Department of Psychology

University of Cape Town

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Task shifting for mental illness in primary healthcare clinics in the Cape Winelands Health

District, South Africa: A mixed design study

Nqabisa Faku and Mandisa Qodashe

FKXNQA001 and QDSMAN001

Professor Catherine L. Ward

(Supervisor)

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Student's Name & Surname: Nqabisa Faku and Mandisa Qodashe

Student Number: FKXNQA001 and QDSMAN001

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Abstract

There is a high mental health burden in South Africa. However, there is an inadequate system of care to address this mental health crisis. The current study aimed to get an indication of how many patients have symptoms of mental illness and assess whether lay counsellors' services could expand their reach to meet mental health service needs in the Klapmuts, Kylemore and Cloetesville Community Health Clinics in the Cape Winelands Health District. Self-report measures on mental health symptoms of the common mental disorders in South Africa were issued to patients. Semi-structured interviews were conducted with staff members in the three clinics, NPOs and the training facility to get their views about the re-imagination of lay counsellors' capacities in the primary healthcare system. Findings reveal the systemic complexity of this. At the management level, the training facility needs to register with an established statutory body to accredit its lay counselling programme. New categories of lay counsellors: lay mental health, HIV and general health counsellors were recommended by staff. At the referral level, a mental health protocol needs to be established for the district. At the supervision level, the psychologist must provide weekly coaching sessions and lay counsellors need to attend them. The lay counsellor training programme needs to be designed with a designated approach whereby each category of lay counselling will have its particular training programme. These problems need to be resolved for staff in the healthcare system to task shift to lay counsellors in the primary healthcare system.

Keywords: Mental health treatment gap; public health; primary healthcare; task-shifting; lay counsellors

South Africa has a high burden of mental illness. The South African Stress and Health (SASH) study is the largest prevalence study of mental disorders that has been conducted in the country (Williams et al., 2008). It had a nationally representative sample of 4351 adults from randomly selected households. Findings revealed that 16.5% of the South African adult population had experienced a mental health problem in the 12 months before the study, and 30.3% of the South African adult population had experienced depression and anxiety disorders in their lifetimes. Although anxiety disorders were the most prevalent, alcohol abuse (4.5%) was rated second. The SASH study also revealed that having survived traumatic events such as an accident (20%), physical abuse (21%), having witnessed violent crimes (4%) or a death (20%) accounted for Post-Traumatic Stress Disorders (PTSD) in the sample (Tomlinson et al., 2016). Depression, anxiety, substance abuse and PTSD are the most prevalent disorders of the country's mental health crisis (Tomlinson et al., 2016). This burden is unlikely to change in a context of high rates of income inequality, poverty, unemployment, urbanization, trauma and violence, and substance abuse which are significant social risk factors for mental illness (Marwaha & Johnson, 2004; Patel, & Kleinman, 2003; Ribeiro, Andreoli, Ferri, Prince, & Mari, 2009; Weich, Lewis, & Jenkins, 2001).

In a recent study, it was estimated that 92% of the adult population in South Africa with a mental disorder do not have access to treatment (Docrat, Lund, & Besada, 2019). In other words, fewer than 1 in 10 South Africans have access to the treatment they need. This is commonly known as the mental health treatment gap. One aspect of the mental health treatment gap is an inadequate system of care. In a 2005 survey it was revealed that very few mental health professionals were available: 0.28 psychiatrists, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists and 10 nurses, per 100,000 population (Lund, Kleintjes, Kakuma, & Flisher, MHaPP Research Programme Consortium, 2010). This had improved by 2017 at least as far as psychiatrists are concerned yielding 1.52 psychiatrists per 100,000 population (WHO, 2017). However, our number of psychiatrists per 100,000 is still significantly lower than other middle-income countries which have 5 per 100,000 population and much lower than high-income countries which have 15 per 100,000 population (Bateman, 2015; Burns, 2011).

Another aspect of the mental health treatment gap is leaving mental health problems untreated costs us money. Previous studies by Lund et al. (2010) estimated the unexpected costs of mental illness per adult with major depression and anxiety disorders to be R54,121 per annum. The SASH study projected that, per annum, it was costing us 2% of the annual GDP between 2003 and 2004 (Williams et al., 2008). A recent study by Docrat et al. (2019)

is the first national representative reflection on the expenditure of mental health in the country. Currently, at a national level, only 5% of the total health budget is allocated to mental health services. Our mental health budget is significantly lower than other international benchmarks that countries are expected to spend on mental health. At a provincial level, there are vast differences in the allocation of money to mental health. For example, R58.80 is spent per uninsured mental health patient in Mpumalanga, whereas R307.40 is spent in the Western Cape. Services at the primary health care level were only allocated 7.9% of the overall mental health budget (Docrat et al., 2019).

Therefore, task shifting to lay counsellors is a viable way of increasing access to mental health services in primary healthcare. The integration of lay counsellors in primary healthcare will not only keep in line with the National Mental Health Policy Framework and Strategic Plan (Department of Health [DoH], 2014), but also the recommendations set out in the South African Human Rights Commission Report (2017) and the recently passed National Health Insurance (NHI) Bill (Docrat et al., 2019; Republic of South Africa, 2019). Policies have been put in place that includes lay counsellors. For example, the National Department of Health HIV Counselling and Testing (HCT) programme appoints lay counsellors to deliver HIV testing and counselling at community-based clinics and mobile clinics (DOH, 2010).

Task-shifting can be cost-effective in limited-resource settings where there is an already over-burdened staff (Yasamy et al., 2011). Task shifting is simply the process by which mental health professionals train and supervise community health workers in mental health to deliver basic counselling. Task shifting enables non-specialist health care workers such as lay counsellors to facilitate the integration of mental health into primary health care (Jacobs & Coetzee, 2018). Lay counsellors can significantly improve mental health service accessibility, availability and affordability by shortening the waiting time for services at clinics, screening for mental disorders, providing brief mental health interventions once the mental illness has been detected and adherence support (Maconick et al., 2018).

A plethora of international research suggests that the integration of lay counsellors into primary health care known as task shifting would help to achieve universal access to not only health care services but also mental health services which will keep in line with section 27 of the Constitution (Republic of South Africa, 1996) and the Mental Health Care Act of 2002 (Burns, 2011). For example, Patel et al. (2010) conducted a cluster randomised controlled trial on the efficacy of an intervention managed by lay counsellors for depressive and anxiety disorders in primary health care facilities in Goa, India. They found that trained lay counsellors in mental health interventions to treat patients with depression and anxiety

were effective (Patel et al., 2010). Also, Chibanda et al. (2015) conducted a cluster randomised controlled trial on the effectiveness of a brief mental health intervention for common mental disorders managed by trained and supervised lay counsellors in primary care clinics in Zimbabwe. This study is commonly known as the Friendship Bench programme. Its findings revealed that mental health intervention led by lay counsellors at primary care level is indeed effective as screening and treatment of common mental disorders was made accessible and reduced the gap between need and service and decreased referral to mental health professionals (Chibanda et al., 2015).

Task shifting has also been investigated in the South African context. Munodawafa, Lund and Schneider (2017) evaluated lay counsellors' experiences of delivering psychosocial support to perinatally depressed mothers in Khayelitsha, South Africa. Findings revealed that the integration of lay counsellors into primary healthcare would need the prioritization of ongoing training and supervision for lay counsellors to deliver good quality mental health interventions in low-resource settings. Petersen, Hancock, Bhana and Govender (2014) conducted a randomized controlled pilot study where a task-shifting model was used to provide group-based counselling for patients with comorbid depression and HIV/AIDS in a public clinic situated in the eThekwini District, South Africa. Their findings suggest that group-based counselling for patients with comorbid depression and HIV/AIDS can be effectively delivered by suitably trained and supervised lay HIV counsellors, although they suggest that there is a need for a larger trial.

Training non-specialist staff to deliver mental healthcare is a sustainable solution to addressing the inadequate system of care. The integration of non-specialist mental health staff into primary care will help to ensure the provision of quality mental health services such as counselling that are accessible, affordable, comprehensive, effective, responsive and offer efficient referral pathways for mental health patients to receive the care they need. Some studies show that task shifting to lay counsellors can be done (Chibanda et al., 2015; Patel et al., 2010). Some studies have identified some areas that need to be paid careful attention (Munodawafa et al., 2017). However, no previous study has reported the views of staff in the health system about the feasibility of task-shifting to lay counsellors in the primary healthcare system.

Research aim and rationale

The aim of this study is twofold. Firstly, to get an indication of the number of patients with mental health disorders attending primary care clinics; and secondly, assess the feasibility of expanding lay counsellors' services in three clinics situated in the Cape

Winelands District as a step towards meeting this need. Since depression, anxiety, substance abuse and PTSD are the most common mental disorders among the adult South African population (Tomlinson et al., 2016; Williams et al., 2008), then training lay counsellors to deliver mental health care may feasibly address this mental health treatment gap as evidenced by previous studies in the field of task shifting (Chibanda et al., 2015; Patel et al., 2010; Petersen et al., 2014). Thus, our objective is to investigate the views of staff in the health system about task-shifting to lay counsellors as a relevant strategy to move towards meeting the mental health needs of most South Africans in the future (Jacobs & Coetzee, 2018; Murray et al., 2014).

Methods

Design and setting

We followed a mixed-methods design. In it, we attempted to get a quantitative indication of how many patients have symptoms of mental illness. Also, we interviewed staff in the healthcare service system on their views about task-shifting to lay counsellors in the primary healthcare system. We also had a reference group of three local experts who have extensive experience in studying task-shifting in the health care system of the Western Cape.

The primary setting of the study was in three clinics which primary health care staff and lay counsellors work in the Cape Winelands District: Klapmuts Clinic, Kylemore Clinic and the Cloetesville Community Health Clinic. The Cloetesville Community Health Clinic is a primary healthcare facility which is funded by the Western Cape Department of Health (Western Cape Government, 2019a). The Klapmuts and Kylemore Clinics are primary healthcare facilities which are funded by Breede Valley local municipality and cater for mother and child health, care for chronic diseases such as HIV and TB, women's health, men's health and acute services (Western Cape Government, 2019b; Western Cape Government, 2019c). Private rooms in these clinics were used to conduct interviews.

The other settings where interviews were conducted were at Non-Profit Organizations namely At Heart and Right to Care which supports lay counsellors. At Heart (2019) is funded by the Western Cape Department of Health to provide the following services: Psycho-social support for people living with HIVAIDS, facility-based and outreach program for HIV Counselling and Testing (HCT), prevention of HIV mother to child transmission, TB screening and testing, condom distribution, adherence support and food parcel program for those on Antiretroviral Therapy (ART), workplace wellness and employee assistance program and life skills program for vulnerable children: Girls Club. Right to Care (2019) is funded by National Department of Health to expand the reach of innovative and quality

health care services for the prevention, treatment and management of HIV, infectious and chronic diseases across five provinces in South Africa primarily Gauteng, Mpumalanga, Northern Cape, Western Cape, and Free State. A board room in At Heart was used to conduct interviews. Interviews were conducted telephonically between staff members of Right to Care and the researchers.

Lastly, the People Development Centre (PDC) was another setting where interviews were conducted. It is a government facility formerly known as Aids Training Information and Counselling Centre (ATTIC) that is responsible for training all lay counsellors in the Western Cape province. Their training programme is geared towards training community health care workers to deliver quality health care services for the care, treatment and management of HIV/AIDS, Sexually Transmitted Infections (STIs) and chronic diseases (Western Cape Government, 2019d). A private room in the regional training facility was used to conduct interviews.

Participants

For the quantitative part of the study, the sampling was convenience and questionnaires were distributed to patients in the three clinics in one day. All the patients who were willing to fill in the questionnaire were recruited to participate in the study. For the qualitative part of the study, the sampling was purposive, and we interviewed 6 lay counsellors who work at the three clinics about the skills they use, their views of their service level agreement and their interest in expanding their skills. Also, we interviewed 10 healthcare providers who provide services in these clinics, including nurses, operational managers, an administration clerk, clinical nurse practitioners and a pharmacist. We asked them whether they would refer to or receive referrals from lay counsellors and what they think would work and would not work in upskilling lay counsellors to expand the mental health service.

We also interviewed 13 staff members from the NPOs, and the regional training facility included: the executive manager and office manager from At Heart; the provincial senior operations manager, regional operations manager and some of their trainers from Right to Care; two regional project managers of the lay counselling programme and regional trainers of the Western Cape from PDC. With these participants, we explored (a) what kind of competencies they think that lay counsellors need to expand their capacities; (b) what they think about the feasibility of setting up a referral system between ordinary doctors, nurses and lay counsellors to expand the service; (c) what is the set-up of supervision of lay counsellors'

services; (d) what do supervisors' need to be able to supervise lay counsellors; and (e) what kind of extra support trainers need to provide extra support to the service.

Measures

Quantitative section.

Patient Health Questionnaire-9 (PHQ-9).

The Patient Health Questionnaire-9 (PHQ-9) was used to screen patients attending these clinics for depression severity (Kroenke, Spitzer, & Williams, 2001). The PHQ-9 asked patients to rate how often they were bothered by specific problems over the last two weeks. It scores each of the nine questions which are derived from the DSM-5 criteria as "0" (not at all), "1" (several days), "2" (more than half the days) and "3" (nearly every day) according to the frequency of the problem (Kroenke et al., 2001). Total scores of 0 to 4, 5 to 9, 10 to 14, 15 to 19, and greater than 20 represent cut-off points for minimal, mild, moderate, moderately severe and severe depression, respectively. The original validation study of the PHQ-9 by Kroenke et al. (2001) found that a cut-off score of greater than 10 produced the highest sensitivity of 88% and a specificity of 88%. It has been used in South Africa before in the study by Petersen et al. (2014) which found the PHQ-9 to have good reliability: The internal consistency reliability (Cronbach's alpha) was 0.81 pre-test and 0.71 post-test which were high. It is a reliable and valid measure for depression severity.

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5).

The Primary Care Post-Traumatic Stress Disorder Screen for DSM-5 (PC-PTSD-5) was used to screen patients attending these clinics for probable PTSD (Prins et al., 2016). The PC-PTSD-5 asked patients to answer "yes" (1) or "no" (0) to answer whether they had experienced a traumatic event over the past month. An indication of "yes" on three or more of the items on the PC-PTSD-5 questionnaire represents probable PTSD. There are limited studies in South Africa that have used PC-PTSD-5. However, the study by Prins et al., (2016) found that the cut-off point score of 3 produced the highest quality of sensitivity score ($\kappa[1] =$ 0.93; $SE = .041$; 95 % CI, 0.849–1.00) and an excellent specificity score (i.e. inter-rater reliability) ($k \geq 0.80$).

CAGE-AID Questionnaire (CAGE-AID).

The CAGE Adapted to Include Drugs (CAGE-AID) questionnaire was used to screen patients attending these clinics for alcohol and drug problems (Brown & Rounds, 1995; Hinkin et al., 2001). The CAGE-AID questionnaire asked patients to answer "yes" (1) or "no" (0) to questions about their lifetime use of alcohol and drugs. An indication of "yes" on any one of the items on the CAGE-AID questionnaire is a positive indication of possible

substance use (Brown & Rounds, 1995; Hinkin et al., 2001). The original studies that used the CAGE-AID did not report reliability statistics. The only study that could be identified in South Africa that used the CAGE-AID found that a cut-off score of more than one "yes" on the items of the CAGE-AID questionnaire indicated a sensitivity of 43 – 100% and a specificity of 65 – 95% in screening for substance use in clinical settings (as cited in Claassen, 1999).

Generalized Anxiety Disorder 7-item (GAD-7).

The Generalized Anxiety Disorder 7-item (GAD-7) was used to screen patients attending these clinics for anxiety. It is a reliable and valid measure for probable generalized anxiety disorder (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007; Plummer, Manea, Trepel, & McMillan, 2016; Spitzer, Kroenke, Williams, & Löwe, 2006). The GAD-7 asked patients to answer "0" (not at all), "1" (several days), "2" (more than half the days) and "3" (nearly every day) to answer whether they felt worried about several different things over the last two weeks. In the GAD-7, total scores of 0 to 4, 5 to 9, 10 to 14 and greater than 15 represent cut-off points for minimal, mild, moderate and severe anxiety, respectively (Kroenke et al., 2001). There have been no previous South African studies that have used the GAD-7. However, according to meta-analyses, the GAD-7 has a sensitivity score of 92% and specificity of 76% for the clinical diagnosis of a generalized anxiety disorder (Kroenke et al., 2007; Plummer et al., 2016; Spitzer et al., 2006).

Therefore, these measures were considered to be appropriate to be used in South Africa. In our study, the self-report measures were translated from English to IsiXhosa and Afrikaans to accommodate patients who were able to read and comprehend IsiXhosa or Afrikaans better than English. The translations were checked by back translations. Also, our Afrikaans-speaking research assistants helped communicate with the locals who understood Afrikaans better than English.

Qualitative section.

Semi-structured interviews.

Qualitative semi-structured interviews with questions outlined in an interview-guide were used to interview lay counsellors, healthcare providers, supervisors and trainers. Using semi-structured interviews in this mixed-design study explored the feasibility of shifting lay counsellors' roles within the clinics. The open-ended questions allowed for the subjective, constructive, as well as objective suggestions of the interviewees on the possibility of upskilling of lay counsellors to be community mental health workers (Holloway & Galvin, 2016).

Procedure

Quantitative data was collected as follows: firstly, one of the nurses was asked to introduce the researchers to the patients in the waiting room. The researchers then proceeded to read out the informed consent form to patients in a group setting seated in the waiting room and answered any questions they had. All patients received an information sheet listing counselling services they could contact in their informed consent form. Secondly, the researchers distributed pens to patients who agreed to participate in the study to complete the different self-report measures to get a sense of the mental health burden in that clinic. The researchers spent one day at each of these clinics collecting data from the patients on their mental health problems.

Qualitative data was collected as follows: Informed consent forms were distributed to the lay counsellors, healthcare providers, supervisors and trainers before the interviews. Interviews with staff were conducted in a private space (usually their offices) to allow the interviewee to give honest answers. All interviews were conducted by the researchers took about an hour each. With permission from the interviewee, the interview was recorded using an electronic voice recorder. The researchers took down notes during the interviews. The recorded information was used simply to supplement the note-taking, to ensure that everything was properly captured. They did not have to answer any questions they did not feel comfortable with answering.

Data analysis

Quantitative section.

IBM SPSS Statistics version 25 was used to run Little's Missing Completely at Random Test (MCAR), establish reliability scores and data imputation. Microsoft Excel for Office 365 (version 1904) was used to estimate the frequencies.

Qualitative section.

Thematic analysis was used to analyse notes taken during semi-structured interviews with lay counsellors, healthcare providers, and supervisors and trainers. This method entailed coding, essentially identifying themes which indicated shared patterns of understanding from notes taken during the various interviews (Braun & Clarke, 2006). Therefore, interpretivist thematic analysis was appropriate in analysing the thick descriptions given by interviewees (Blanche, Durrheim, & Painter, 2006). To ensure reliability and accurate identification of themes, the researchers worked independently on identifying themes. Discrepancies between the raters were resolved by discussion until consensus was reached.

Ethical considerations

Ethical approval was gained from the University of Cape Town Humanities Faculty Ethics Review Committee (*see appendix A*) and the Health Sciences Faculty Human Research Ethics Committee (*see appendix B*) as well as the Western Cape Health Research Committee (*see appendix C*). All participants provided informed consent (*see appendices D & E*) to complete the questionnaire (*see appendix F*) or to be interviewed (*see appendices G, H & I*). Confidentiality was maintained by not revealing the names of staff members to fellow staff members in each interview and patient names were not required on the questionnaires. Interviews were conducted in private staff offices. All patients were given a list of counselling services that they could contact if the questions were in any way distressing to them.

Results

Numbers of patients with mental health symptoms

The overall sample (N = 64) included patients who came for any service at the Cloetesville (n = 20), Kylemore (n = 27) and Klapmuts (n = 17) clinics. We estimated that approximately half of the patients on any day did not agree to complete the questionnaires and so this gave us an estimate of the minimum number of people who would use mental health services in the Cape Winelands District.

Reliability. As can be seen in Table 1 below all the scales meet the Cronbach's alpha criterion of greater than .7 (Tredoux & Durrheim, 2013) for research instruments. Therefore, they were considered sufficiently reliable to be interpreted within the South African context.

Table 1

Reliability Statistics

Name of Measure	Cronbach's Alpha	N of Items
PHQ-9	.84	9
CAGE-AID	.78	4
GAD-7	.92	7
PC-PTSD-5	.85	5

Normality and imputation. 5 participant responses were removed from the original sample of 64 because more than 50% of their responses had missing values. Therefore, 59 participant responses were retained. Of these, there were 126 (8.5%) total missing data points out of 1,475 total number of data points. The Little's MCAR test revealed that the data points were not missing completely at random (i.e. there were significant differences in the missingness of the data), $X2 (152, N = 59) = 187.74, p = .026$. To compensate for this missing data, we used data imputation to retain as many participants as possible. It was

suitable for addressing item non-response as some participants only answered some of the items on each scale (Garson, 2015). None of the data was normally distributed (*see appendix J*) and therefore we used median imputation (Van Buuren, 2018).

Frequency of disorders. These instruments have been validated to give a good indication of whether these disorders would be diagnosed by a mental health professional. As can be seen in Table 2 below, 40 (71.19%) patients had depressive symptoms, 40 (67.80%) patients probably had substance use disorders, 31 (62.71%) patients had anxiety and 23 (38.98%) patients had probable PTSD that would need treatment.

The number of patients that probably had comorbid disorders and needed treatment for any disorder was 53 (89.83%) which is very close to the estimated 92% of South Africans who do not have access to the treatment they need.

Table 2

Frequency of disorders

Name of Measure	Categories	N	%
PHQ-9	Minimal depression	17	28.81
	Mild depression	10	16.95
	Moderate depression	13	22.03
	Moderately severe depression	12	20.34
	Severe depression	5	8.48
	Total	57	96.61
	Missing	2	3.39
Total		59	100.0
CAGE-AID	Possible substance use	40	67.80
	No substance use	19	32.20
	Total	59	100.00
	Missing	0	0.00
Total		59	100.00
GAD-7	Minimal anxiety	22	37.29
	Mild anxiety	9	15.25
	Moderate anxiety	11	18.64
	Moderately severe anxiety	5	8.48
	Severe anxiety	6	10.17
	Total	53	89.83

	Missing	6	10.17
Total		59	100.00
PC-PTSD-5	Probable PTSD	23	38.98
	No PTSD	25	42.37
	Total	48	81.36
	Missing	11	18.64
Total		59	100.00
Any	0 disorder	6	10.17
	1 disorder	16	27.12
	≥ 2 disorders	37	62.71
	Total	59	100.00

In conclusion, all these mental disorders are common and are represented in the Cape Winelands District.

The views of staff in the health care system on the feasibility of task shifting mental health services to lay counsellors in the primary health care system

The re-imagination at management level. All staff members recognize there is a high mental health burden, and this is related to social problems in the community such as unemployment rate, domestic abuse, substance abuse and other circumstances of inequality and disadvantage that plague poor communities.

> Clinic operational manager (OM) 2: "We come across a lot of depression, stress, given the fact that we have a high unemployment rate so stemming from those. Then we have drug abuse in the area whether it is the person who is the abuser that is the problem, but then it also becomes a family problem. It starts affecting the rest of the family. Then it becomes a problem in the home and the community, given the low-cost economic area that we are in and comes with its types of mental health illnesses associated with this."

> Clinic Pharmacist 1: "In terms of mental health, we issue out medication for like your schizophrenia, your psychotic disorders, your anxiety patients, MDD, your bipolar patients – that is your general. Depression is a lot now."

With these mental health problems in the community, lay counsellors want to help their patients further and aspire to be better equipped to do this job.

Lay counsellor 6: "I think we must have a quicker way of how to help the patients. I don't know how we can help … the patient can feel ok … I think maybe they should look at the counsellors and how they can help in the clinic, because sometimes there's not even enough staff here. So maybe as assistants to the nurses as well. It'll be of help, for them as well. So that is one of the things, the challenges that we sit with here. Less staffed and if we have that information and that training, we can be of more help to the facility for the sisters in charge or whoever is here running the clinic. "

But there are things to be taken into consideration. The managers and supervisors say that there is a need for HIV counselling and those lay counsellors should only do that. But people who provide mental health counselling should be a separate group of people. They need training. At the moment lay counsellors were only trained to refer and not even diagnose.

Lay counsellor 4: "….but the problem that you see in the patient you can let the nurse know that you noticed oku, na oku [this and that] etc. For example, with suicidal patients, you cannot say that they have a mental health problem because they talk about suicidality. You are not the one who decides that this person has a mental health problem. But when you refer them you will say that this person constantly talks about suicide. So, I am fearful that …. But you cannot say that the person has a mental health problem. [The training that they received about mental health was centred on] If you encounter someone with mental health issues, then you should know what to do [which is to refer to the nurse]."

Staff were clear that there would be a need for a mental health protocol in consultation with other staff members. A very clear protocol with the boundaries and referral lines needs to be set. For example, what if a lay counsellor sees someone who is beyond what they can treat them where do they refer them to. That is what the management of the district needs to look at.

NGO manager 1: "Where or who do you refer mental health patients in the Stellenbosch sub-district? What happens from the receptionist? How do you transport psychiatric patients? In terms of waiting time: Mental health patients cannot or rather

should not have to wait long for mental health services. When the protocol is written, staff who work in specific clinics need to be consulted."

There is a need for different categories of lay counsellors. Most staff members agreed that the existing HIV counsellors have a heavy workload as they are mandated to see 15 patients per day. Their service level agreement stipulates that they must see 5 patients for HIV testing and counselling and 10 patients for adherence support (DoH, 2010). Also, they must do outreach.

Lay counsellor 5: "So, I tend to squeeze if I do have the time one or two of them. Per day, maybe I do six or seven people to be … also safe on my side. Because anything can happen. Maybe when I come back home my child gets sick (you know). Because there are targets that need to be reached per month (you see). It is 50 inside the clinic and 50 outside the clinic. You must go and do outreach (yourself). This requirement comes from the government. So, they fund the NGO and then the NGO must follow the rules and guidelines set by the Department of Health. Per month you must at least have 100 people. So, if you count that 5 per day, it is 25 per week. But we do more than that 100 because we don't stick to that 100. It may so happen that my child gets sick at home and then I won't be able to work for two days. Then, I don't want to be behind in terms of my target. That is why I am saying that I sometimes tend to squeeze in two or one so that I do not fall behind because anything can happen (you see). It is better to be safe than sorry."

To alleviate this workload and increase access to mental health resources to close the gap between service and need, a suggestion was made that there should be different categories of lay counsellors. Two models were proposed. In the first model you have suitably trained lay HIV counsellors, mental health counsellors and adherence counsellors for chronic medication. The other model lay counsellors will HIV counselling, mental health counselling and general adherence counselling on a rotational basis. Given that these are lay staff some consideration needs to be given to their limits and skills. In other words, lay counsellors would need fairly structured training, a mental health protocol and understand their boundaries. It would be recommended that lay counsellors be trained in designated counselling services than on a bit of everything.

Clinic operational manager 3: "I think the lay counsellors can play such a big role to take a lot of the burden from the clinical staff. If they are well trained and they are vibrant and willing to do it. They can do a lot of work. Because by the time, because you know we got the patients lined up. So, if they can do the therapy and the talks and the behavioural changes speeches and stuff. By the time they get to us, they have all the information. Then it makes it easier for us if they can."

NGO manager 2: " … in my opinion, I would say there needs to be a differentiation: a specific mental health lay counsellor and a more general type of counsellor who is doing all the other things [adherence support]."

Regional trainer: " … I am thinking that suggestion that if you have a split, a division of labour whereby you have mental health, you have your HCT and adherence and then just a general health person doing chronic diseases that could ease the burden and they could do it on a rotational cycle. Because I have gone to one of the clinics in Khayelitsha and they have 6 counsellors. What they do is: Two in one term will do the adherence clubs. Next term the other two will have a go at it. Then those two go back to HCT normal testing. To kind of let everyone have that skill of running the clubs, but they do it at a rotational basis."

It would be useful to develop a mental health counselling tool or guide for lay mental health counsellors that they could use daily to guide them on screening and other information related to mental health as noted by the Friendship Bench study (Chibanda et al., 2015).

Regional lay counsellor programme manager 2: "So, with HIV testing services with the test, they've got the ACTS counselling tool, they can refer to in their hand out pack and guide them. With ART initiation counselling uhm, it's very guided and scripted."

There is a need to change the recruitment and selection criteria of lay counsellors in the future. This needs to be based on different factors such as life and work experience, and the core competencies of a counsellor as suggested by the regional trainers.

Regional trainer: "Experience… it must be work in any related field. Yes!"

Regional trainer: "… I say grade 12 [should be] there but the other criteria …[can be] grade 10 and 9 with Recognition of Prior Learning."

Regional trainer: " … [In terms of age] maybe for mental health counselling we can say 30 years [old] maybe for a general counsellor we can say 25 [years old]."

Regional trainer: "When we do our assessments hey, we assess on four different things but we don't just assess on whether they are competent with the theory...there's practical competence then there's the personality one that we also do so and coz...on a few occasions when you come across students who are judgmental and you cannot reach out to them and they are opinionated, they pose their own views on clients and they just not fit into any qualities, they don't have any qualities of a counsellor so there's no qualities of a counsellor. So that's what we must also look out for when we run an assessment. I already on a few occasions found students not yet competent because they didn't have qualities appropriate for...to do...to be a counsellor and then we had to let them go. So unfortunately, not everyone can be a counsellor. Not everybody's a people's person."

Regional trainer: "What's important is that the NGO's listen to our recommendation and it's not one thing that counts. It's the age, the RPL, interview, the grade and the training will determine whether you get the job or not [in the future]".

Another criterion suggested for selection criteria was an educational background in Psychology as suggested by some reservations of staff members on the expansion of lay counsellors' skills. However, anyone who is willing to learn and has an interest in mental health care can be suitably trained to become a lay mental health counsellor as evidenced by previous studies (Chibanda et al., 2015; Patel et al., 2010).

Clinic operational manager 2: "When you say the lay counsellor, I expect the lay counsellor to be trained in psychology; you're a psychologist in the making. A lay counsellor cannot just be someone who asks questions. They have to understand the depth. You have to have the psychological background or the theoretical background for you to be able to answer and ask the questions based on … how are you going to answer the question based on what the patient wants. How are you going to answer the patient if you don't have the knowledge base?"

There is a need for PDC to register with a relevant Sector Education and Training Authority (SETA) to have their regional lay counselling training programme accredited. Currently, their lay counselling training is not accredited. Unfortunately, there is no career pathing, even though they are passionate about their job and helping the community.

NGO manager 1: "ATTIC [contracted by government] is not accredited; accreditation was lost at some point. Only one module that is accredited. Sometimes attendees don't even receive a certificate of attendance. There is nothing to show that you have received training in ATTIC. If At Heart were to close down, the counsellors would have nowhere to go, in essence they can't use this "qualification" to apply elsewhere. They do not have the paper to show for it, but they have the skill. These counsellors are excellent at counselling."

Cloetesville lay counsellor 2: "This is not just a job. You must have patience. You must have passion. You must love what you are doing. You must wake up every morning with that thing of today you are going to help somebody. That then makes you feel good when you are sitting at home. Even if you are tired. Just to think today my day was productive in this and that way. At least there was a life that I saved even if it was one. There is a change that I enacted in a person's life. So, it also makes you feel good and proud of yourself. And more especially when a client comes back to you saying "iyoh sisi enkosi kanje nakanje [Oh gosh thank you sister for this and that]…."

Further, structural changes in the clinics are needed. Lay counsellors need private rooms. At the moment the situation is not working. One of the lay counsellors described that they were treated like "inkomer" [an incomer]. The attitude or rather the sentiment from other staff members was that "the organisation [NGO] will see how you are doing." They have to share office space. All three lay counsellors share one room in one of the three clinics. There were two tables at which two lay counsellors could see patients. This infringes on the confidentiality and privacy of the patients when they see the lay counsellors. The third lay counsellor had to wait for one of the two lay counsellors to be done before she could start counselling the next patient. They rotate office space amongst each other.

Only one clinic was the exception – they had office space for the lay counsellors and any other staff member that would come to the clinic to offer health or mental health services.

Clinic managers advise creativity, but that does not does not work at all clinics. Infrastructural plans by government would need to be considered if new categories of lay counsellors are introduced into primary health care clinics.

Clinic OM 1: "And at the moment he's [the psychologist] not coming to Kylemore anymore because the infrastructure is of such a manner that he's disturbed all the time. He used to come here, but space is a problem, we've got space concerns, we don't even have enough space for everyone here you know."

Clinic OM 2: "… Umm, should they tell me tomorrow that we will be sending you a mental health counsellor, I would take them because of the plight in the community. And work with anything. Our social worker has worked in little hokkies. The idea is to have that person here, infrastructure will come afterwards. You cannot curb a service where there is a need because of infrastructure. You make a plan even if it means the mental health counsellor comes in three days a week or two days a week – you know. If it's a permanent thing we will make a plan. I am currently taking my baby room and putting in a bed in there because of the need that I've got at Klapmuts to get people out and getting patients' blood pressure down – you have to neh. In the Department of Health, we have values and one of the latest values is innovation. If you don't have, you do with what you got. Infrastructure would be a constraint, but it would be something that we could workaround. I have given my room for MMCs (Male Medical Circumcisions), but it is done. I will move out for the day even if it in the kitchen – I will move out because the need is there for the patients."

Clinic operational manager 3: "We do have a few rooms available that the outreach people use for example SASSA, occupational therapist, the psychologist, the psychiatrist sister. So, they are not occupied daily. So, those offices are available daily and the counsellors also have their own offices. So, if a counsellor is allocated a day sheet. They do have space, an office that they can use. We have quite a big clinic as you can see. We are lucky for space and unlucky for walking up and down. All the patients see they are walking up and down today."

The re-imagination of the referral system. In the clinics there are limited mental health staff, as a result the referral system is not working well. The referral system could be

redesigned to have a quicker way for patients to receive mental health care and their medication. Maybe the lay mental health counsellors could provide counselling and the psychiatric nurse could prescribe medication.

Clinic Pharmacist 1: "…we have a mental health sister. She only comes in once a month which is bad in my opinion at the moment. It is escalating at the moment. Like you said now, it is once a month. It is once every two weeks kind of. She's booked full. So, where else must the patient go?"

Lay counsellor 2: "The psychologist comes once a month to the clinic; the psychologist has to have a date to see Klapmuts clinic patients once a month. If the psychologist has been booked to see ten people on that day, the psychologist will only see those ten people. They will come next month to see the other patients."

Clinic operational manager 3: "To get patients booked to see the clinical psychologist is quite difficult. We only have one clinical psychologist for the whole Stellenbosch sub-district. So, what we usually do is, refer the patient to the CNP, the clinical nurse practitioner - that is me. If it's like an urgent referral then [I] write a letter and then we fax it to them or email it to them. Then, there is a whole panel that discusses that I am going to give an appointment to this and this patient. It is quite a lengthy procedure, but I understand because there is only one psychologist… It is just not easy to refer to the psychologist. Jah, they [lay counsellors] need training, but they still need to go the route via the clinical nurse practitioner – you understand. So, they cannot refer to the psychologist. The lay counsellors need to refer to one of us who is the clinical nurse practitioner and then we need to refer to the psychologist. The counsellor can't refer to the psychologist."

There were some suggestions on the re-imagination of a referral system that includes lay counsellors because of lack of mental health staff. There needs to be a referral system that works well so that patients get counselling and if they need medication, they can get it fast. This would need to be resolved to have an effective mental health system.

Clinic Pharmacist 1: "So, you can a baseline of depression and then you can have a lay counsellor who will write down everything that the patient says. And then from there, the doctor can also work because if the lay counsellor can say that the patient

has depression and then the sister says we must start them on medication. The doctor is the only one that writes down the medication. So, then the patient must be referred to the doctor even in a couple of weeks, days, months depending on the doctor's appointments. And then, we start them on the medication. Because the doctors are also booked full and we don't have a lot of doctors. It's usually just because of the staff. In government, there is usually not enough staff."

Clinic OM 2: "I would rather have the lay counsellor be the one that I can refer somebody to once I have seen them. Identifying is fine, but also the referral of that patient to the lay counsellor. Because for me my idea would be for the lay counsellor would be somebody that would for the interim alleviate the stress that the patient has, and not just identify the stress the patient has and leave them there. Because through alleviation, it addresses the plight that we got – the whole waiting to be seen is high and the care that needs to be given to that patient."

The re-imagination at the supervision level. There is a need for lay counsellors to receive supervision. Mackereth, White, Cawthorn and Lynch (2005) state that supervision offers the time, space and the supportive networks that allow deep reflection to take place. This has benefits not only on an individuals' practice, but it creates fertile ground for professional growth as well. The supervision that lay counsellors currently receive is operational. It is concerned with whether they have completed their monthly statistics for the month regarding the targets they needed to reach as set by their service level agreement. After training, lay counsellors do not have a specialist assigned to them to assist with maintaining or developing their skills or with debriefing. They do however receive this through the NPO's, which they refer to as 'mentoring' - a facilitator presents on certain topics to teach lay counsellors. This happens every month and is held with groups. Some lay counsellors expressed they have no supervision at the clinic and others have debriefing meetings as their supervision in the clinic. Also, some of them expressed they do not have any supervision needs.

Regional lay counsellor programme manager 1: "In the Department of Health, we more often refer to mentoring not what we know as supervision, not in the counselling world. Because to them supervision is 'Are you on duty today? Are your cases covered?' finish. It's operational... to the Department of Health, supervision is 'are

you in your job? Did you sign your leave forms?' It's not about being debriefed if they having a difficult time maybe. Updating on their skills or on anything that they need, it's not that."

Lay counsellor 4: "I receive no supervision at the clinic. I can contact the operational manager to tell them that I have a problem with whatever. But normally, I receive supervision from her NGO once a month, a mentoring session. I have no particular needs when it comes to supervision from her NGO."

Lay counsellor 5: "Yes, the way that you put it: There is supervision at the NGO. Then here in the clinic every day we [clinic staff members] meet and talk about our day and how our day is going to be blah blah blah. And sometimes, if we quickly get things done or the next day, we will talk about the challenges that a person may have had the previous day. It is the same because at mentoring we go once, but here it is something that we do every day. Here, in a group setting, you can say "I experienced this, and that challenge and I solved it like this and that way. There is no specific person that I can go to other than the operational manager whom I can go to and talk to them."

The re-imagination of supervision needs to have ongoing skills coaching by a trained mental health professional. Or, the regional trainers who are social workers could be trained as supervisors on a rotational basis or contract. The Chibanda et al. (2015) study suggests that supervisors should be District Health Promotion Officers who are master's level Social Sciences or Public Health university graduates. They, in turn, will be supervised by clinical psychologists and psychiatrists.

Lay counsellor 3: "Since the psychologist rotates every clinic once a month, he could monitor us as he makes his rounds in the clinics. He can train and supervise one set of lay counsellors of a particular clinic one week and the next clinic another week."

Regional trainer: "I think to go back to what you were saying about supervision, that it's not our responsibility it's the responsibility of the organization. The departments do give them the money."

One of the trainers interjects: "Unless they can increase our salaries and bring it this side."

The reimagination of the training programme. Many a times lay counsellors would reveal that they do not feel they have the capacity to assist patients beyond what they have been trained in HIV Counselling and Testing (HCT), ART (AntiRetroviral Treatment) adherence, general counselling skills, and some training on substance abuse, mental health, gender and other topics.

Most of the staff members concurred that the lay counsellors training programme needs to be informed by the social risk factors of mental illness, in order for these cadre of staff to have a meaningful impact on the lives of the mentally ill, especially in poor communities.

NGO manager 1: "There is a need for lay counsellors to be taught:

- How to take down clinical notes when they see patients with mental health issues.
- Mental health issues.
- Adherence training.
- Substance abuse counselling.
- Trauma counselling concerning rape, gender-based violence etc.
- Gender and sexuality education.
- IsiXhosa and/or Afrikaans. On-going counselling in the patient's mother-tongue would be greatly appreciated. There are no counsellors who speak isiXhosa, it is very hard to express one's emotions in English when it is not you."

Discussion

Our qualitative data shows there is an appetite for the expansion of lay counsellors' skills to deliver mental health services, but it would need significant revisioning of the entire system. At the management level, the lay counselling training programme needs to be accredited. PDC needs to register with the Health and Welfare Sector Education and Training Authority (HWSETA), an accreditation provider that aims to educate, train and develop skills necessary for the health, social development and veterinary sectors (HWSETA, 2019). The lay counselling training programme offered by PDC will need to be structured according to the South African Qualifications Authority (SAQA) registered unit standard known as

"Counsel an individual in a structured environment". This unit standard is suitable because it mirrors the practice framework of registered counsellors. Also, it is geared towards training people who are not registered mental health professionals such as psychologists to be able to counsel people in various counselling contexts, these includes the South African Police Service, schools, NGOs, public hospitals, clinics and social services facilities (SAQA, 2019).

With this unit standard put in place, the district office can set a standard of the educational level that NGOs must employ lay counsellors who possess either an NQF level 4 (i.e. matric), or recognition of prior learning or Psychology graduate.

In light of the workload and burden of disease, there needs to be an introduction of new categories of lay counsellors. Lay counsellors in the National HCT policy should be retained (DoH, 2010). However, after the year 2020, the government needs to include lay counsellors in the Mental Health Policy Framework and Strategic Plan to expand the reach of mental health services (Docrat et al., 2019; SAHRC, 2017). There should be three categories of lay counsellors which include lay HIV, mental health and general health counsellors. Lay general health counsellors will focus on chronic disease care and adherence support.

In 2006 (Uys & Klopper, 2013), the ratio of categories of nurses in the public healthcare system was 3:2:1:4 for Enrolled Nurse Auxiliaries: Enrolled Nurse: Registered Nurse /Midwife: Specialist Registered Nurse /Midwife. Each category of nursing has a mandated role and scope of practice in the health care service, which is distinct. In terms of the number of lay counsellors in the clinics, there is no data available perhaps a ratio of lay HIV, mental health and general health counsellors to patients could be 3:3:2 appointed at each clinic. However, future studies will have to be conducted in these clinics to determine whether this is an optimal ratio for all three categories of counsellors. This means with an increase in the deployment of lay counsellors, the government needs to come up with infrastructural plans to accommodate for more members of staff who will need their own office space to ensure confidentiality and privacy is ensured during their counselling sessions at the various clinics.

The service level agreement of lay mental health counsellors should reflect the following: (a) Provide quality mental health interventions that do not require specialist mental health care in community-based clinics (Chibanda et al., 2015; Lund et al., 2012; Semrau et al., 2015). (b) In terms of the number of therapy sessions per patient for lay mental health counsellors in the clinics, there is no data available perhaps a minimum of 6 and a maximum of 8 therapy sessions could be established. If the patient requires more sessions, they may refer them to specialist care. However, future studies will have to be conducted in these

clinics to determine whether this is an optimal number of sessions for lay mental health counsellors. (c) In terms of contact time per patient for lay mental health counsellors in the clinics, there is no data available perhaps lay mental health counsellors could be expected to see between 6 to 8 patients for counselling sessions per day for 45 minutes. Per month their target could be between 120 and 160 mental health patient encounters. This would be one of the key performance areas of lay mental health counsellors. Depending on the number of community members and surrounding communities that each clinic serves these expectations and targets will be adjusted accordingly. However, future studies will have to be conducted in these clinics to determine whether this is an optimal number of patients and contact time for lay mental health counsellors. (d) Lay mental health counsellors should have the authority to refer their patients who may need additional services to mental health professionals.

At the referral level, the government needs to develop a Mental Health Protocol for the Cape Winelands District that will assist in the adequate management of mentally ill patients from the moment they walk into the clinic to when they receive mental health care that they need. In other words, this will need to entail specific referral pathways with the range of clinic staff that the patient will encounter to ensure the provision of mental health services to meet the mental health need. Lay counsellors need to be included in the structure of referral pathways. Also, the protocol should ensure members of staff at each clinic must refer their mental health patients to lay mental health counsellors.

At the supervision level, supervision in the qualification framework of lay counsellors can be defined as coaching from professional mental health workers to update lay counsellors' core competencies (Kohrt et al., 2018). A supervision system must be set up. A key performance area should include the supervisor providing weekly supervisions and the lay counsellor attends them. This will ensure accountability for the person who employs the psychologist supervises lay counsellors. There are two options in terms of supervisors that could be appointed. One option could be to employ additional supervisors in NGOs who have are master's level Social Sciences or Public Health university graduates. They, in turn, will be supervised by clinical psychologists and psychiatrists (Chibanda et al., 2015). The second option can be community psychologists could get additional training as supervisors. It would be best to retain these people in the system as it is not sustainable to be training and paying new people to be supervisors. Alternatively, the psychologists could supervise lay counsellors on a rotational basis. Ongoing supervision is important for continuous monitoring of lay counsellor competencies and skills (Munodawafa et al., 2017; Myers, Stein, Mtukushe, & Sorsdahl, 2012). (3) The lessons learnt from studies conducted by Patel et al. 2010, Petersen

et al. 2014 and Munodawafa et al. 2017 are lay counsellors that are suitably trained and supervised can be effective at treating common mental disorders. However, there needs to be a prioritization of ongoing supervision to ensure the provision of quality mental health services by lay mental health counsellors in primary health care facilities.

At the training level, the lay counsellors training programme needs to be designed with a designated approach in mind as postulated by Project MIND (2019) which has been successfully used across 24 primary healthcare clinics in the Western Cape such as Worcester, Mfuleni, Khayelitsha site B, Browns Farm, Elsies River and many more treatment sites. This approach would entail training all lay counsellors be trained to become specifically either a lay HIV counsellor or mental health counsellor or adherence support counsellor. The objective of this designated approach is to provide effective health and mental health services in the various clinics in the Cape Winelands District. In terms of training lay mental health counsellors to provide brief mental health interventions, the Teachable Moments training programme could be used since it is a blend of motivational interviewing and problem-solving therapy (Sorsdahl & Roelofse, 2012).

Limitations and future research

The quantitative data had several flaws. Firstly, prevalence rates could not be established for this sample because this was not a representative sample of the patients using each clinic. However, this sample was able to give us a minimum number of patients with mental health symptoms across the three clinics in the Cape Winelands District. The patients' responses indicated that at least 53 patients had symptoms ranging from mild to severe would use treatment on that day. Although this doesn't represent all the patients who use that clinic, this suggests that the numbers needing treatment are high. Even though filling in a questionnaire is not a solid diagnosis. Further studies should use a representative sample over many years to estimate the mental health burden in these three clinics in the Cape Winelands District.

Secondly, missing data was another flaw. This was expected given that the first aim of the proposed study was cross-sectional. Many of the patients were Afrikaans and some were Xhosa-speaking so the questionnaires may not have translated well from English. Hence, some missing data was due to item non-response. To minimise this, future studies should use private individual interviews or Audio-Computer Assisted Self-Interview (ACASI) as methods of data collection to capture sensitive information such as experiences of mental health symptoms (Falb et al., 2016).

Reflexivity

Reflexivity emphasizes the importance of being self-aware and being able to reflect on your position concerning the research one is conducting (Finlay & Gough, 2008). The research was conducted in NGOs and clinics in the Stellenbosch area. Stellenbosch is a predominantly Afrikaans area. As Black Xhosa women, we expected to not be welcomed in the area as a result of the area being infamously known for racism. However, our experience was contrary. The patients and staff were warm and willing to help us with our study and even referred us to extra resources that could help bring substance to our findings. Additionally, we experienced some language barriers particularly with patients since we do not speak Afrikaans. But, our Afrikaans-speaking research assistants were there to communicate with patients who understood Afrikaans better than English. We saw a typical representation of the public healthcare system in South Africa available to those unable to access and afford private healthcare such as long waiting lines before service hours begin and lack of capacity. Coming from an institution such as the University of Cape Town, which is associated with having resources (i.e. as a result of its high status) we were viewed as outsiders and there was some reluctance from patients to participate in our research.

Significance

Staff in the health care system are eager about task shifting to lay counsellors in the primary care system. But there needs to be a system-wide change. There needs to be a training system, accreditation, career pathing, supervision system and referral system. This would need to be resolved to have an effective provision of mental health services in community-level clinics.

References

At Heart. (2019). Services [Online website]. Retrieved from
        http://student.sun.ac.za/org/AtHeart/services.html

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

Blanche, M. T., Durrheim, K., & Painter, D. (Eds.). (2006). *Research in practice: Applied
        methods for the social sciences*. Cape Town: Juta and Company Ltd.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research
        in Psychology, 3,* 77-101. Retrieved from
        https://doi.org/10.1191/1478088706qp063oa

Brown, R. L., & Rounds, L. A. (1995). Conjoint screening questionnaires for alcohol and
        other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical
        Journal*, *94*(3), 135-140.

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

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

Claassen, J. N. (1999). The benefits of the CAGE as a screening tool for alcoholism in a
        closed rural South African community. *South African Medical Journal*, *89*(9).

Department of Health [DoH]. (2010). National HIV Counselling and Testing (HCT) policy
        guidelines [pdf file]. Retrieved from
        https://aidsfree.usaid.gov/sites/default/files/hts_policy_south-africa.pdf

Department of Health [DoH]. (2014). National Mental Health Policy Framework and
        Strategic Plan [pdf file]. Retrieved from https://health-e.org.za/wp-
        content/uploads/2014/10/National-Mental-Health-Policy-Framework-and-Strategic-
        Plan-2013-2020.pdf

Docrat, S., Lund, C., & Besada, D. (2019). An evaluation of the health system costs of mental
        health services and programmes in South Africa [Report]. Retrieved from
        https://zivahub.uct.ac.za/articles/An_Evaluation_of_the_Health_System_Costs_of_M
        ental_Health_Services_and_Programmes_in_South_Africa/9929141

Falb, K., Tanner, S., Asghar, K., Souidi, S., Mierzwa, S., Assazenew, A., ... & Stark, L. (2016). Implementation of Audio-Computer Assisted Self-Interview (ACASI) among adolescent girls in humanitarian settings: feasibility, acceptability, and lessons learned. *Conflict and Health*, *10*(1), 32.

Finlay, L., & Gough, B. (Eds.). (2008). *Reflexivity: A practical guide for researchers in health and social sciences*. Hoboken, New Jersey: John Wiley & Sons.

Garson, G. D. (2015). *Missing Values & Data Imputation.* Asheboro, North Carolina: Statistics Associates Publishing.

Health and Welfare Sector Education and Training Authority [HWSETA]. (2019). The Health and Welfare Sector Education and Training Authority [Online website]. Retrieved from http://www.hwseta.org.za/

Hinkin, C. H., Castellon, S. A., Dickson-Fuhrman, E., Daum, G., Jaffe, J., & Jarvik, L. (2001). Screening for drug and alcohol abuse among older adults using a modified version of the CAGE. *The American Journal on Addictions*, *10*(4), 319-326. Retrieved from https://doi.org/10.1111/j.1521-0391.2001.tb00521.x

Holloway, I., & Galvin, K. (2016). *Qualitative research in nursing and healthcare (4ᵗʰ ed.).*
United Kingdom: Willy Blackwell Publishing Ltd.

Jacobs, N., & Coetzee, D. (2018). Mental illness in the Western Cape Province, South Africa: A review of the burden of disease and healthcare interventions. *South African Medical Journal*, *108*(3), 176-180. doi:10.7196/SAMJ.2018.v108i3.12904

Kohrt, B. A., Mutamba, B. B., Luitel, N. P., Gwaikolo, W., Onyango Mangen, P., Nakku, J., ... & Baingana, F. (2018). How competent are non-specialists trained to integrate mental health services in primary care? Global health perspectives from Uganda, Liberia, and Nepal. *International Review of Psychiatry*, *30*(6), 182-198.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of general internal medicine*, *16*(9), 606-613. Retrieved from https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Kroenke, K., Spitzer, R. L., Williams, J. B., Monahan, P. O., & Löwe, B. (2007). Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. *Annals of internal medicine*, *146*(5), 317-325.

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

Lund, C., Tomlinson, M., De Silva, M., Fekadu, A., Shidhaye, R., Jordans, M., ... & Thornicroft, G. (2012). PRIME: A programme to reduce the treatment gap for mental disorders in five low-and middle-income countries. *Public Library of Science Medicine*, *9*(12), e1001359.

Mackereth, P. A., White, K., Cawthorn, A., & Lynch, B. (2005). Improving stressful working lives: complementary therapies, counselling and clinical supervision for staff. *European Journal of Oncology Nursing*, *9*(2), 147-154. doi: 10.1016/j.ejon.2004.04.006

Maconick, L., Jenkins, L. S., Fisher, H., Petrie, A., Boon, L., & Reuter, H. (2018). Mental health in primary care: Integration through in-service training in a South African rural clinic. *African Journal of Primary Health Care & Family Medicine*, *10*(1), 1-7. doi: 10.4102/phcfm.v10i1.1660

Marwaha, S., & Johnson, S. (2004). Schizophrenia and employment. *Social Psychiatry and Psychiatric Epidemiology*, *39*(5), 337-349.

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

Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., … & Bolton, P. (2014). A common elements treatment approach for adult mental health problems in low-and middle-income countries. *Cognitive and Behavioral Practice*, *21*(2), 111-123. doi: 10.1016/j.cbpra.2013.06.005

Myers, B., Stein, D. J., Mtukushe, B., & Sorsdahl, K. (2012). Feasibility and acceptability of screening and brief interventions to address alcohol and other drug use among patients presenting for emergency services in Cape Town, South Africa. *Advances in Preventive Medicine*, *2012*.

Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*, *81*, 609-615.

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

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

Plummer, F., Manea, L., Trepel, D., & McMillan, D. (2016). Screening for anxiety disorders with the GAD-7 and GAD-2: A systematic review and diagnostic meta-analysis. *General Hospital Psychiatry*, *39*, 24-31. Retrieved from https://doi.org/10.1016/j.genhosppsych.2015.11.005

Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., & Jenkins-Guarnieri, M. A., … Tiet, Q. Q. (2016). The primary care PTSD screen for DSM-5 (PC-PTSD-5): Development and evaluation within a veteran primary care sample. *Journal of General Internal Medicine*, *31*(10), 1206-1211.

Project MIND. (2019). Project MIND [Online website]. Retrieved from http://projectmind.mrc.ac.za/index.html

Republic of South Africa. (1996). Constitution of the Republic of South Africa. *Government Gazette*, *378*(17678).

Republic of South Africa. (2019). *National Health Insurance Bill* (No. 42598). Retrieved from https://www.gov.za/sites/default/files/gcis_document/201908/national-health-insurance-bill-b-11-2019.pdf

Ribeiro, W. S., Andreoli, S. B., Ferri, C. P., Prince, M., & Mari, J. J. (2009). Exposure to violence and mental health problems in low and middle-income countries: a literature review. *Brazilian Journal of Psychiatry*, *31*, 49-57.

Right to Care. (2019). About us [Online webpage]. Retrieved from https://www.righttocare.org/about-us/

Semrau, M., Evans-Lacko, S., Alem, A., Ayuso-Mateos, J. L., Chisholm, D., Gureje, O., ... & Lund, C. (2015). Strengthening mental health systems in low-and middle-income countries: The Emerald programme. *BioMedical Central Medicine*, *13*(1), 79.

Sorsdahl, K., & Roelofse, M. (2012). The Teachable Moment Programme: The road from research to implementation [pdf file]. Retrieved from http://www.uct.ac.za/sites/default/files/image_tool/images/116/calendar/29th%20August%20-%20Prof%20Katherine%20Sorsdahl%20%20Marinda%20Roelofse%20%28002%29.pdf

South African Human Rights Commission [SAHRC]. (2017). Report of the national
        investigative hearing into the status of mental health care in South Africa [pdf file].
        Retrieved from
        https://www.sahrc.org.za/home/21/files/SAHRC%20Mental%20Health%20Report%2
        0Final%2025032019.pdf

South African Qualifications Authority [SAQA]. (2019). South African Qualifications
        Authority registered unit standard: Counsel an individual in a structured environment
        [Online website]. Retrieved from
        http://allqs.saqa.org.za/showUnitStandard.php?id=252512

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for
        assessing generalized anxiety disorder: the GAD-7. *Archives of Internal
        Medicine*, *166*(10), 1092-1097. doi:10.1001/archinte.166.10.1092

Tomlinson, M., Breuer, E., Onah, M., Skeen, S., Baron, E., Lund, C., … & Schneider, M.
        (2016). Integrating mental health into South Africa's health system: Current status and
        way forward. *South African Health Review*, *2016*(1), 153-163.

Tredoux, C. G., & Durrheim, K. (Eds.). (2013). *Numbers, hypotheses and conclusions: A
        course in statistics for Social Sciences*. Cape Town: Juta & Company Ltd.

Uys, L. R., & Klopper, H. C. (2013). What is the ideal ratio of categories of nurses for the
        South African public health system? *South African Journal of Science*, *109*(5-6), 01-
        04.

Van Buuren, S. (2018). *Flexible imputation of missing data* (2 ed.). Boca Raton, Florida:
        Chapman and Hall/CRC Press.

Weich, S., Lewis, G., & Jenkins, S. P. (2001). Income inequality and the prevalence of
        common mental disorders in Britain. *The British Journal of Psychiatry*, *178*(3), 222-
        227. Retrieved from https://doi.org/10.1192/bjp.178.3.222

Western Cape Government. (2019a). Cloetesville Community Health Clinic [Online website].
        Retrieved from https://www.westerncape.gov.za/facility/cloetesville-community-
        health-clinic

Western Cape Government. (2019b). Klapmuts clinic [Online website]. Retrieved from
        https://www.westerncape.gov.za/facility/klapmuts-clinic-0

Western Cape Government. (2019c). Kylemore clinic [Online website]. Retrieved from
        https://www.westerncape.gov.za/facility/kylemore-clinic-0

Western Cape Government. (2019d). People Development Centre (PDC) [Online website].
        Retrieved from https://www.westerncape.gov.za/your_gov/185

Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., Moomal, H., &
        Kessler, R. C. (2008). Twelve-month mental disorders in South Africa: prevalence,
        service use and demographic correlates in the population-based South African Stress
        and Health Study. *Psychological Medicine*, *38*(2), 211-220.
        doi:10.1017/S0033291707001420

World Health Organization [WHO]. (2017). Mental Health ATLAS 2017 Member State
        Profile [pdf file]. Retrieved from
        https://www.who.int/mental_health/evidence/atlas/profiles-2017/ZAF.pdf?ua=1

Yasamy, M. T., Maulik, P. K., Tomlinson, M., Lund, C., Van Ommeren, M., & Saxena, S.
        (2011). Responsible governance for mental health research in low resource countries.
        PLoS Medicine, *8*(11), e1001126. doi: 10.1371/journal.pmed.1001126

Appendix A

UNIVERSITY OF CAPE TOWN

Department of Psychology

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

25 October 2019

Nqabisa Faku and Mandisa Qodashe
Department of Psychology
University of Cape Town
Rondebosch 7701

Dear Nqabisa and Mandisa

I am pleased to inform you that ethical clearance has been given by an Ethics Review Committee of the Faculty of Humanities for your study, *The assessment of lay counsellors' capacities in primary healthcare clinics in Stellenbosch, South Africa: A mixed design study*. The reference number is PSY2019-034.

I wish you all the best for your study.

Yours sincerely

University of Cape Town
¶PSYCHOLOGY DEPARTMENT
Upper Campus
Rondebosch

Lauren Wild (PhD)
Associate Professor
Chair: Ethics Review Committee

Appendix B

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

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6626
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

02 August 2019

HREC REF: 442/2019

Prof Catherine Ward
Psychology
Room 2.09
PD Hahn Building
Chemistry Mall
Upper Campus

Dear Prof Ward

PROJECT TITLE: THE ASSESSMENT OF LAY COUNSELLORS' CAPACITIES IN PRIMARY HEALTHCARE CLINICS IN STELLENBOSCH, SOUTH AFRICA: A MIXED DESIGN STUDY

Thank you for submitting your response to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study subject to adding the HREC contact details to the informed consent form.

Approval is granted for one year until the 30 August 2020.

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

Please quote the HREC REF in all your correspondence.

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

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

The HREC acknowledge that the students, Nqabisa Faku and Mandisa Qodashe will also be involved int this study.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

HREC 442/2019

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines.

The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

Appendix C

Western Cape Government
Health
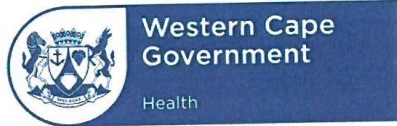
Health Impact Assessment
Health Research sub-directorate
Health.Research@westerncape.gov.za
tel: +27 21 483 0866: fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201908_011
ENQUIRIES: Dr Sabela Petros

University of Cape Town
Anzio Road
Observatory
Cape Town
7925

For attention: Prof Catherine Ward, Ms Nqabisa Faku, Ms Mandisa Qodashe

Re: **The assessment of lay counsellors' capacities in primary healthcare clinics in Stellenbosch, South Africa: A mixed design study**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact **Dr Richard Davids on 021 808 6173** to assist you with any further enquiries in accessing the following sites:

Cloeteville CDC
Klapmuts Clinic
Kylemore Clinic

Kindly ensure that the following are adhered to:
1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. By being granted access to provincial health facilities, you are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of your project. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M MOODLEY
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE
CC

Dr Melvin Moodley
Director: Health Impact Assessment

1 0 SEP 2019
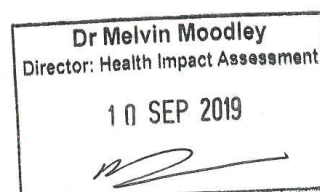
Appendix D: Informed consent forms for patients

University of Cape Town

Consent to participate in a research study:

Lay counsellors' capacities to meet the basic mental health needs of most South Africans

Dear patient,

Study Purpose

You are invited to participate in a research study being conducted by researchers from the University of Cape Town. The purpose of this study is to find out how many people in this clinic might find counselling helpful.

You are being invited to participate in this study because you come for health care services to this clinic.

Study Procedures

If you decide to participate in this study, you will complete a short questionnaire about how you feel and give it back to us after you've seen the doctor or nurse. All information obtained from you will be kept strictly confidential, and your name will not be associated with the information that appears in our report.

Possible Risks

The questions might make you aware of feelings, traumatic events, your lifetime use of alcohol and drugs and a number of different things that you might worry about which you would rather not have remembered or acknowledged. If this happens, a list of counselling services that can help you is provided below.

Possible Benefits

We hope that information gained from this questionnaire will help us answer important questions about health services which need to be addressed in the country today.

Voluntary participation and alternatives

Participation in this study is completely voluntary (it is your choice). You are free to say yes or no, or to refuse to answer any question. Your decision regarding participation in this study will not affect your patient record. If you decide to participate, you are free to change your mind and stop at any time without an effect on your patient record or your relationship with the clinic in any way.

Confidentiality

Information about you obtained for this study will be kept anonymous. Your name and other identifying information will not be kept with the questionnaire information. Your responses on the questionnaire and this consent form will be kept in separate, locked file cabinets, and there will be no link between the consent form and the questionnaire. The information obtained from the questionnaire will not become a part of your patient record in any way, nor will it be made available to anyone else. Any reports or publications about the study will not identify you or any other study participant.

Questions

Any study-related questions, problems or emergencies should be directed to the following researchers:

Nqabisa Faku (researcher):   071 489 2691

Mandisa Qodashe (researcher):   072 927 7487

Dr Catherine Ward (supervisor):   021 650 3422

Questions about your rights as a study participant, comments or complaints about the study also may be presented to the Research Ethics Committee, Department of Psychology, University of Cape Town, or by telephone to Rosalind Adams at 021 650 3417.

Resources you may find helpful:

The South African Depression and Anxiety Group (SADAG)
To contact a counsellor between 08h00 to 20h00 Monday to Sunday via:
Call: **011 234 4837** or Fax number: **011 234 8182**
For a suicidal Emergency contact them on: **0800 567 567**
24hr Helpline: **0800 456 789**

Lifeline
Telephone counselling
Lifeline offers confidential and anonymous counselling. If you need to speak to a counsellor, you can contact them between 09h30 to 22h00 Monday to Sunday via:
Call: **021 461 1111**
Whatsapp*: 063 709 2620
*Calls only
The cost of the call is the ONLY charge.
Face-to-face counselling
Face to face counselling is available from 09h00 to 16h30 by appointment. They offer up to four sessions with the same counsellor.
Should you prefer to see a counsellor, please use one of the following numbers:
Cape Town: **021 461 1113**
Khayelitsha: **021 361 9197**
Their face-to-face counselling services are free of charge.

South African National Council on Alcoholism and Drug Dependence (SANCA)
SANCA Western Cape
Physical Address: 18 Karoo Street, Bellville
Call: **021 945 4080**
Email: sanca@sancawc.co.za
Website: www.sancawc.co.za

I have read the above and am satisfied with my understanding of the study, its possible benefits, risks and alternatives. My questions about the study have been answered. I hereby voluntarily consent to participation in the research study as described. I have been offered copies of this consent form.

I agree to the use of my responses from the questionnaire.

_____   _____

Signature of participant   Date

_____   _____

Signature of researcher   Date

Appendix E: Informed consent for interviews with healthcare providers

Informed Consent Form

University of Cape Town

Consent to participate in a research study:

Lay counsellors' capacities to meet the basic mental health needs of most South Africans

Dear health care provider,

Study Purpose

You are invited to participate in a research study being conducted by researchers from the University of Cape Town. The purpose of this study is to estimate the burden of mental health problems of patients in Klapmuts Clinic, Kylemore Clinic and the Cloetesville Community Health Clinic in the Stellenbosch area. We also aim to assess whether lay counsellors' skills can be expanded to meet the mental health needs of most South Africans in community-based clinics.

Your suggestions and thoughts will be very helpful to us in thinking this through.

Study Procedures

If you decide to participate in this study, you will be interviewed for approximately an hour. The interview explores your views on lay counsellors' capacities to expand the reach of mental health services in primary health care at community and clinic levels as a step towards whether task-shifting can be carried out. In addition, your views on the referral

system between general practitioners, nurses and lay counsellors within the primary

healthcare system, will also be explored.

All information obtained from you will be kept strictly confidential, and your name

will not be associated with the information that appears in our report.

Possible Risks

The interview may bring to mind, for example, a difficult encounter with a patient

who was struggling with mental health problems. We have provided a list of places below

where you can access counselling, if you feel you need it.

Possible Benefits

We hope that our work will assist in the task of expanding mental health services for

those who have mental health problems. We also hope that information gained from this

study will help us answer important questions about access to mental health services, which

is a serious issue facing the country today.

Voluntary Participation and alternatives

Participation in this study is completely voluntary. You are free to refuse to answer

any question. Your decision regarding participation in this study will not affect your

employment. If you decide to participate, you are free to change your mind and discontinue

participation at any time without an effect on your employment, or your relationship with the

clinic in any way.

Confidentiality

Information about you obtained for this study will be kept anonymous. Your name

and other identifying information will not be kept with the interview information. It and this

consent form will be kept in separate, locked file cabinets, and there will be no link between

the consent form and the interview. The information obtained from the interview will not

become a part of your employment record in any way, nor will it be made available to anyone

else. Any reports or publications about the study will not identify you or any other study

participant. We would like, if you agree, to tape-record this interview, as it makes it easier

for us to be sure that we have correctly written down what you have told us. As soon as we

have listened to the tape and corrected our notes, the recording will be destroyed. Until then,

it will be stored either in a locked filing cabinet or on a password-protected computer to

which only the researchers will have access.

Questions

Any study-related questions, problems or emergencies should be directed to the

following researchers:

Nqabisa Faku (researcher):   071 489 2691

Mandisa Qodashe (researcher):   072 927 7487

Dr Catherine Ward (supervisor):   021 650 3422

Questions about your rights as a study participant, comments or complaints about the

study also may be presented to the Research Ethics Committee, Department of Psychology,

University of Cape Town, or by telephone to Rosalind Adams at 021 650 3417.

Resources you may find helpful:

The South African Depression and Anxiety Group (SADAG)
To contact a counsellor between 08h00 to 20h00 Monday to Sunday via:
Call: **011 234 4837** or Fax number: **011 234 8182**
For a suicidal Emergency contact them on: **0800 567 567**
24hr Helpline: **0800 456 789**

Lifeline
Telephone counselling
Lifeline offers confidential and anonymous counselling. If you need to speak to a counsellor,
you can contact them between 09h30 to 22h00 Monday to Sunday via:
Call: **021 461 1111**
Whatsapp*: 063 709 2620
***Calls only**

The cost of the call is the ONLY charge.

Face-to-face counselling

Face to face counselling is available from 09h00 to 16h30 by appointment. They offer up to four sessions with the same counsellor.

Should you prefer to see a counsellor, please use one of the following numbers:

Cape Town: **021 461 1113**

Khayelitsha: **021 361 9197**

Their face-to-face counselling services are free of charge.

South African National Council on Alcoholism and Drug Dependence (SANCA)

SANCA Western Cape

Physical Address: 18 Karoo Street, Belville

Call: **021 945 4080**

Email: sanca@sancawc.co.za

Website: www.sancawc.co.za

I have read the above and am satisfied with my understanding of the study, its possible benefits, risks and alternatives. My questions about the study have been answered. I hereby voluntarily consent to participation in the research study as described. I have been offered copies of this consent form.

* * *

_____   _____

Signature of participant   Date

_____   _____

Signature of researcher   Date

* * *

My interview may be recorded to assist the interviewer with remembering the information. The only person who will listen to the tape is the interviewer. After she has listened to it, it will be destroyed. Information from the interview will be recorded anonymously.

I agree that the conversation may be recorded.

_____   _____

Signature of participant   Date

_____   _____

Signature of researcher   Date

Appendix F: Measures

How are you feeling?

We are interested in how you have been feeling, and whether anyone at the clinic has asked you about these feelings.

Thank you for agreeing to fill in this short questionnaire!

Department of Psychology

University of Cape Town

South Africa

Section 1: Patient-Health Questionnaire-9 (English version)

This questionnaire aims to understand your feelings in the last two weeks.

Over the last <u>two weeks</u>, how often have you been bothered by any of the following problems? (please circle your answer)

	Not at all.	Several days.	More than half a day.	Nearly every day.
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself or that you're a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

Did anyone ask you about these feelings today? Yes ☐　or No ☐

Section 2: CAGE-AID Questionnaire

This questionnaire aims to understand your lifetime use of alcohol and drugs.

Please circle your answer to the following questions:

	No	Yes
1. Have you ever felt that you ought to <u>C</u>ut down on your drinking or drug use?	0	1
2. Have people <u>A</u>nnoyed you by criticizing your drinking or drug use?	0	1
3. Have you ever felt bad or <u>G</u>uilty about your drinking or drug use?	0	1
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (<u>E</u>ye opener)?	0	1

Did anyone ask you about these things today? Yes ☐ or No ☐

Section 3: Generalized Anxiety Disorder 7-item (GAD-7) Questionnaire

This questionnaire aims to understand your worry about a number of different things in the last two weeks.

Over the last <u>two weeks</u>, how often have you been bothered by the following problems? (please circle your answer)

	Not at all.	Several days.	More than half a day.	Nearly every day.
1. Feeling nervous, anxious or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it is hard to sit still.	0	1	2	3
6. Being easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3

Did anyone ask you about these feelings today? Yes ☐ or No ☐

Section 4: Primary Care PTSD Screen for DSM-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

• a serious accident or fire

• a physical or sexual assault or abuse

• an earthquake or flood

• a war

• seeing someone be killed or seriously injured

• having a loved one die through homicide or suicide

Has something like this ever happened to you? **Yes ☐ or No ☐**

If yes, please answer the rest of the questions on this page. If nothing like this has ever happened to you, you can stop here.

Please circle your answer to the following:

In the past month, have you ….

	No	Yes
1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?	0	1
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	0	1
3. Been constantly on guard, watchful, or easily startled?	0	1
4. Felt numb or detached from people, activities, or your surroundings?	0	1

5. Felt guilty or unable to stop blaming yourself or others for the events(s) or any problems the event(s) may have caused?	0	1

Did anyone ask you about these feelings today? Yes ☐ or No ☐

 THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE. AS A TOKEN OF OUR APPRECIATION,

PLEASE KEEP THE PEN YOU USED TO FILL OUT THIS QUESTIONNAIRE!

Appendix G: Interview schedule (Lay counsellors' competencies and needs)

This interview schedule is to address the following research question: The assessment of lay counsellors' capacities to expand counselling services in the clinics to address mental health problems in the community. The objectives of this study are to explore and describe whether lay counsellors can be upskilled to registered counsellors in the mental health system to meet basic mental health needs of most South Africans.

Participant number: ………………………….

Questions
Introductory question
1. Tell me about how you decided to become a lay counsellor.
Questions on counsellor self-efficacy: 1. Are there any issues your patients have raised that you feel you are not equipped to respond to?   2. What skills do you think would better equip you to respond to these issues?   3. To what extent are you able to implement the content that was taught to you previously? (**Note to interviewer:** Show them the training schedule to remind them of what was taught as they might not remember.)   4. Which skill(s) which you learnt do you actually use?   5. What limits do you experience in attempting to implement the content?   6. What is your contact time with your clients?   7. Have you heard of an approach to treatment called "motivational interviewing"? What do you think about it? [At this point, take the time to explain what motivational interviewing is and the fact that it only takes 20 minutes to implement.]

8. Do you know of any intervention for taking one's medication as prescribed?

   <u>Many patients struggle with adhering to medication, sometimes as a result of being busy or an interruption of their routine, sometimes because they are depressed, sometimes because they do not have the belief that they will get better or do not have the will to get better, and lots of other reasons</u>. [**Note:** Introduce adherence support as a possible counselling services they could provide. Ask them: What do you think about this?]

9. Would you be willing to further explore why patients may not be adhering to medication?

10. Do your clients come with mental health problems? If so, what kinds of mental health problems do your clients come seeking counselling for?

11. Which counselling services would you like training or extra support to deliver to your clients?

12. How many clients are you expected to see a day?

13. Are there any particular needs you have specifically when it comes to supervision?

14. Who do you refer severe cases to in the clinic?

Concluding questions:

13. Is there anything you would like to add that you think might be beneficial for this research study?

14. Do you have any questions or concerns about the research study or me?

Thank you for your time and participating in our study!

Appendix H: Interview schedule (healthcare providers such as, nurses, an administration clerk, clinical nurse practitioners and operational managers).

This interview schedule is to address the following research question: The feasibility of having lay counsellors to expand counselling services. The objectives of this study are to explore and describe whether task-shifting can be carried out in the mental health system to meet basic mental health needs of most South Africans.

Please ensure that you have given the researcher your written consent before taking part in this research study, also note that any information you choose to share during this interview will only be used for research purposes by the Department of Health. The researcher will assign a participant number to ensure anonymity.

Participant number: ………………………….

Questions
Introductory question
1. Do you think mental health problems are prevalent in your patients? What kinds of problems do you see?
Questions on lay counsellors' services and feasibility: 2. Do you think lay counsellors are well trained to screen for mental health problems? Why do you say this? 3. In your opinion, how successful is treatment for depression, PTSD and substance abuse in the clinic? 3a.) If you think it is successful: Do you think it should be widely advertised within the community?

4. Do you think lay counsellors would be able to provide brief behaviour modification therapy? Do you think it would be effective for depression, PTSD, substance use or other common mental disorders?

5. How would you set up a system to screen for patients' mental health problems and refer them to lay counsellors? Do you have any reservations about this? Do you think lay counsellors need a training course on screening and brief behaviour modification therapy?

Concluding questions:

6. Is there anything you would like to add that you think might be beneficial for this research study?

7. Do you have any questions or concerns about the research study or me?

Thank you for your time and participating in our study!

Appendix I: Interview schedule (supervisors and trainers)

This interview schedule is to address the following research question: The set-up of supervision of lay counsellors' services. Supervisors' needs to be able to supervise lay counsellors. The kind of extra support trainers need to provide extra support. In addition, their thoughts on the setting up a referral system between ordinary General Practitioners, nurses and lay counsellors to expand the service. The objectives of this study are to explore and describe whether task-shifting can be carried out in the mental health system to meet basic mental health needs of most South Africans.

Participant number: ………………………….

Questions
Introductory question
1. What are your thoughts on the lay counselling training programme? Do you have any recommendations of the counselling training programme?
Questions on supervision, lay counsellors' services and referral system: 2. What do you think about lay counselling services being extended? What kind of extra support do you think lay counsellors might need to provide extra services? (**Note:** Direct this question to folks who train them specifically). 3. What do you feel like extra support would be like for their services? (**Note:** Directed this question to operational managers specifically). 4. What extra support do you need in supervision? (**Note:** Direct this question to supervisors.) 5. What skills do you think lay counsellors need to provide mental health services?

6. How would they set up a system to screen for patients' mental health problems and refer them to lay counsellors? How would that work?

Concluding questions:

7. Is there anything you would like to add that you think might be beneficial for this research study?

8. Do you have any questions or concerns about the research study or me?

Thank you for your time and for participating in our study!

Appendix J

Histograms (Figure 1 to Figure 4) showing the distributions for each scale used to estimate the mental health burden in all three clinics.
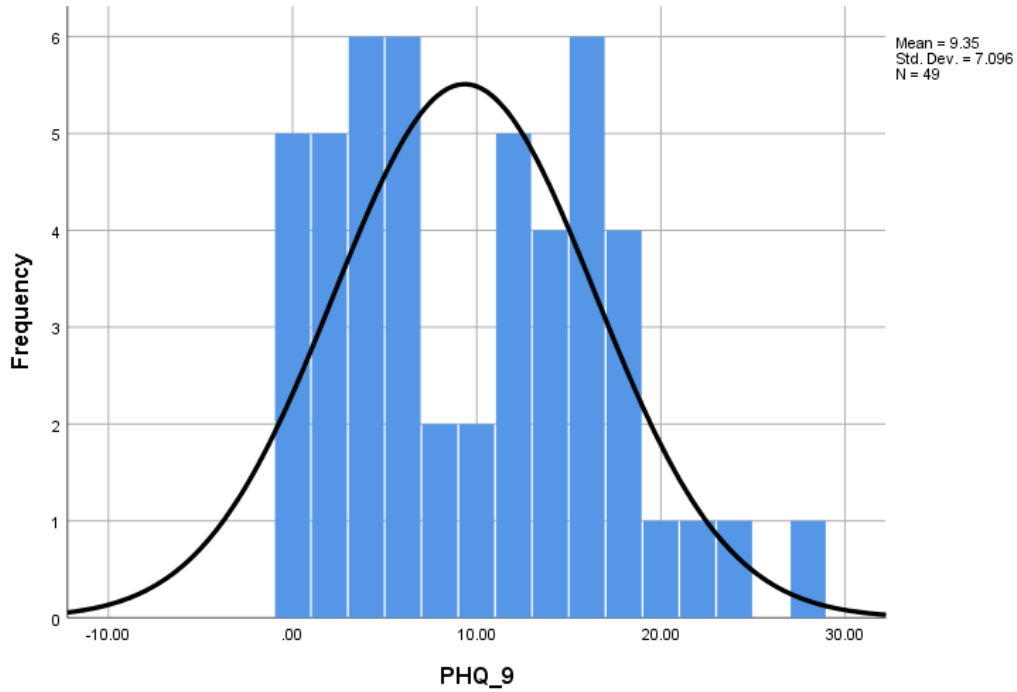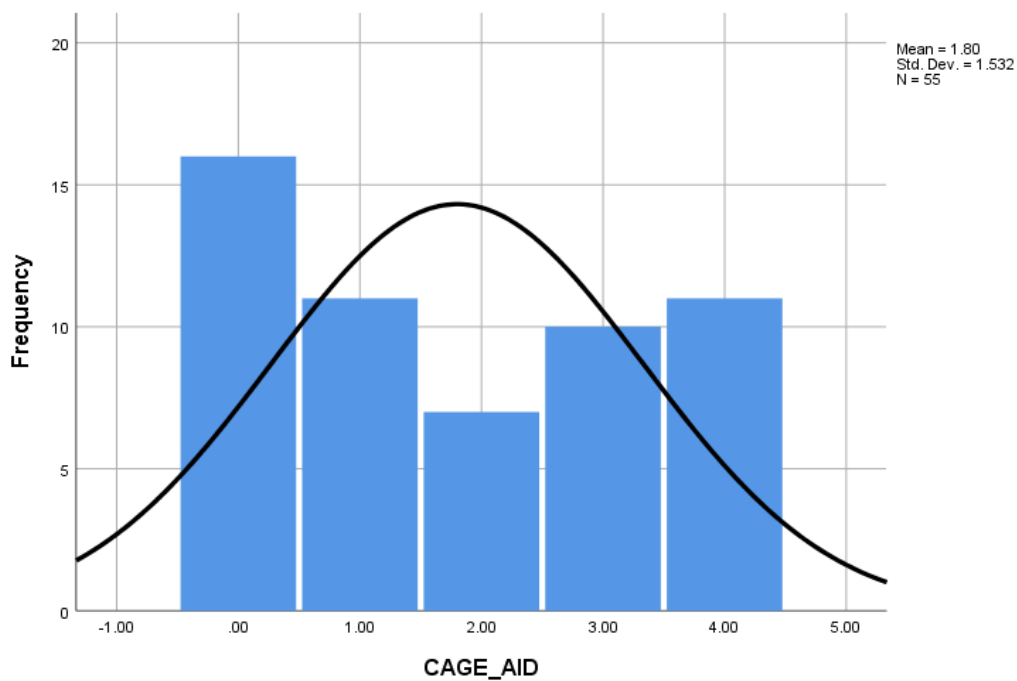

Figure 1 *Histogram of depression (PHQ-9)*

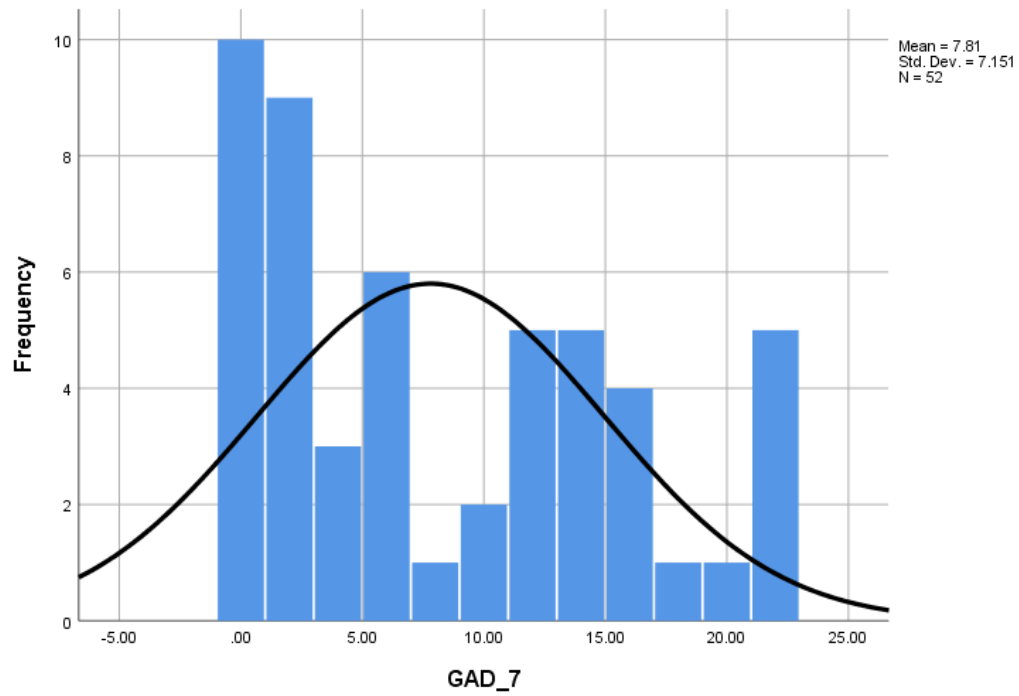Figure 2 *Histogram of substance abuse (CAGE-AID)*

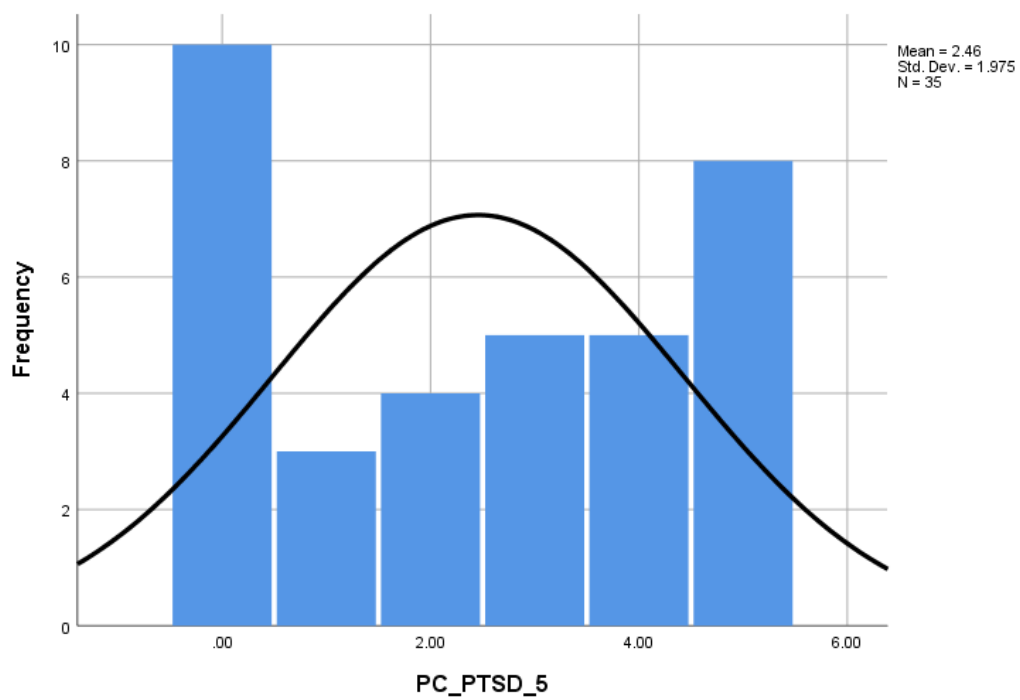Figure 3 *Histogram of Generalised Anxiety Disorder (GAD-7)*

Figure 4 *Histogram of Post-Traumatic Stress Disorder (PC-PTSD-5)*