following quotes.

> *"It is very important, because if I am not going to look after myself, how am I going to look after someone else that needs me."* (ID11, designated counsellor)

> *"It is very important, because before I used to take on the whole world. Now, I know that as I care for my client, I must care for myself, because if I do not care for myself, I am going to burn out."* (ID18, designated counsellor)

4.4.2 Perceptions of the content and format of supervision and debriefing

Although some designated counsellors reported that they were not accustomed to getting regular supervision and debriefing from their NGO's, the majority of FBCs were satisfied with the format of supervision and debriefing provided through project MIND. The structure and format of supervision and debriefing was consistent across all sites and followed the format as described above, under the main theme. When asked about the ideal format of supervision and debriefing, the FBCs had the following to say.

> *"…I do not think that it is a problem with the supervision. Everything is perfect the way it is."* (ID03, designated counsellor)

> ***"****I do not think supervision needs to be improved. I think what is in place now is good."* (ID18, designated counsellor)

Initially, all FBCs were anxious about their sessions being audio recorded for supervision purposes. They indicated that this supervision approach was completely novel with none of them having any previous experience of this form of intensive clinical supervision. At first, counsellors felt that it would be used to check on their mistakes and for criticising their work. Despite some counsellors being anxious initially, the majority of counsellors expressed positive views about the counselling sessions being audio recorded to assess intervention fidelity and receiving feedback as part of supervision. After completing their first few counselling sessions and receiving fidelity feedback, most of the counsellors were able to adjust to this method of receiving feedback. Among the positive views, counsellors expressed that it helped them to identify the areas where they needed improvement and it motivated them to deliver the intervention to the best of their ability.

> "The supervisor *will listen to the recording and then he comes every week for supervision. So at least he will tell me this, this and this we must improve there and there. We did well here, very good, this and this. So, the supervision helps me…"* (ID06, designated counsellor)

"Knowing that someone is going to be listening to me, put me on that edge to want to give my best." (ID18, designated counsellor)

Only one designated counsellor had serious reservations about the counselling sessions being audio recorded. The counsellor was not comfortable with someone else, in this case the counsellor supervisor, listening to the audio recorded sessions. The counsellor felt that patient confidentiality was being breached. Despite completing a few recorded sessions initially, the counsellor was unable to adjust to this method of clinical supervision and requested to be withdrawn from the study. This is captured in the following response.

"…I did not like that [recording of sessions] *and that is why I end up not doing."* (ID01, designated counsellor)

4.4.3 Logistics of supervision and debriefing

When asked about the frequency of supervision and debriefing sessions while working as a project MIND counsellor across both dedicated and designated arms, the majority of counsellors preferred the current frequency of receiving supervision and debriefing rather than the irregular supervision they had previously obtained. This includes a combination of weekly visits at the PHC facilities or weekly telephonic sessions. The latter was particularly useful during times of community violence or riots where face to face supervision was difficult to provide. Between these formal supervision and debriefing sessions, brief communication also occurred via text or WhatsApp messaging to troubleshoot any challenges in real-time. These FBCs who preferred receiving supervision and debriefing once a week said they felt more supported and contained as evidenced by the following quote.

"…I think the supervision is okay…especially every week." (ID06, designated counsellor)

Some designated counsellors who reported that they only received supervision and debriefing (or mentoring as they referred to it) once a month from their NGO, preferred the intensity of the project MIND supervision and debriefing. These FBCs felt that they were not receiving enough support for the work they do in the primary healthcare facilities from their NGOs.

"Once a week, at least, yes, it is enough." and "…to compare to our other department [NGO]*, I think we also doing* [supervision] *once a month. At least for me you see that* is *four week - four days* [four times a month with project MIND]." (ID16, designated counsellor)

In addition to those who reported receiving counselling support once a month from their NGOs, a few designated counsellors described having received no supervision and debriefing from their NGOs for many months. These FBCs also felt unsupported by their NGOs.

> *"I think we were a little bit uptight before* [project MIND supervision and debriefing] *because at our own NGO for a long time we did not get mentoring."* (ID18, designated counsellors)

Between the dedicated and designated counsellors, there was no clear consensus as to how much time per week should be spent on supervision and debriefing. In general, most counsellors across both research arms felt that between 1 to 2 hours of supervision and debriefing per week were sufficient.

> *"To be honest I think maximum two hours."* (ID15, dedicated counsellor)

> *"I would say 1 hour 30 minutes to two hours."* (ID17, dedicated counsellor)

However, a few dedicated and designated counsellors felt that having more time with the counselling supervisor could have been useful to address additional logistical and counselling issues. This is captured in the following responses.

> *"I think time is just a little against us because you need to put on the recorders, do the filing of the participants, handling the situations and then we role-play the situations and that takes a bit time because you see how many people -how many clients per week. What if I see two or three or five maybe per week then to deal with each and every one, it takes a lot of time."* (ID03, designated counsellors)

> *"…sometimes I feel that it is short." and "…when he leaves, I just feel that, oh, I needed one more hour."* (ID04, dedicated counsellors)

4.4.4 Counsellors' perceptions of challenges to the uptake of supervision and debriefing

According to the FBCs, some of the main challenges to supervision and debriefing uptake were space, a lack of privacy, and difficulties adhering to the supervision schedule. However, these challenges differed across the dedicated and designated arms. For instance, with dedicated counsellors, challenges relating to lack of private space for clinical supervision and debriefing were more prominent, with no difficulties adhering to the supervision schedule. Dedicated counsellors were more flexible with their time and was able to schedule their supervision and debriefing session earlier in the day when they have not seen too many clients.

"…If it is Tuesday [supervision day] *and* [the fieldworker] *has booked participants for me, I just tell him…I do not want to be tired when* [the counsellor supervisor] *comes in…because I have to focus."* (ID04, dedicated counsellor)

In contrast, space was not an issue for most of the designated counsellors. However, adhering to the supervision schedule was a major challenge. Often, the primary healthcare facilities were very busy with high patient volumes with the designated counsellors having to prioritise attending to those patients at the expense of supervision and debriefing. This is indicated with the following quotes.

"…before he [counsellor supervisor] *comes, each and every Wednesday…he phones and says I am on my way…and when we have a problem that we cannot have that supervision, we will tell* [the counsellor supervisor] *that the clinic is busy today and then this and this and this is going on…so the times of supervision…it is not going to work. So it is flexible".* (IDO6, designated counsellor)

"there are days we have to put him off because we had training or we are having meetings…" and "sometimes the difficult times is when we maybe saw our last person at half past two maybe and you did not even have tea or lunch yet. So then we go in there, we are eating maybe or we are having a cool drink… –and then there are days that we maybe finish off by two o'clock, then you still have half an hour to have your lunch." (ID11, designated counsellor)

4.4.5 Characteristics of counsellor supervisor

The majority of FBCs highlighted that having a good working relationship with the counselling supervisor is critical for effective supervision and debriefing support. Among the characteristics identified as being important for a clinical supervisor were trustworthiness, respect, and being non-judgmental.

"I feel a supervisor is the one you can always go to, the one that always listens to you and not judge you on everything or point out your wrongs and so. At the same time help you where you need." and "…he [counsellor supervisor] *is always available no matter what…he is always there whenever I need him when I call him. He will never shut me down or not help or so."* (ID03, designated counsellor)

"The reason why I have got a good relationship with him is because he is non-judgemental." (ID07, dedicated counsellor)

Importantly, the majority of FBCs emphasised how valuable it was to know that the counsellor supervisor was always available either telephonically or via instant messaging to troubleshoot challenges and debriefing on-the-go.

> *"…he is available, all the times. He does not mind, even if I am calling him, telling him something that is stressing, he does not mind"* (ID05, Designated counsellor)

> *"…he* [counsellor supervisor] *is always there to support, even via WhatsApp. I can ask him anything, any time he will respond swiftly."* (ID15, dedicated counsellor)

4.5 Counsellor recommendations for improving the project MIND training, supervision and debriefing model, and implementation

Fewer than half of the FBCs suggested that reducing the amount of training hours per day would improve the structure and format of training. These FBCs felt that the training hours, which lasted between six to seven hours per day, were too long. Although this is comparable to normal working hours, the FBCs were not adapted to sit as students in training workshops all day. Usually, FBCs would be actively busy in the facilities performing a range of duties. Maintaining concentration while processing the information during training was therefore challenging. As a result, counsellors felt tired which impacted on their ability to remain focused on the content.

> *"…the hours were too long also and I mean too long hours can also put a person to like…get tired."* (ID17, dedicated counsellor)

Additionally, a minority of FBCs recommended that moving the training location to within their community where travelling is convenient would improve the training experience. For instance, counsellors highlighted that travelling to the training location was challenging. It was too far travelling to the venue meaning they had to wake up earlier than usual to get public transport such as a taxi. In some cases, counsellors arrived late for training because they had to take more than one taxi to get to the training venue. Similarly, they felt anxious towards the end of training day out of concern that they still needed to get public transport home. These views are captured with the following quotes.

> *"Instead of going there, like it was –I do not know where is that place but I think if the training can come maybe in our facility".* (ID16, designated counsellors)

> *"So, that was the only problem, coming there and going home. That was stressful. So, when we are in class, we rush to go home and when we come, we rush to be there on time."* (ID11, designated counsellor)

Most FBCs suggested that training could be enhanced by incorporating more opportunities for role-play and skills rehearsal exercises. Role-playing stood out as one of the training aspects that the majority of counsellors considered most beneficial to test their counselling skills and readiness to deliver the intervention in primary healthcare facilities. As a result, many counsellors reported that more role-playing was needed to help them feel more confident in delivering the intervention.

> *"I learned so much about role plays so that we can familiarise…how the intervention it should be like…from session one to session three."* (ID08, dedicated counsellor)

> *"…the role play really, really helps a lot. It is good to understand content, but role play that is what matters when you do this counselling intervention."* (ID15, dedicated counsellor)

A minority of FBCs recommended that the project MIND training (and intervention) could be improved by adding psychoeducational and counselling content related to substance use (e.g. methamphetamine use). According to these FBCs, they struggled to deliver the intervention whenever they were faced with a patient whose problems were more complexed. It was felt that by expanding the training and intervention to include these counselling components, they would be better prepared in dealing effectively with patients who were using drugs or whose children were using drugs. This is evidenced by the following quote.

> *"…I remember I had a client who was not having problems with her and the husband but having problems with their kids. They are on tik* [abusing methamphetamine] *you know? So, I think Project Mind will add that; how to deal with the patient who comes because they are stressed with the kids.* (ID01, designated counsellor)

The FBCs recommended that more effort is needed by NGO and facility staff to attend the project MIND training to increase their awareness and understanding of mental health counselling. It was felt that this will provide an opportunity for facility staff such as nurses, NGO coordinators and NGO line supervisors to gain insight into what the counsellor's do on a day to day basis. This is captured by their following responses.

> *"They* [NGO coordinators and senior facility staff] *must know what is going on about the whole session* [mental health counselling]*."* (ID09, dedicated counsellor)

> *"Yes, because then they know what you are actually busy doing, because for them it does not sound* [they don't understand] *…how long you are with the patient* [and why it takes so long]*."* (ID13, designated counsellor)

Despite most FBCs expressing satisfaction with the supervision and debriefing received, one dedicated and three designated FBCs suggested that the supervision and debriefing could improve by incorporating occasional group supervision and debriefing. The FBCs felt that their interactions

with all FBCs working on project MIND could benefit their counselling practice and ability to cope with mental health counselling in general.

> *"I think it will be helpful, because when you meet the other counsellors is where you could learn new things... how they the dealt with those problems."* (ID05, designated counsellor)

> *"If they can have mentoring* [supervision and debriefing] *where all the counsellors get together and then they debrief…with different cases and how they struggle and how do they cope."* (ID06, designated counsellor)

Only a few designated counsellors recommended adding a "dedicated" counsellor to the chronic disease team in order to integrate mental health counselling successfully. These FBCs felt that their competing task demands are too much which limits their capacity to add additional tasks due to time constraints and high caseloads.

> *"…I do not know why you do not have your own counsellor. Somebody…who is focused – because -you know, sometimes it is very hectic."* (ID01, designated counsellor)

> *"The Project MIND, if they had their own counsellors, dealing with their own clients…So that it doesn't disturb at the clinic."* (ID06, designated counsellor)

CHAPTER 5: DISCUSSION

This qualitative study was the first to examine the experiences of dedicated and designated FBCs working on Project MIND who provided psychosocial counselling to individuals with a CMD in primary healthcare settings in the Western Cape. Four major themes emerged: 1) counsellors' perceptions of the benefits of the project MIND training; 2) barriers and facilitators related to the implementation of the project MIND intervention; 3) counsellor perceptions of the clinical supervision & debriefing provided by project MIND; and 4) counsellor recommendations for improving the training, supervision and debriefing model, and implementation. These will be discussed in detail. Thereafter, the strengths and limitations are highlighted followed by concluding remarks.

5.1 Counsellors' perceptions of the benefits of the project MIND training

In the present study, all FBCs found the project MIND intervention to be relevant and appropriate for their patients who were receiving chronic disease care at PHC clinics in the Western Cape and helpful for addressing their psychosocial problems. This is essential given that research suggests that for a psychological intervention to be acceptable, it needs to be culturally appropriate, contextually relevant and useful (Chowdhary et al., 2014). It was found that the FBCs experienced first-hand how useful the intervention was to the patients enrolled in the project MIND programme as many of their patients were able to resolve their problems using the PST method, which previously would have gone unsolved and thereby impacting their health. This supports evidence from other studies which found PST to be beneficial in guiding patients with CMDs to solve their own problems (Chibanda et al., 2015; Sorsdahl et al., 2015c). Despite the project MIND intervention being culturally appropriate, contextually relevant and useful, the FBCs suggested that further modifications such as simplifying the language and grammar of the intervention guide and including content related to illicit drug use and trauma could enhance its usefulness.

Not only was the project MIND training viewed as acceptable by the FBCs, but they described improvements in their mental health literacy and in their capacity and confidence to provide counselling to patients with CMDs. Consistent with the literature on mental health literacy among healthcare providers (Egbe, 2015; Egbe et al., 2014), the FBCs from this study reported low levels of mental health literacy prior to receiving the project MIND training. They described having stigmatizing views towards people living with a mental illness, in line with studies suggesting that those perpetuating stigma (in this case the FBCs) act as "stigmatizers" (Egbe, 2015). After receiving the project MIND training, the FBCs' felt that their previously held stigmatizing beliefs and attitudes towards people living with mental illness dissipated to being more benevolent. However, this finding

should be interpreted with caution as it is limited by the absence of reliable pre-and-post testing using validated instruments.

It was found that all FBCs experienced the project MIND training as novel. Their previous training equipped them with counselling skills limited to HIV and AIDS such as sharing disease specific information, imparting disease specific motivation and providing adherence support. In contrast, the MIND-model is more generic in that it provided the FBCs with generic counselling skills which can be applied to all patients attending primary healthcare, regardless of diagnosis. Moreover, the MIND-model prepared the FBCs to use these counselling skills along with the structured intervention guide to: 1) build readiness for treatment and motivation for change; and 2) help patients to identify and address problems in their life that could be causing mental health difficulties, but could also be impacting on their ability to cope with a chronic disease (HIV or diabetes) or adhere to their medication. In this sense, the project MIND training broadened the FBCs' scope of practice from an HIV and AIDS-focused model to a more holistic psychosocial model in addressing patient needs.

This expansion in scope of practice was important considering South Africa is challenged by an ever-burdening quadruple burden of disease including chronic communicable (e.g. HIV) and non-communicable disease (e.g. diabetes), injury, and mental disorders (e.g. depression) (Mayosi et al., 2012). Moreover, the integrated chronic disease management (ICDM) model was developed in South Africa to re-orientate health services in a way to respond comprehensively to patient needs in light of the growing disease burden (Mahomed & Asmall, 2015). A key focus of the ICDM is empowering patients to take better care of their own health (Mahomed & Asmall, 2015). The expansion of the FBCs' scope was therefore a practical step in line with the ICDM's focus as patients were taught evidence-based strategies to solve their common everyday problems. As the expansion of the FBC's scope is aligned with the priorities identified by the ICDM model, future considerations for scaling up the MIND training is warranted. The potential for these skills to be generically applied to all patients irrespective of their diagnosis, is demonstrated through designated counsellors' accounts of how the MIND training and counselling programme assisted them with interacting more effectively with patients regardless of project MIND. There is also extensive research showing how PST has been applied successfully to treat CMDs and to assist people cope with chronic diseases including promoting adherence to treatment (Chibanda et al., 2015; Fitzpatrick, Schumann, & Hill-Briggs, 2013; Lee et al., 2015; Malouff, Thorsteinsson, & Schutte, 2007; Sorsdahl et al., 2015c). In light of this, the project MIND training improved the overall micro-counselling skills of the FBCs, providing the foundation for quality counselling.

Building on the benefits of PST, the most valued component of the project MIND training according to the FBCs was the role play exercises. Miller (1990) identified a hierarchical framework for assessing clinical (or counselling) skills according to four levels: Level 1) "knows" (knowledge of intervention);

level 2) “knows how” (understanding practical application); level 3) “shows how” (demonstration of skills); and level 4) “does” (application of skills in practice). Through role plays, and in line with this framework, the FBCs familiarised themselves with the manualized structure and content of the intervention (Levels 1 and 2). This is important considering HIV adherence counsellors are not trained to follow a manualized structure during HIV adherence counselling. Furthermore, role plays enabled them to rehearse their project MIND counselling skills through simulation exercises and simultaneously provided feedback regarding their counselling readiness (level 3). This finding is not surprising given that research involving counselling training has shown that role play is an essential component of assessing counselling competency (Fairburn & Cooper, 2011; Miller, 1990; Roth & Pilling, 2008). A recent systematic review (Singla et al., 2017) of psychological treatments in LMICs found a majority of studies utilized role playing as a component of training non-specialist providers to deliver mental health counselling, which further highlights its importance. Overall, findings from this study indicated that the project MIND training was acceptable to FBCs and equipped them with micro-counselling skills required to provide high quality MI-PST in the context of chronic disease care (Myers et al., 2019b).

This study also presents evidence that the project MIND training benefitted counsellors personally, beyond their role in counselling patients. The newly acquired counselling skills helped the FBCs cope more effectively with their daily stresses. This finding converges with other studies which showed that mental health training enhanced the coping skills and problem-solving abilities of lay health workers (Abas et al., 2016; Pereira, Andrew, Pednekar, Kirkwood, & Patel, 2011; Petersen, Ssebunnya, Bhana, Baillie, & Consortium, 2011). FBCs in the present study applied the PST method successfully to address many of their own personal problems which previously would have lingered on and caused psychological distress. In addition, these coping skills were further strengthened by receiving regular debriefing from the registered counsellor. FBCs noted how some of their distress emanated from dealing with patients whose problems were more complexed and which made them feel ill-equipped to address it. By receiving weekly debriefings, the FBCs were better able to manage their distress caused by delivering the MIND counselling. Given the evidence of CHWs experiencing psychological distress while delivering psychosocial counselling in PHC settings (Mendenhall et al., 2014; Munodawafa et al., 2017; Petersen et al., 2011), equipping them with skills to cope better and providing regular psychological support as demonstrated by the present study is crucial to improve or maintain the quality of counselling and prevent burn-out. By experiencing the benefits of successfully implementing the PST method in their own lives in combination of receiving weekly debriefing, the FBCs grew in their conviction of its effectiveness.

5.2 Barriers and facilitators related to the implementation of the counselling programme.

Despite the FBCs appreciating the value of the MIND training and counselling programme, several barriers hindered the FBCs' ability to implement the MIND counselling programme. These are discussed below.

It was found that the FBCs felt disrespected and marginalized within the primary healthcare facilities which is in concordance with a systematic review (Petersen et al., 2014a). This was exacerbated by a lack of credence given to the work they performed and, as a result, the FBCs felt like they were treated as outsiders. In addition, by referring to them as ' lay counsellors', the idea of a "lower class" worker was conveyed, which another study has shown impacts the self-esteem and confidence of FBCs (Rohleder & Swartz, 2005). Most FBCs also lacked dedicated counselling space to deliver the counselling sessions. Patient rooms were occupied more often by nurses or other healthcare staff. When space became available to deliver the counselling sessions, it was often interrupted by nurses, which in turn compromised patient confidentiality. This impacted the therapeutic relationship with patients negatively and resulted in the patients being reluctant to opening-up about their problems. This issue of confidentiality being compromised mirrors previous research with FBCs working in PHC settings (Mendenhall et al., 2014) and which resulted in reduced satisfaction of counselling among patients (Jordans, Keen, Pradhan, & Tol, 2007). In light of the above, it stands to reason that the combination of the FBCs' perceived low status and marginalized role contributed to them competing for space. This low priority to counselling could have been due to nurses not understanding mental health counselling as was found in another study in Nepal (Jordans et al., 2007). These barriers would need to be addressed if the MIND counselling programme were to be integrated successfully in a sustainable way.

This study showed that unlike dedicated counsellors, the designated counsellors were challenged by competing task demands. They had to fulfil in their primary HIV duties while simultaneously providing counselling to project MIND patients. According to designated FBCs, it was too much work with the MIND counselling being time consuming despite the benefits to the patient (Mendenhall et al., 2014). These competing task demands also impacted the rest of the designated counsellor team who had to provide cover by taking on an additional patient-load while the FBCs were busy counselling project MIND patients. These competing task demands caused frustration among the designated counsellors as their workload increased without receiving additional compensation or an increase in salary. Further, this impacted their job motivation and likely the quality of their counselling. These findings are consistent with those found in Nepal, where FBCs already performing counselling duties found the additional task of delivering mental health counselling as distracting, time-consuming, and in some

instances incompatible with their role (Jordans et al., 2007). However, a study in Pakistan found the opposite, whereby the majority of CHWs experienced the additional mental health counselling as non-burdensome and compatible to their existing duties (Rahman, 2007). Their experience could have been due to the strong supervisory mechanisms being in place such as the monthly half day group supervision and fidelity checking by experienced mental health experts (Rahman, 2007). These findings suggest that further considerations are needed on how to restructure the work of FBCs to help them manage competing task demands better without compromising on the quality of counselling.

Findings from this study revealed that the majority of FBCs experienced counselling difficulties with patients who presented with more complex problems such as trauma or illicit substance use. Given the high levels of trauma (Abler et al., 2014) and high prevalence of polysubstance use in South Africa (Dada, Burnhams, Laubscher, Parry, & Myers, 2018), this finding is important for future adaptation of the MIND intervention. These complex problems overwhelmed the FBCs which brought up feelings of inadequacy. These negative feelings in turn impacted their ability to deliver the MI-PST intervention adequately. One of the ways in which the FBCs dealt with this situation was by means of contacting the registered counsellor for guidance in order to complete the session. Despite the benefits of having a registered counsellor to provide guidance in such circumstances, additional modules on dealing with trauma and polysubstance use could be added to help counsellors broaden their scope of work to other disorders. This finding highlights the need to further adapt the MIND training and counselling content in such a way that would equip FBCs with tools to respond more confidently to the above-mentioned issues. One of the ways in which the MIND intervention can be adapted is by adding additional modules on dealing with trauma and illicit substance use.

5.3 Counsellor perceptions of supervision & debriefing provided by Project MIND.

Studies involving task shared interventions have recommended that providing FBCs with regular supervision and debriefing as a means of counselling support is not only critical (Ngo et al., 2013), but may further strengthen their ability to deliver interventions optimally (Myers et al., 2019b; Petersen et al., 2014a; van Ginneken et al., 2013). Despite these recommendations, evidence from systematic reviews (Petersen et al., 2014a; van Ginneken et al., 2013) found that supervision of FBCs are generally poor. Project MIND responded to this challenge in that supervision and debriefing addressed the inconsistent, and in some instances, the lack of regular structured supervision provided by some NGO's to some of the designated counsellors working on project Mind.

Supervision and debriefing started with the FBCs reflecting on their own state of psychological wellbeing, followed by discussing patient progress, resolving difficult counselling impasses through role play simulations and discussing counselling performance using fidelity feedback. Similar to the project MIND training, the FBCs viewed the project MIND supervision and debriefing model delivered by a registered counsellor as acceptable and beneficial. The FBCs felt more supported through weekly face-to-face supervision and debriefing sessions and viewed it as a continuation of training. In general, these findings concur with other studies conducted in South Africa (Munodawafa et al., 2017; Petersen, Hanass Hancock, Bhana, & Govender, 2014b), Zimbabwe (Chibanda et al., 2015), Pakistan (Rahman et al., 2008) and India (Patel et al., 2010). These studies showed that FBCs (or lay health workers) delivering psychosocial counselling felt more supported, grew in confidence and improved their micro-counselling skills (e.g. asking open-ended questions and using reflective statements) through supervision. In some instances, supervision and debriefing was done telephonically due to community unrest, such as gang violence and protests, making travel to sites unsafe for research staff, and due to geographical limitations, as the time to travel one-way to some sites ranged from one hour to four hours. Supporting FBCs telephonically is not a new concept as various studies have shown that it is feasible and acceptable in the context of task-sharing interventions in different settings (Bolton et al., 2007; Nonaka et al., 2014; Patel et al., 2010).

Despite the perceived benefits of supervision highlighted in previous evidence, there is wide variation with regards to the method, frequency and delivery agent of supervision. The method of supervision which generally involved meeting reviews between the supervisors and FBCs varied in line with the interventions being delivered as was the case in the present study. However, none of the previous studies reported using role-playing exercises as an integral component of supervision. Project MIND on the other hand incorporated role-playing exercises into the supervision time in order to enhance and maintain the micro-counselling skills of FBCs. The FBCs found this novel approach to supervision particularly useful as it provided them with opportunities to reflect on challenging past counselling scenarios while simultaneously practicing how to respond more effectively if faced with similar scenarios in the future.

The frequency of supervision varied from four times per week (Munodawafa et al., 2017), to once a week (Chibanda et al., 2015; Petersen et al., 2014b), to once a month in some studies (Patel et al., 2010; Rahman et al., 2008). In the present study, weekly structured supervision and debriefing of between one to two hours was considered necessary and sufficient. Through this regular counselling support, the FBCs reported being better able to navigate the stressful PHC environment. In addition to weekly structured supervision and debriefing, the FBCs felt more supported knowing that the registered counsellor was available in “real-time”, often virtually, to address challenges and problems as they arose. This suggests that there is potential to further develop and utilize mobile applications for enhancing real-time support of FBCs especially where geographical locations are a challenge.

This may prevent the occurrence of adverse events arising from poorly managed crises during counselling and may also enhance the quality of counselling provided.

The delivery agents of supervision in previous studies varied as well from a clinical social worker with a masters qualification (Munodawafa et al., 2017), to clinical psychology trainees (Petersen et al., 2014b), to a psychologist (Chibanda et al., 2015), and psychiatrists (Patel et al., 2010; Rahman et al., 2008). However, the present study provides evidence of a novel approach in providing regular supervision and debriefing to FBCs working in PHC facilities. The registered counsellor, who has an Honours-level qualification in Psychology, and utilised on project MIND, was perceived as an acceptable component of the task-sharing model. Although in this instance the registered counsellor was externally based, for this model to be implemented in PHC facilities, supervision and debriefing would need to be integrated as part of this counselling approach in chronic disease care to enhance regular support of FBCs. There are several potential benefits for integrating registered counsellors into PHC to support FBCs. First, despite registered counsellors being widely available, they are currently underutilized in South Africa (Abel & Louw, 2009; Elkonin & Sandison, 2006; Kotze & Carolissen, 2005). Second, registered counsellors could immediately alleviate the large health worker shortages which impact healthcare delivery including mental healthcare in South Africa (Lund & Fisher, 2002; Lund et al., 2010). Third, registered counsellors could act as a referral source ("upward and "downward") to address more complex counselling issues within their scope of practice.

Therefore, in contrast to traditional approaches of supervision (by highly specialised psychologists for example), project MIND trained a registered psychological counsellor (with a four-year Psychology Honours degree and experience in delivering MI-PST) to provide supervision using a standardised format, the quality of which was monitored by a psychologist. Given the FBCs reflections on what facilitated a good working relationship with the supervisor, having a registered counsellor rather than a specialist psychologist in this role may have reduced the power differential. Given the limited availability of specialists to provide supervision for task-shared counselling in LMICs (Singla et al., 2014), this cascade approach to supervision offers a potentially scalable alternative. For this model to be implemented at scale in South Africa, training curricula of registered counsellors needs to expand to include a stronger emphasis on the development of supervision and debriefing skills. They will also need to be employed within the public health system with supervision of generalist counsellors integrated into their job description.

It was found that selecting a registered counsellor as counselling supervisor with person-centred characteristics such as trustworthiness, respect, and being non-judgmental is crucial for a positive working relationship with the FBCs. These characteristics fostered a climate where FBCs could express themselves freely and disclose personal challenges without fear of being judged. A

systematic review (Petersen et al., 2014a) found that FBCs delivering task-shared interventions are often mistreated in PHC settings which impacts their motivation and self-esteem negatively. Given that FBCs are considered the backbone of a well-functioning health system, ensuring that they are valued and respected is key (Schneider, Blaauw, Gilson, Chabikuli, & Goudge, 2004). These findings highlight the importance of deploying a task-sharing and a task-caring approach to supervision. Not only will this ensure that FBCs are optimally cared for and valued, but will enable them to deliver high quality MI-PST and ensure the sustained acceptability of the task-sharing model (Mendenhall et al., 2014).

5.4 Counsellor recommendations for improving the project MIND training, supervision and debriefing model, and implementation.

FBCs provided a number of suggestions which could improve the project MIND training, supervision and debriefing model, and future implementation. These are described below.

First, some FBCs recommended that the daily time spent on training should be reduced as they struggled to transition from a working environment in the primary healthcare clinics to an environment of learning. These FBCs felt that the information was a lot and required more time to assimilate the information. Initially, all FBCs received formal training across five days (equivalent to 40 hours). However, some designated counsellors were only permitted to attend the first three days of formal training due to staffing constraints in their facilities. For these designated counsellors, the rest of their training were staggered and took place during times when the facilities were not too busy with patients and to bring them on par with the rest of the MIND FBCs. Despite this challenge, all FBCs received informal on-the-job booster training to solidify the training content and to address uncertainties of implementing the MIND counselling programme. Considering fewer than half of the FBCs described having difficulty to assimilate the information, factors such as their background, age and counselling experience could have impacted on their ability to adapt to the MIND programme. In comparison, training of lay health workers in Zimbabwe lasted eight days, whereas training of CHWs in India lasted two months (Patel et al., 2010). Despite the difference in training duration in both studies, the lay health workers were perceived as ready to deliver the mental health counselling. In contrast, a study in Nepal found that a significant proportion of paraprofessionals reported not feeling ready to deliver mental health counselling despite receiving five months of training (Jordans et al., 2007). Extending the length of formal training is likely to be impractical as this would impact the delivery of HIV services negatively in the absence of the FBCs. In light of this, a practical way forward to optimize FBC training could be to include videos explaining the training content and demonstrating applying this content in

counselling. This would provide FBCs with opportunities for self-study in combination with face-to-face formal and booster training.

Moreover, role plays stood out as one of the training and supervision components which enhanced counselling readiness and proficiency. FBCs from this study therefore recommended that more time needs to be allocated for role plays in future MIND training. Allocating more time for role plays could be beneficial for at least two reasons: 1) it provides an opportunity to rehearse skills using simulated counselling scenarios which may improve counselling readiness and proficiency; and 2) it provides an opportunity to adjust to counselling within the PHC environment by introducing integrated real-life skills rehearsal. Therefore, providing additional opportunities for skills rehearsal exercises in preparation of delivering mental health counselling is likely to impact the FBCs' experience of implementing the counselling programme favourably and enhance the quality of counselling.

A finding which was unsuspected is that a few FBCs suggested having occasional group supervision to enhance learning and establish a community of practice. These FBCs felt that group supervision could have provided them with an additional opportunity to debrief and learn how different individuals managed and cope with their problems. A research study (Hill et al., 2014) which reviewed supervision strategies for various healthcare providers in LMICs found that group supervision was as affective as standard supervision. However, a more recent study (Kok et al., 2018) in four African countries found that combining group supervision with individual supervision including using performance measurements and feedback had the potential to impact community health workers' motivation and performance positively. Moreover, CHWs in the same study described several perceived benefits from having group supervision, including cross learning and the sharing of skills, feelings of recognition, feeling supported, learning new knowledge, experiencing a sense of community and having a shared burden (Kok et al., 2018). These findings suggest that the combination of individual with group supervision could have further strengthened the intensity of the project MIND supervision and debriefing approach, though holding occasional group supervision in the present study would have proved impractical due to geographical and logistical challenges. One potential way to address this challenge is to divide FBCs into smaller clusters based on their geographical location with each cluster having group supervision once a month.

While acknowledging the support afforded through supervision, findings from this study point to a need for health systems change to enable the integration of mental health counselling in PHC facilities. FBCs identified the need for more implementation support from the PHC facility to help them navigate systemic challenges to integrating mental health counselling into primary care. As previously mentioned, designated FBCs were particularly concerned about 'task dumping', anticipating that they would be expected to deliver mental health counselling in addition to their other tasks with no re-negotiation of their existing job descriptions and targets or additional remuneration. Concerns about

FBC work demands and lack of additional capacity to provide mental health counselling have been consistently raised by other researchers in this area (Padmanathan & Silva, 2013). Should the South African Department of Health proceed with training designated FBCs to deliver mental health counselling, their job descriptions, workload and daily targets will need to be re-assessed and adjusted so that they have the capacity to deliver mental health counselling with fidelity. This is in keeping with recommendations for supporting task-sharing of mental health interventions from other health system strengthening initiatives, such as the Emerald programme (Petersen et al., 2017).

Related to this, FBCs also recommended that more effort is needed by facility staff such as nurses, NGO coordinators and NGO line supervisors to attend the project MIND training. FBCs felt that this would increase facility staff's insight of mental health counselling thereby fostering an understanding of the role FBCs play when delivering the counselling. In general, FBCs spent less than 10 minutes doing adherence counselling (excluding newly diagnosed individuals), whereas with the project MIND intervention it increased from between 25 minutes to an hour. The facility staff therefore struggled to understand why counselling sessions were taking so long which also became a source of frustration for the FBCs. Despite the FBCs' recommendation however, implementing this at scale would logistically be impractical as healthcare facilities are already challenged by human resource constraints (Lund et al., 2010; Scheffler et al., 2011). Instead, and in accordance with research, a practical step forward would be to enhance mental health literacy within existing PHC services through initiatives such as in-service staff training (Maconick et al., 2018), mental health awareness drives, and integrating mental health promotion initiatives into workplace policies (Petersen et al., 2016). These considerations are important for planning future implementation of mental health counselling as a recent research study showed that one of the constraints to adopting a counselling innovation such as project MIND among healthcare staff is a lack of understanding of its potential benefits (Brooke-Sumner, Petersen-Williams, Kruger, Mahomed, & Myers, 2019). It stands to reason that improving mental health literacy among other staff through awareness campaigns that addresses the impact of untreated CMDs and the benefits of mental health counselling may also help create a facility climate conducive to counselling implementation (such as making available confidential space and time) required to provide adequate care. This is supported by a recent study that showed strong leadership from facility managers can help staff navigate many of the resource challenges to counselling implementation (Brooke-Sumner et al., 2019).

5.5 Strengths and limitations

There are several limitations that need to be considered while interpreting the findings of this study. However, the main limitation of this study was social desirability bias. Dedicated counsellors potentially may have provided socially desirable responses considering that they are directly employed by project MIND and did not want to jeopardize their employment. Similarly, considering the involvement of NGOs on project MIND, the designated counsellors also might have given socially desirable responses to avoid risking their position at the NGOs they work for. Despite the FBCs being interviewed by someone independent of project MIND, there may still have been a measure of response desirability among the dedicated and designated counsellors such as wanting to be perceived positively regarding the work they have been doing. It is also highly likely that the FBCs knew of my involvement in the study due to the topics discussed. A few FBCs who left project MIND were not available for interviews due to finding a new job which offered a higher salary, and unable to get time off due to job demands. Considering the relatively small sample size, the study is limited by its generalisability to other contexts. Despite these limitations, this research study has provided an in-depth understanding of the FBCs' experience of delivering psychosocial counselling in PHC facilities within the dedicated and designated approaches. A particular strength of this study is that it provided in-depth insight into the experiences of FBCs who delivered psychosocial counselling in PHC facilities. Moreover, it also provided rich insight into FBCs' experiences of receiving the MIND training, supervision, and debriefing from a registered counsellor, which is a novel approach. In addition, the insight gained from FBCs also highlighted the perceived benefits of incorporating role-play exercises as a novel, yet crucial, component of supervision to enhance FBCs' counselling skills and counselling practice.

5.6 Concluding remarks

This study contributes to the emerging evidence on training and supervision models for task-shared counselling interventions in LMIC settings. Our findings highlight the value of emphasising role play and skills rehearsal during training and suggest that counsellor competency may be enhanced through ensuring that the structure and content of training is maximised. Second, this study presents evidence of the acceptability of a cascaded approach to supervision in which supervision and debriefing is task-shifted from psychologists to registered psychological counsellors. As no differences emerged between dedicated and designated counsellors' experiences of this approach to training and supervision, findings suggest that the models proposed here are suitable for both types of counsellors. Nonetheless, findings highlight opportunities to enhance this model of supervision through the

addition of virtual peer group supervision and increasing the amount of contact with FBCs, through the use of technology. Finally, findings confirm that FBCs perceived many benefits to providing mental health counselling to patients with chronic diseases, but systemic interventions are needed to create a PHC facility climate conducive to the sustained implementation of mental health counselling. Unlike dedicated counsellors, designated counsellors experienced workload and workflow difficulties that require structural interventions to ensure that they have the time and institutional support they need to deliver counselling.

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Appendices

Appendix A

Participant information sheet and consent form for interviews with counsellors

The Experiences of FBCs who Provide a Psychosocial Intervention for Mental Illness in Primary Healthcare facilities in the Western Cape

Introduction.

Hello. My name is_____. I am from the South African Medical Research Council (SAMRC). We are asking you to take part in an in-depth interview for the trial phase of project MIND. Before you agree to take part, you should understand what it involves. This pamphlet is to help you decide if you would like to take part in this study. If you have any questions, which are not fully explained in this pamphlet, please ask the interviewer. You should not agree to take part unless you are happy about all that is involved.

Why are we doing this?

The purpose of this study is to explore the experiences of FBCs working on Project MIND who provide psychosocial counselling to individuals with a common mental disorder in primary healthcare settings in the Western Cape. We would like to hear your thoughts about the process of implementing the project MIND intervention, barriers to providing mental health counselling in chronic disease services and how these barriers can be addressed, and the supervision and training you received. The information you provide will be used to identify lessons so that we can improve our collaborative care models (dedicated and designated).

What We're Asking of You.

If you agree to take part in an interview, you will be one of up to 20 counsellors we interview. You will be asked a series of questions on your experiences of delivering the mental health intervention, possible challenges and how these challenges can be addressed, and the benefits of training and supervision. We are asking for your permission to audio-tape these interviews so that we don't miss out on any of the information you provide. Each interview will last about an hour. We value your input, because the information you provide will help us improve counselling services in primary healthcare settings.

Potential Risks and Discomforts.

We do not foresee any risk with participating in this interview; however, some of the questions or discussions may make you feel uncomfortable. You will never be pressured to answer the questions. Participation is fully voluntary.

Potential Benefits of Taking Part in the Study.

There are no direct benefits to you for participating in this interview. However, the interview will help you to reflect on your experiences as a counsellor. Your participation will also help us gain a better understanding of the barriers to integrating screening and brief interventions for common mental disorders into chronic disease care. The information and feedback you provide will help us to improve mental health service provision going forward.

Confidentiality and Privacy.

Digital recordings of the interviews will be encrypted and stored on a password protected computer for the duration of the research study, after which they will be destroyed. Transcriptions of the digital recordings and consent forms will be stored in a double-locked filing cabinet in a locked office at a security-controlled premises. Transcriptions and consent forms will be kept for 15 years as part of the South African Good Clinical Practice requirements.

Who is funding the study?

This work is part of the African Mental Health Research Initiative (AMARI) supported by the Wellcome Trust, United Kingdom.

Reimbursement

At the end of the interview, we will give you R150 voucher to compensate you for your time.

Participation and Withdrawal.

Participation is voluntary. You can choose not to participate in the interviews. If you decide to participate, you may choose to stop your participation at any time. There will be no consequences. Your decision to take part or not take part in this study will not affect your work conditions or work benefits. You may also refuse to answer any questions you do not want to answer.

Who to Contact with Questions about your Rights as a Participant?

This study has been approved by the University of Cape Town's Ethics committee. 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 Mr Yuche Jacobs (principle investigator) at 021 938 0240 or write to yuche.jacobs@mrc.ac.za, or Medical Research Council (MRC) P.O. Box 19070, Tygerberg 7505, South Africa.

Alternatively, you can contact Associate Professor Katherine Sorsdahl (supervisor) at 021 650 4798 or write to katherine.sorsdahl@uct.ac.za, Alan J Flisher Centre for Public Mental Health, Department of Psychiatry and Mental Health, University of Cape Town. You can also contact Professor Marc

Blockman (chairperson), Human Research Ethics Committee, Faculty of Health Sciences, University of Cape Town, telephone 021 406 6338.

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/disagree to what is required:

Agree	**Disagree**	
		I agree to take part in the study, which has been fully described to me, by participating in this interview
		I agree to receive a voucher reimbursement to the value of R150 upon completion of the interview.
		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 this interview being audio-taped.

Agree	**Disagree**	
		I agree to the interview being audio-taped

DECLARATION BY PARTICIPANT

By signing below, I, _____ ***(Participant's Full Name*)** agree to take part in the Project MIND Study.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.

- I understand that taking part in this study is **voluntary** and I have not been pressured to take part. I also understand that I do not give up any rights by signing below.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I have received a card with information about rights of research participants and who to contact with questions.

Participant's Signature	**Date**	**Signed at (Place)**
	(DD/MM/YYYY)	

Appendix B

The Experiences of FBCs who Provide a Psychosocial Intervention for Mental Illness in Primary Healthcare facilities in the Western Cape

Interview guide for FBCs

Interviewer to read: Thank you for taking some time out of your busy schedule and agreeing to have this interview with me. This interview provides us with an opportunity to talk about your experiences of delivering the mental health service offered as part of project MIND. My role is to ask you a few questions about your experience as we are interested in learning about your views of delivering the intervention.

1. **First, tell me a bit about yourself, your position at the NGO and health facility, and how many years you have worked here:**

   Record gender: _____

   Prompts:

   1. How old are you?
   2. What are your qualifications
   3. What position do you hold in this facility?
   4. How long have you worked here for?

2. **Please tell me about how you came to work on project MIND?**

   Prompts:

   1. Were you hired specifically or is it part of your normal work?
   2. What is your role on the project team?
   3. How was project MIND introduced to you?
   4. How did you feel when you were asked to deliver the project MIND intervention?

3. **Please describe to me what you know about mental disorders?**

   Prompts:

   1. What did you understand about mental disorders before receiving the MIND training? i.e. how did you think people developed a mental disorder?
   2. How has your understanding of mental disorders changed since receiving the MIND training?
   3. How did you feel about people living with a mental disorder before receiving the MIND training?
   4. How do you feel about people living with a mental disorder since receiving the MIND training?

5. How did you feel when you were asked to work with patients that might have a common mental disorder?
6. What are some the names you use to refer to people with a mental disorder?

4. **To what extent did the training and support you received adequately prepare you to deliver the intervention?**

Prompts:

1. Should training have covered more topics- if so, what
2. What do you remember most about the training you received?
3. What did you enjoy most about the training you received?
4. What did you dislike about the training you received?
5. To what extent was the level of support provided sufficient?
6. Do you think your NGO coordinator/programme manager should participate in the training? If yes, why?
7. Do you have any suggestions for improving training (Probe: training venue, time of training, materials used etc.)

5. How often did you see the counselling supervisor for supervision (this includes face to face and telephonic)?

Prompts:

1. How easy or difficult was it to attend supervision and debriefing?
2. What are some of the things you covered in the supervision sessions?
3. What do you think about the number of supervision and debriefing sessions you received? Do you think it was enough? Why/why not?

6. To what extent did the supervision and debriefing provided by the counselling supervisor help you to deliver the MIND intervention?

Prompts:

3. How, if anything, do you think supervision improved your counselling skills?
4. Did it help you cope better with your daily duties in the facility including project MIND? If so, how?
5. Do you have any suggestions for improving supervision and debriefing? (Probe: venue, time, individual or group supervision, training, materials used etc.)

7. **(Before I ask the next question, I want you to describe to me one of the "good" cases you had and what made it so good. I also want you to describe one of the "not so good" cases you had and what made it not so good).**
   To what extent do you think the MI-PST Intervention helped patients with their depression and/or alcohol use? Please provide reasons for your answer?

   Prompts:

   1. Did they actively participate in the intervention sessions?
   2. Was language an issue? What about literacy? How did you manage these challenges if they were present?
   3. Did the patients find the information easy to understand?
   4. What kind of feedback did patients give about the intervention, if any?
   5. What did patients say about the homework component of the intervention? Did they do it? Why/why not?

8. Tell me a bit about your experiences of the project MIND intervention. I am interested in hearing about both the positive (good) and not-so-good experiences.

Probes:

1. What did you like about implementing the intervention? Please elaborate.
2. What did you not like? Please elaborate.
3. What, if anything, would have made your experience of implementing the intervention better?
4. Do you have any suggestions for improving the intervention or the way in which it was delivered?

9. What is your opinion about having this MI-PST intervention as part of routine care for people with a chronic disease such as HIV or Diabetes?

Probes:

1. What are the barriers to implementation in routine care?
2. What needs to happen in this facility to allow for routine implementation of this intervention?

10. How has the facility environment supported or made the delivery of this intervention difficult?

Probe:

1. Were you always able to find a room to do counselling?
2. Did you experience any interruptions while doing counselling?

11. How has the rest of your healthcare team allowed or supported you to deliver the intervention?

12. What other challenges have there been to delivering this intervention?

13. What do you think can be done to address the challenges you experienced?

14. Working with patients in the facility can be a challenging experience. Can you tell me about the things you have done to care of yourself when you not working?

Prompts:

1. Describe what you do after experiencing a difficult day/week at work?
2. How important do you think it is to take care of yourself as a counsellor? Why/Why not?

15. In what ways, if any, did delivering this intervention benefit you?

(Probe: personal benefits, career and skill development, helped them work with patients in a different way?)

Read: *These are all the questions I have for you today. You have provided us with a lot of useful information in this short amount of time. Thanks for your time—we appreciate all of your help.*