Task-shared counselling for depression in routine primary health care services
Outcomes and multilevel factors influencing service-user uptake

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BACKGROUND

The large treatment gap for common mental disorders combined with a disproportionately low mental health spend in the public health sector in South Africa [1], calls for integration of contextually suitable evidence-based interventions into primary health care (PHC) at scale. Novel and evidence-based approaches have been used to address this gap at primary health care (PHC) in high and low income countries using counselling task-sharing approaches for depression to devolve mental health care from specialist to generalist health care [2]. In South Africa this approach was tested through the **PR**ogramme for **I**mproving **M**ental Health Car**E** in the North West Province using project employed lay counsellors [3]. The resulting evidence-based intervention was scaled up in real-world PHC clinics in one district in KwaZulu-Natal using existing PHC-based HIV counsellors, and evaluated using an iterative two–stage observational implementation science design by the Southern African Research Consortium for Mental health INTegration (SMhINT) [4].

OBJECTIVES

1. Evaluate outcomes of PHC service users referred for co-located depression clinic counselling services by HIV counsellors within routine PHC services in the first stage.
2. Assess multilevel influences affecting counselling uptake of the co-located counselling service that was embedded within the 2nd stage strengthened collaborative care package

METHODOLOGY

Iterative observational implementation science design across two stages with depression counselling implemented by existing HIV counsellors.

Study Site: Amajuba District, KwaZulu-Natal

The SMhINT stepped up collaborative care model introduced various systems strengthening features, principally enhanced mental health training for PHC service providers to promote identification and management for depression in chronic care patients with co-located counselling in a real-world setting using CBT techniques which have been shown to be as effective as pharmacotherapies in the short term, and more effective long-term [5].

STRENGTHENED COLLABORATIVE CARE PACKAGE

Promote buy-in

- Learning sessions with Operational Managers, Professional Nurses, Cinical Nurse Practioners, Mental Health Coordinator and District Trainer
- Meetings with Province (Mental Health and Substance Abuse Directorate), Mental Health Coordinators , District office and Clinics

Service Providers

- Implement a standardised screening tool (Brief Mental Health/ BMH) to address depression, anxiety and alcohol abuse. Professional Nurses and Enrolled Nurses were trained to screen patients using the BMH.
- Mental Health Coordinators were capacitated to support the nurses.
- Capacitate professional nurses in APC mental health guidelines
- Capacitate existing HIV counsellors training as Social Auxilairy Workers to provide manulalized depression counselling

Service Users

- Address poor mental health literacy through:
- Daily psychoeducational waiting room talks
- Psychoeducational posters and pamphlets
- Psychoeducational videos

Design: Cohort design to assess patient level depression outcomes of patients referred and not referred to the counselling intervention in stage one. Linked project record data to determine counselling uptake of those referred in stage one and two. Semi-structured interviews using the Consolidated Framework for Implementation Science (CFIR) were conducted to understand multilevel factors that influenced service user uptake of the counselling services from the perspectives of service providers and service users in stage 2.

Stage 1 2018-2019
- 10 Urban clinics
- 3 and 9-month follow between service users diagnosed with depression and referred for treatment, and those diagnosed with depression but not referred for treatment

Stage 2 2021-2022
- Based on Stage 1 results, the package was strengthened and scaled up to 19 urban, semi urban and rural clinics
- Qualitative interviews post 3 months

RESULTS

Cohort study: Services users referred in Stage 1, were shown to have clinically significant reduction in depression symptoms at 3 months compared to those diagnosed and not referred [4]. Counselling uptake by referred service users was low across both stages although referrals increased in Stage 2 (Petersen et al., 2011. Manuscript under review).

Qualitative interviews: In Stage 2, qualitative interviews at 3 months revealed the most common barriers to counselling uptake as inconsistent availability of counsellors, poor communication about counselling appointments, and competing priorities for counsellors. Facilitators included counsellor availability, use of the BMH for depression screening, use of the Adult Primary Care (APC) guide to diagnose depression, self-identification and/or referral for depression attributed to mental health literacy including increased facility-based patient psychoeducation with accessible content at home, service user self-observed improvement of symptoms, and relatable and useful counselling content.

Stage 2 CFIR interviews with counsellors (n =12); Nurses (n=14); Service users (n=19)

Individual Characteristics

Enabling
- Counselling was helpful and encouraged continuity for some service users
- Empathethic counsellors

Barriers
- Low self confidence in counselling

Inner Setting

Enabling
- Use of BMH screening and APC guide
- Psychoeducational waiting room talks (literacy) promotedself referral

Barriers
- Workload/ other targets/competing roles
- Need for more additional counsellors
- Lack of dedicated co-located counsellors andof counselling space

Outer setting Characteristics

Enabling
Supportive family and community structures

Barriers
- Lack of formalization of MhINT counselling in current job descriptions
- Lack of targets
- Transport
- Lack of access to smart phones, illiteracy

Intervention Characteristics

Enabling
- Co-located counselling service helps with immediate service
- Appropriate and relatable content

Barriers
- Counsellors not giving or keeping appointments
- Lack of clarity for patients regarding continuity of counselling

Service users reported improvement following depression counselling.

***"It was affecting me so much that it felt as if I'm insane and my body was aching. I couldn't even eat. And not sleeping at night, when you fall asleep you wake up thinking about this painful thing you see and hear. Eh, when I got counseling it all got better"*(Service user)**

Service user psychoeducation also increased demand for services through self-identification and referral.

"***When some come in you hear them saying that ' I heard what the lady was reading out there, and I realised that I can't sleep due to this and this'. He heard the scenario that was read to them and now reports that I also have a problem" (Nurse)***

The strengthened psychoeducation for service users increased demand for depression counselling services, and training health providers in the use of the BMH and APC mental health modules encouraged referrals for depression, yet uptake of counselling was poor in comparison to referrals. In the SMhINT study, the co-located counselling was predicated on the presence of facility-based HIV counsellors who were also tasked with various other duties and who were not dedicated specifically to the counselling programme. Thus, counselling services were compromised by competing priorities [6].

"I think for it to be improved, whoever doing it must only focus on it cause you end up disturbed a lot if you are busy with mental health … the nurses refuse to do testing." (Counsellor).

CONCLUSION AND ADVOCACY MESSAGE

The testing and adoption of appropriate models of care for task-shared, co-located mental health services requires careful consideration of the resources and the need to strengthen the specific health system context for successful integration. Task shared co-located counselling for depression within routine PHC services presents as an option to provide care for depression and address the treatment gap in resource-scarce contexts. The SMhINT findings indicate that training PHC health workers to identify and refer for depression treatment within a collaborative task-shared model encouraged the use of co-located/ facility-based counselling delivered by non-specialist mental health workers as part of real-world PHC services. Uptake is, however, contingent on consistent availability of either a dedicated or designated cadre within PHC who are trained, supervised, supported within the health system, and mandated to provide this service. The benefits of improved mental health may have ripple effects on managing other chronic health conditions, including treatment adherence for other chronic conditions.

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