HEALTHY ACTIVITY PROGRAM

TRAINING MANUAL

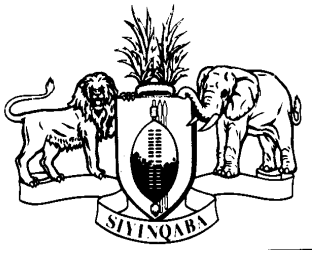
A Psychosocial Intervention for the treatment of depression in clinics

Eswatini

Version 3.0

November 2018

Produced by COMDIS-HSD in collaboration with the National Psychiatric Referral Hospital



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Acknowledgements

This training manual was adapted with permission from resources created by Sangath, the creators of the Healthy Activity Program. These resources are adapted from training manual from the PREMIUM Healthy Activity Program (HAP), which was written by Arpita Anand, Dr Neerja Chowdhary, Dr Sona Dimidjian, and Professor Vikram Patel. Original work developing the Healthy Activity Program was funded by the Wellcome Trust.

Further information and training resources are available from the PREMIUM Healthy Activity Program website: http://www.nextgenu.org/course/view.php?id=178#0.

COMDIS-HSD co-ordinated the adaptation of these materials to the local context in Eswatini, southern Africa. This work was led by Dr Nicholas Riches with support from Ian Walker, Archibald Nyamayaro, Dr Nina Putnis, Dr Violet Mwanjali and Professor John Walley. COMDIS-HSD is a UK-based research collaboration focused on conducting embedded health research in low and middle-income settings. This manual was initially created to support a study evaluating the delivery of an intervention to improve psychosocial care for HIV/TB patients living in the Lubombo region. This research study was funded by UKAID. This study indicated that the Healthy Activity Program is acceptable and feasible in the Eswatini setting. More information about this study is available here: http://comdis-hsd.leeds.ac.uk/projects/

How to use this Manual

This manual aims to educate and guide non-specialist healthcare professionals in Eswatini to understand depression, understand how to screen for depression in clinics or facilities where the risk is higher, how to detect depression and how to manage it in a primary care level clinic or department. This manual has been developed to be used with the Kingdom of Eswatini Ministry of Health Mental Health Desk Guide (July 2016). Any reference to the **Mental Health Desk Guide** refers to this national guide. It is important that this guide is available when using this manual.

Chapter 1: Introduction

Good mental health is an asset which promotes wellbeing at every stage of life. The recent production of the Kingdom of Eswatini **Mental Health Desk Guide**[1] demonstrates the commitment of Eswatini to improving the mental health of its population. Depression is one of the most common mental health problems and the Desk Guide highlights the role of counselling as one of the first-line treatments for depression. There is a shortage in the number of trained specialists able to deliver counselling in Eswatini. This manual (and accompanying training) aims to provide non-specialists (i.e. those with no formal training in psychology or counselling) with the skills to deliver basic counselling.

The form of counselling described in this manual is called the "Healthy Activity Program" (HAP). This is based on a theory called Behavioural Activation. Behavioural Activation is recommended as a treatment for depression in the WHO mhGAP Intervention Guide,[2] either alone or in combination with antidepressant medication. This manual should be used together with the Mental Health Desk Guide, which provides advice on general counselling skills and also outlines treatment and referral pathways for any patient presenting with mental health problems in Eswatini.

Clear guidance is provided on how to structure counselling sessions, based on the three phases of HAP. The manual also outlines specific strategies for dealing with common causes of stress and low mood. Throughout the manual there are boxes containing suggested questions or phrases to help support you in delivering the sessions. However, we recommend that you develop your own questions and phrases as you become more experienced.

The approach outlined in this manual does not replace any aspect of existing mental health provision in Eswatini – it adds to it. Any concerns about a patient's wellbeing during a counselling session should be escalated in accordance with the **Mental Health Desk Guide**. Counsellors should be supported with regular supervision to support them with the process of delivering HAP and to discuss any difficult cases. Counsellors must ensure they are aware of the details of supervision arrangements before starting to deliver HAP.

This version of HAP was developed as part of a research study in 7 health facility sites across the Lubombo Region. This updated version takes into account feedback and the study evaluation and makes changes to provide a more contextualised and Eswatini-specific package. The study developed a number of documents which may be helpful to you to provide counselling in your clinic, health centre, primary care, TB or HIV-ART clinic or department. These are referred to throughout the manual and are summarised in the Appendix, which also gives a description of when these resources can be used. The appendix can be used as a tool to avoid running out of the necessary documents.

[1] Ministry of Health (2016). Mental Health Desk Guide.
[2] WHO (2016). mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialised health settings. http://apps.who.int/iris/bitstream/10665/250239/1/9789241549790-eng.pdf?ua=1.

What is depression?

It is important to understand the nature of depression before delivering counselling. This will make it easier to understand what patients are experiencing in order to help them recover. Here is a list of some important facts about depression to help address common misconceptions:

- Depression is a treatable illness
- Depression is a stress-related mental illness, which causes disturbances in a person's mood.
- Depression, if untreated, can be fatal. Approximately one in ten people with depression die by suicide. Suicide is generally more common in men.
- Depression can also affect a person's physical health by increasing the risk of heart disease and diabetes. When people with physical illness have depression, they are less likely to seek help for their physical problems
- Depression can make it harder for people with medical conditions to adhere to regular treatments, such as taking medications for HIV and TB.

The main symptoms of depression are listed on page 12 of the **Mental Health Desk Guide**. These can be grouped into those which relate to the *physical body* (e.g. weakness), *emotions* (e.g. sadness), *thoughts* (e.g. hopelessness), and *actions* (e.g. withdrawal).

Also, the presenting symptoms of depression (WHO mhGAP pages 19-23 weblink on page 3) are listed as:

- Multiple persistent physical symptoms with no clear cause (other causes **excluded)**
- Low energy, fatigue, sleep problems
- Persistent sadness or depressed mood, anxiety
- Loss of interest or pleasure in activities that are normally pleasurable

Chronic diseases (e.g. HIV and TB) and depression

We know that people living with serious or chronic disease including communicable diseases such as HIV and TB and non-communicable diseases such as diabetes and asthma have a higher risk of depression. This is likely due to a combination of the physical impact of illness, the psychological impact of being concerned about health or death, the social impact such as stigma and the financial impact of e.g. being unable to work or travelling to healthcare facilities.

In the Lubombo pilot of this package, 19% of the 324 people living with HIV and/or TB screened had depression. International studies estimate that depression may affect over 30% of people living with HIV[3] and as high as 50% of people living with TB[4]. This represents a significant number of people in Eswatini.

Co-morbid depression in this group has a significant impact on these patients health and happiness, in addition to a potential impact on their condition such as self-care and treatment adherence.

[3] Bernard et al (2017) Prevalence and factors associated with depression in people living with HIV in sub-Saharan Africa: A systematic review and meta-analysis, *PloS One*, 12(8), 1-22.

[4] Sweetland et al (2014) Depression: a silent driver of the global tuberculosis epidemic, *World Psychiatry,* 13 (3), 325-6; Addis Alene (2018) Mental health disorders, social stressors, and health-related quality of life in patients with multidrug-resistant tuberculosis: A systematic review and meta-analysis, *Journal of Infection,* 77, 357-67.

How is depression detected?

Patients may present with symptoms of low mood or some of the other symptoms outlined in the **Mental Health Desk Guide**. These symptoms may present during a routine consultation about another health matter. In such a scenario it is vital that these problems are acknowledged and that patients receive the necessary support.

Another approach to detecting depression is to screen for it routinely in settings where it is expected to be more common, such as among HIV and TB patients. Both of these approaches are described further in Chapter 3. Both of these approaches are discussed in this guide. If screening is implemented in a clinic, there must be an Organisational Structure put in place. This is discussed more in Chapter 3.

How is depression treated?

There are different ways to treat depression (Table 1). Two broad categories of treatment are *talking treatments* (counselling) and *medication*. Depression can be treated by counselling, by medication, or by a combination of both. A person suffering from depression may have additional problems such as anxiety, harmful drinking, or physical health problems. It is important to treat these problems in addition to treating the depression.

Table 1: Treatments for depression	
Counselling	Talking therapies (including HAP) involve talking to patients about their concerns and improving depression by helping them make changes in their behaviour. This is outlined in page 42 of the **Mental Health Desk Guide**. See also page 27 of the WHO mhGAP.
Medication	Antidepressants improve depression by changing the chemical balance in the brain, which is disturbed during depression. Page 13 of the **Mental Health Desk Guide** outlines factors which may require the use of antidepressant medication in Eswatini.

What is the Healthy Activity Program (HAP)?

Depression symptoms can affect the physical body, emotions, thoughts, and actions. The Healthy Activity Program is a form of counselling which focuses on changing the “actions” category in order to change the other three categories – i.e. body, emotions (feelings), and thoughts.

The focus of HAP is on what patients are doing (or not doing). HAP treats depression by helping patients do activities that are pleasurable and activities that solve problems. We may refer to this as “Doing Therapy”.

As a HAP counsellor, you will help your patients to identify the links between what they do and how they feel, and to use this information to identify specific at-home activities that will help them begin to feel better and solve problems. HAP is delivered in a maximum of eight sessions over three phases (early, middle, and ending phase).

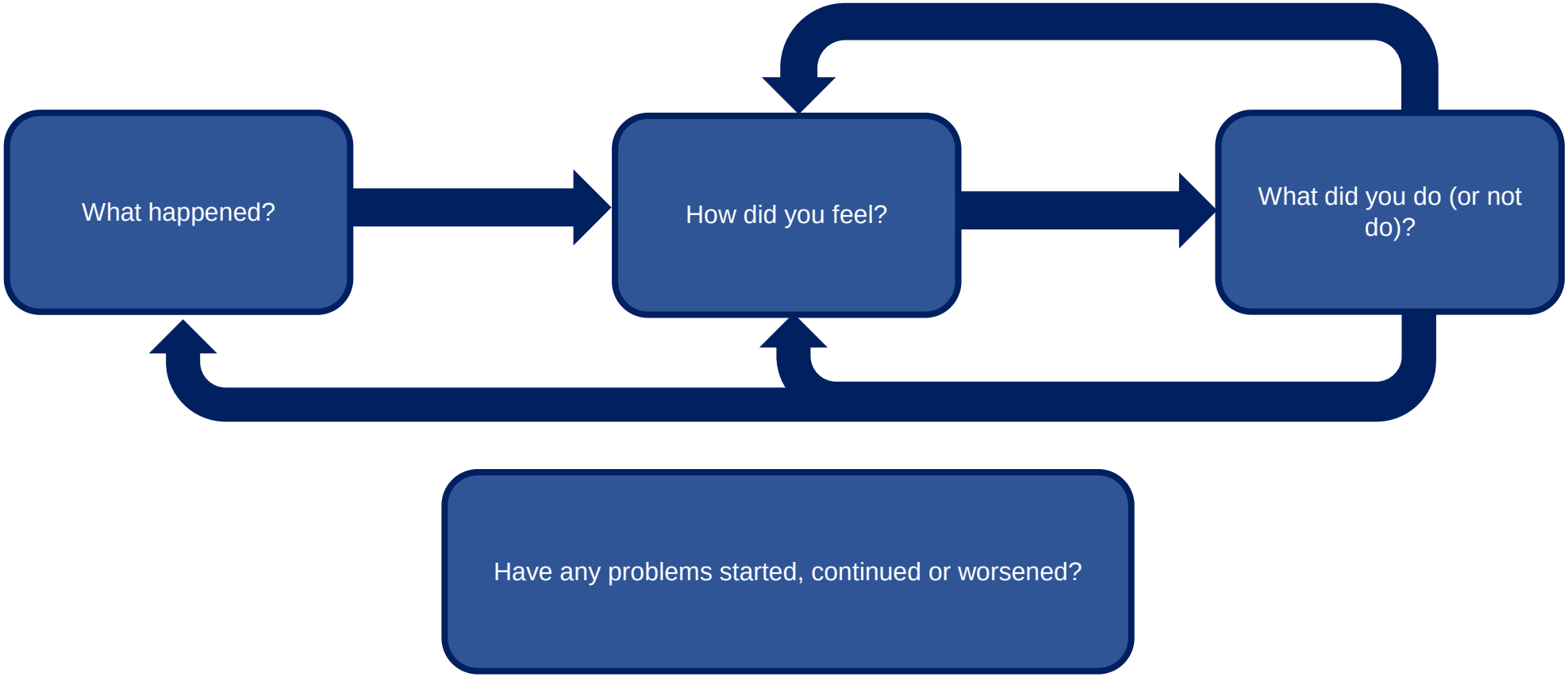
This counselling can be delivered by any nurse who has attended training with both the Mental Health Desk Guide and HAP counselling or the combined training.

Healthy Activity model of depression

The Healthy Activity model of depression supports our understanding of what depression is and how to treat it. It has four main components. These are framed as questions that are simple and easy to recall (see Figure 1). It is based on an understanding that events can lead to us choosing to do (or not do) specific actions, and that these choices can either improve or worsen our mood.

This model provides a useful guide for you when getting to know your patient and when helping your patients to understand the relationship between their mood and their actions.

Figure 1: Healthy Activity model of depression



Healthy Activity Program structure

This model of depression informs the Healthy Activity Program (HAP) which aims to promote healthy activities as a way of recovering from depression. The basic structure of HAP consists of three different phases and is outlined in Table 2, which describes the main objectives for each phase. The content of each phase is outlined in greater detail in the subsequent chapters.

Table 2: Healthy Activity Program Phases

Phase 1 (0.5 - 2 sessions)	• Establish an effective counselling relationship. • Help patients understand the HAP approach. • Gain their commitment for counselling, addressing barriers to treatment engagement.
Phase 2 (2 - 6 sessions)	• Consists of Phase 2a (Learning together) and Phase 2b (Getting active and solving problems). • Assess activation targets and encourage activation. • Identify barriers to activation and learn how to overcome these. • Help patients to solve (or cope with) life problems.
Phase 3 (0.5 - 1 session)	• Review and strengthen gains that the patient has made during treatment in order to prevent relapse. • Ensure patients know how and where to ask for help if they feel unwell again

Chapter 2: Key Counselling Skills

Page 42 of the **Mental Health Desk Guide** provides an overview of general counselling skills which can support any counselling session. This section of the manual gives further information on the following counselling skills which are particularly relevant to the successful delivery of HAP:

- Maintain session structure.
- Keep the focus on action.
- Learn together collaboratively.
- Be non-judgemental.
- Acknowledge the patient's experience.
- Recognise traumatic experiences
- Encourage progress.
- Express warmth and be genuine.
- Ask for help
- Maintain confidentiality

Maintain session structure

A counselling session is different to a friendly chat. At the start of a session, it is recommended that you and the patient set a clear agenda together. This agenda is a list of topics to discuss, or tasks to complete, in the session. It should be flexible to allow new topics to be added when necessary.

Keep the focus on action

HAP emphasises action and doing things differently to help the patient feel better. In a HAP session, keep the focus on action, and limit the time spent on topics that are not central to the patient taking action aimed at solving problems and feeling better.

Learn together collaboratively

Counsellors and patients must work together as a team. Introduce the patient to each step and encourage them to take an active role during the session – this includes identifying activities that will be targets for change. Often at the start of treatment (or with patients experiencing severe depression symptoms at any point), the counsellor will have to be more directive in setting the agenda and suggest actions to take (or even require them to be taken if the patient is at risk of self harm or suicide), but even at such times, patients should understand the reasons for what is being recommended.

It *may* also be helpful to collaborate with a family member who is close to the patient and who may be available to support and help the patient through the treatment – a Treatment Supporter.

Be non-judgmental

Being critical or judgmental often gets in the way of active problem solving because it makes it harder to learn collaboratively with the patient. Patients have often been subjected to judgmental comments from others like "*get yourself together*" or "*you need to be strong*". Do not do this. They may also have many judgemental thoughts about themselves, such as "*I'm a bad person*". If you are judgmental, it can make it harder for patients to connect with you or to work with you in sessions. Instead, practising a non-judgmental style helps you to focus specifically on what has happened,

rather than on your own opinions or reactions. Your non-judgmental attitudes can help you build trusting relationships with patients and support the patient in opening up and sharing more with you.

Acknowledge the patient's experience

In addition to being non-judgmental, it is also important to acknowledge the patient's experience and to communicate the fact that their experience makes sense to you. For example, many patients with depression attribute their problems to physical illness and focus a lot of attention on their physical health. It is important to accept and acknowledge the patient's experience of such physical health concerns. You can build on such acknowledgment by explaining the link between physical health and stress and describing how the Healthy Activity Program will help them feel better.

Recognise traumatic experiences

Traumatic experiences can have a major impact on mental health, This includes experiences such as: violence, abuse, sexual assault or rape, bereavement such as loss of a child or witnessing a traumatic event such as a fatal car accident. These events may be quite common in Eswatini. It is important that you recognise the negative impact this can have on someone's wellbeing and reassure them that it is normal to be upset. Listen to the patient's story, be empathetic and do not dismiss their experience. **If the patient expresses current abuse, sexual assault, violence or trauma, discuss and refer to a psychiatric nurse, social worker, gender-based violence services or the police. If you think they are currently at risk of harm, inform the police.** See the box on page 28 for more information on this serious issue.

Encourage progress

A counsellor's role is to encourage the patient every step of the way, looking out for even the smallest signs of progress and improvement. The nature of depression is such that it tends to take away from the patient's confidence and motivation. It is your job to help patients set small manageable tasks and encourage even the smallest signs of action and improvement in mood.

Express warmth and be genuine

Being warm and genuine with clients can also help to establish a positive working relationship. We can communicate warmth verbally and non-verbally in ways that are genuine and natural for each of us. Verbal expressions of care (e.g., *"I'm happy to see you today*" or "*I'm sorry that was so hard*") or non-verbal expressions of warmth (e.g., a smile, body language, eye contact, tone of voice) are simple ways in which this can be done.

Ask for help

It is important that you recognise when a case might be out of your competency. If you are concerned about a patient, the patient is very distressed, you are worried that may be suicidal or they have symptoms such as hallucinations, delusions or abnormal behaviour you must discuss this with a trained colleague. See also **Mental Health Desk Guide page 19-25** for more information. Your first option should be to discuss this with your mentor or supervisor for this programme, who is likely a mental health nurse at your regional hospital. Make sure you have this person's details. Patient's experiencing traumatic experiences and/or exhibiting severe distress, refer to a clinical psychologist

if possible (likely at the National Psychiatric Referral Hospital). If you are unable to contact them you remain concerned or the patient is seriously unwell, please refer **urgently** to a doctor.

In addition, it is important that you look after yourself. If you are feeling drained or upset by a discussion, apply HAP rules to yourself, employ health activities, use self-care and discuss this with a colleague, friend or doctor.

Confidentiality

Any information the patient shares with you, in addition to any patient notes, must be kept **strictly confidential between you and the patient (unless when referring to another healthcare professional).** There may be stigma towards patients with mental illness. Discussing patients with other people may put your patient at risk or affect a trusting relationship, which is crucial for effective counselling.

Chapter 3: Screening and Diagnosing Depression

There are two key ways that depression can be detected:

Symptoms (this page)

- Patients may present with symptoms of low mood (feeling down/sad or loss of interest) or some of the other symptoms outlined in the **Mental Health Desk Guide**.
- These symptoms may also present during a routine consultation about another health matter. In such a scenario it is vital that these problems are acknowledged and that patients receive the necessary support.

Screening (page 21)

- Routine screening can help to detect depression at an earlier stage **or** in those who otherwise do not disclose symptoms
- Screening can be effective in groups where depression symptoms are felt to be more common - such as among HIV and TB patients.
- This can be implemented in your clinic
- This is the approach we used in our Lubombo pilot of this package
- Use the PHQ-2 (see page 21)

Symptoms

Refer also to the Mental Health Desk Guide pages 12 – 18. See also the PHQ-9 questions on page 19.

People may **report**:

Feeling sad or low mood

Little or no pleasure in doing things they normally enjoy

Disturbed sleep or appetite

Poor concentration

Loss of confidence of self-esteem, feeling worthless, guilt

Irritable, finding it difficult to concentrate

Low energy

Alcohol Excess

Suicidal Ideas

Patients may **look**:

Agitated, restless

Sad

Tired

Unkempt or dirty

Not making eye contact

Tearful

If patients report hallucinations (seeing things or hearing voices that are not there) or delusions (believing things that are not true), display abnormal behaviour or are disorientated they may have a more serious mental illness such as Bipolar Disorder, schizophrenia or other psychoses – see your Mental Health Desk Guide pages 19-22 and refer the patient to the hospital.

Be careful not to misdiagnose depression

If a patient presents with these symptoms, **first make sure there is no physical cause for these issues.** Patients can screen positive for depression when they are otherwise ill. Ask about symptoms and examine to make sure they do not have signs or symptoms of other illness, **for example** cough, weight loss, fever, rash, bowel or urinary symptoms, headache, high blood pressure. Consider testing for Diabetes, TB and HIV and check their blood pressure.

If you are sure your patient does not have another cause for their symptoms, or you feel that their physical condition may be complicated by depression, you can use a questionnaire to detect depression called the **Patient Health Questionnaire-9 (PHQ-9).**

The PHQ-9 form (Table 3) measure the symptoms of depression in each patient and decide whether they have depression. It can be used to both diagnose and monitor depression. PHQ-9 forms in both English and SiSwati will be available in your clinic or department or you can use the forms in the appendix of the guide. Literate patients should be encouraged to self-administer the form. Alternatively, you or another member of the clinical team may complete the form on their behalf. Completed forms or documentation of the PHQ-9 score should be kept in the patient notes.

Ask these questions in a private area, as are confidential, sensitive and may be upsetting. See the appendix for the SiSwati version of these questions.

Table 3: PHQ-9 questions

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	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 are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper?	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

The questionnaire in Table 3 gives a score, marked out of 27. Interpret according to Table 4.

Table 4: PHQ-9 thresholds		
Score	**Depression severity**	**Action**
0-4	**None**	Re-test if needed in the future
5-9	**Mild**	Give a leaflet with explanation. Re-test after 3 months or anytime if needed
10-14	**Moderate**	Consider offering HAP, **if you have capacity.** Give a leaflet with explanation Re-test after 3 months of anytime if needed
15-19	**Moderately severe**	Offer HAP counselling Consider referral to a doctor (or refer if the **repeat** PHQ-9 remains > 15)
20-27	**Severe**	Offer HAP counselling **and** refer to doctor
Suicidal ideation (Question 9)	**N/A**	**Urgent referral** for review by a doctor
Any score with social issues such as child support issues, orphan school fees support etc	**N/A**	**Referral to a social worker**

All patients scoring **10** or more have significant disturbances in day-to-day function and could benefit from HAP counselling. Therefore, if your clinic has capacity, this should be considered.

Patients scoring **15** or more on initial assessment should be offered HAP counselling. You may be able to do that on the same day or you may need to make an appointment. In addition, *consider* referring these patients to a doctor to consider the need for antidepressant medication. This should include a discussion with the patient and a consideration of the degree of their distress. If you are unsure, discuss with your HAP mentor.

Patients scoring **20** or more on initial assessment should be referred to a doctor. Patients that have a PHQ-9 score of above 15 in subsequent sessions (after receiving 1 or more sessions of HAP) should be referred to a doctor.

Question 9 refers to suicidal thoughts. Patients giving a positive answer (1, 2 or 3) to this question (regardless of PHQ-9 score) should be referred for urgent review by a doctor. Further information is outlined on page 18 of the Mental Health Desk Guide.

Patients should be referred using the national referral process. It is important that the following is documented:

- That this patient is being seen in the 'Healthy Activity Program' and has been offered/accepted to start HAP counselling for depression
- The patient's PHQ-9 score and interpretation as in Table 4 (e.g. scored 22 and so should be seen by a doctor to consider anti-depressants)
- If you are concerned that the patient has suicidal ideas (urgent referral needed)
- That you would like to have information about the patient treatment so that you can include this in your counselling.

Screening

The alternative method for detecting depression is to implement **routine screening** into clinics or departments where you know patients will have a higher risk of depression, for example in HIV, TB or noncommunicable disease (NCD) clinics. We know that depression might not always be obvious in many patients, that depression is more common in this group and that depression may affect treatment adherence.

Screening includes assessing **all patients**, regardless of symptoms. To manage capacity and focus the intervention, you could decide to only screen a sub-group for example patients that are non-adherent, or newly diagnosed patients, as they could be at more risk of depression. However, it is important to be fair and screen **all patients** in that group *or* sub-group if you decide to implement screening.

Screening all patients attending HIV clinics is included in the Eswatini National HIV Guideline. Screening TB and NCD patients is likely **just as important**. Patients with Drug Resistant TB have an even higher risk of depression.

To screen patients without symptoms, you can use a shortened questionnaire, called the **PHQ-2** (Table 5). This involved just asking the **first 2 PHQ questions.** If the patient scores 2 or more, you should do the **full PHQ-9 and interpret the same as outlined above.** This is shown in Table 6.

Table 5: PHQ-2 questions

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	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

Table 6: PHQ-2 thresholds		
Score	**Depression ?**	**Action**
0-1	**No Evidence**	Re-test if needed in the future
2-6	**Possible**	Complete full PHQ-9 – see Table 3 and 4

Implementing Screening in your clinic/health facility

If your clinic or department decides to implement screening, you will need to consider the following:

- All clinic staff need to be sensitised
- There should ideally be at least 2 HAP trained nurses in your clinic, to manage patients during leave etc. The should have attended training for both the Mental Health Desk Guide and HAP or the combined training.
- Who will screen patients? Your HAP trained nurse is not likely to be able to screen all of the patients. Decide who else could be involved. For example, all nurses when they see patients for their TB or ART follow ups. Consider a simple in-service PHQ-2/-9 training for these staff.
- If they screen positive, send to the HAP trained nurse, but if not available make a plan for what to do. For example, give general counselling, explain about the HAP and give an appointment by the HAP trained nurse. All staff that are screening need to be aware of criteria for **urgent referral to a doctor (see Table 4)**
- Where will they be screened? These questions are personal. It is not appropriate for patients to be screened where other patients can hear them.
- Can patients self-complete the PHQ-2? Consider whether this is possible for some literate patients, as this will help manage staff capacity.
- How will you record the results? Positive results must be documented in patient notes, but negative results will be able to give you more information about the number of patients suffering from depression. Consider recording this information
- How will nurses be supervised/mentored? (see page 25). Nurses providing HAP counselling should have access to regular support from a trained mental health nurse at their regional hospital or elsewhere, in addition to the ability to discuss/refer to the National Psychiatric Referral Hospital.

Information, Education, and Communication (IEC) materials

Empowering patients to choose actions to improve their mental health is a vital part of HAP. In addition to the support offered through HAP counselling, this study also aims to support patients through the provision of appropriate IEC resources. These can be shared with the patient at any stage once they have been screened using the PHQ-9 form and found to have probable depression.

Several resources are available to support patients. These include patient information leaflets on depression and suicide produced by the National Psychiatric Referral Hospital, in collaboration with the WHO. Another important resource is the use of the “8 steps to wellbeing” cards (see Figure 2 and Patient Record Card in appendix). These outline examples of eight different activities which can improve mental health and wellbeing. These cards should be given with explanation to people from the outset of HAP counselling. Patients with **mild** depression (or **moderate** not receiving HAP) give these leaflets, discuss these healthy activities and advise to continue their usual social activity. Ask them to return routinely if continues or urgently if become worse.

Figure 2: "8 steps to wellbeing" card

HEALTHY ACTIVITIES

Take regular exercise

Shukumisa umtimba njalo njalo

Spend time socialising with friends

Citsa sikhatsi uhlanganyela ne-bangani

Have a regular sleeping habit

Tetayete kuphumula ngalokwenele

Avoid drugs and alcohol

Gwema tjwala netidzakamiva

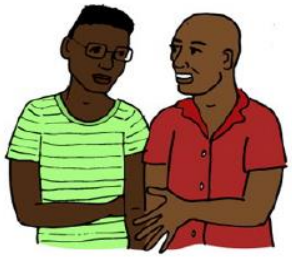
IMISEBENTI LENEMPILO

Make time for spiritual health

Tinikete sikhatsi ngempilo yakho yakamoya

Have healthy eating habits

Kudla lokunemphilo



Share your feelings with a friend

Cocisana nebantu lobatsembako ngetindzaba takho

Seek help if you feel worse

Funa lusito um utiva ungalungi

Chapter 4: Delivering a course of HAP

Structuring a course of HAP counselling

The three phases of HAP treatment (Table 2) are delivered over *ideally* five to eight sessions at intervals of two to four weeks for example alongside regular ART follow-up visits. Each session should last 30–40 minutes. The first session is always devoted to the goals of Phase 1; although some patients may require two (or, rarely, more) sessions to achieve these goals.

The number of sessions in each phase is flexible, based on whether the goals of the previous phase have been achieved. PHQ-9 scores are measured every 2-3 sessions and used to determine progress (or more often if patient is unwell or you are concerned – see page 32 for more information). **Initial** scores of 20 or more (or any suicidal thoughts) require review by a doctor. **Subsequent** scores remaining 15 or over also require review by a doctor.

For most patients, you should expect to achieve the goals of all phases by session 5 or 6. However, if at the end of four sessions, the patient does not show improvement, this means that you may have to extend the middle phase. You may need to discuss this with your mentor/clinic supervisors and offer up to two more sessions to achieve the goals of the middle phase. Some patients, however, will achieve their goals sooner and in that case, you may be able to shorten the phases, especially if the patient may struggle to attend 5 – 8 sessions. Be open about this with the patient.

If the patient has not recovered at the end of eight sessions, the needs of the patient and the progress made must be reviewed with the supervisor and the patient should be referred to a doctor to consider antidepressant medication. Patients already taking antidepressant medication will also need to see a doctor to review their treatment regime.

Structuring an individual session

The content of an individual HAP session varies depending on which phase the patient is at. However, there is a standard structure to each session which it is important to maintain where possible. See Table 7. Each section is described further in the subsequent chapters. “Special Tasks” are skills or activities which are specific to each phase of treatment.

Table 7: General structure of individual HAP sessions	
1. Open the session	Introductions; Review progress and assess suicide risk; Involve the treatment supporter.
2. Set the agenda	Agree, in collaboration with patient.
3. Review homework	As agreed in previous session.
4. Complete special tasks	Phase-specific: see below.
5. Agree homework	Examples include completing the activity plan or practising activation.
6. Close the session	Summarise; Set the next session date; Complete documentation.

Supervision and Mentoring

Every nurse counsellor offering HAP should have access to a supervisor or mentor. This should be a mental health specialist who can offer advice, support and education to the nurse counsellors, ideally from your regional hospital. Nurses should be regularly in contact with this person. Make sure you have this person's contact details. This should be in regular scheduled visits, in addition to discussion when needed over the phone. This should include:

- Any questions about delivering HAP
- Complicated patients
- Any discussions on past trauma or adverse childhood experiences
- Any questions about referrals
- Any referrals they make to the mentor's regional referral hospital (so that they can follow up, if needed)

In turn, the mental health team at the hospital should discuss any serious cases with the National Psychiatric Referral Hospital.

Any concerns should be also discussed directly with the Clinical Psychologist at the National Psychiatric Referral Hospital and/or a doctor:

- Serious mental illness
- Suicidal thoughts
- Other serious mental health signs or symptoms

See the **Mental Health Desk Guide** for further information on referring to the National Psychiatric Referral Hospital.

Chapter 5: Getting started (Phase 1)

At the start of a HAP course, it is important to build a good relationship with the patient. The content of the first session is critical to this. Pacing the session so that the patient understands the information and believes that you have understood their experience is important. Table 8 summarises the main components of Phase 1. These are described in further detail below.

Table 8: Getting started – Phase 1 overview	
Duration	0.5 - 2 sessions.
Goals	• Engage and establish an effective relationship. • Help patients understand the Healthy Activity Program. • Elicit commitment for counselling.
Actions	1. Open the session. 2. Set an agenda. 3. SPECIAL TASK 1: Get to know your patient. 4. SPECIAL TASK 2: Elicit commitment for counselling. 5. Agree homework. 6. Close the session.

Open the session

Introductions

Make the patient feel comfortable and welcome from the outset. Greet the patient, introduce yourself and explain about confidentiality. Indicate to the patient that their PHQ-9 score indicates that they might be suffering from depression, in addition to any physical complaints. Ask permission to address these problems.

Patients may not have planned to do a counselling session as part of their health clinic visit, and some may not be able to stay for the entire duration of the 30–40 minutes required for a first HAP session. It is important to check with the patient about their availability and make a collaborative plan for how to proceed.

If the patient is happy to proceed, then briefly share information about depression and how HAP counselling can help to overcome depression. Provide practical information including:

- your training and supervision arrangements;
- the length of counselling – number of sessions and over how much time;
- where the sessions will be conducted;
- how the patient can access help outside the sessions, and in what circumstances.

It may be useful to ask the patient how life would be different if their stress or tension was addressed. Based on the response, provide encouragement and hope that through the process of counselling, they can be treated.

> *“I’ve received training in providing counselling for patients with stress-related problems. I work with supervisors, who have been trained by experts in this field. They will supervise my work. I would like to share with you that the doctor in the clinic will be providing you with any medicines that you need. As far as the counselling is concerned, in our experience, we find that we need about five to eight sessions of about 30–40 minutes each time, spread over two to three months or so, to help you feel better/overcome your difficulties.”*

Review PHQ-9 score and assess suicide risk

You will need to review the PHQ-9 screening score and ensure that appropriate actions have been taken (in accordance with Table 4). If the suicide question (Q9) is positive on the PHQ-9 screening tool, or you identify suicide risk during your assessment, then you must add this to the agenda and this becomes the immediate focus of the session. **Patients giving a positive answer to this question (regardless of PHQ-9 score) should be referred for urgent review by a doctor. Further information is outlined on page 18 of the Mental Health Desk Guide.**

Ensure verbal consent

It is important that patients understand what you are telling them, their diagnosis, what HAP counselling is and that it will involve 5-8 session at two to four weekly intervals. They are allowed to decline. Make sure you have obtained verbal consent to progress with the course. **If the patient declines counselling, but has a PHQ-9 of 20 refer to the doctor to assess for review +/- antidepressants. If the PHQ-9 suicide question 9 positive, you will still need to refer them to a doctor as they are at risk of harm or suicide.**

Involve a Treatment Supporter

As part of the introduction, a Treatment Supporter (TS) - usually a close family member or friend – should be identified for the patient. A TS is someone who can support the patient through HAP, encourage them to make positive changes and help them to overcome any barriers. They should also make sure that the patient takes their medication and other disease treatment and returns for appointments. If the patient wishes, the TS can be the same person who is supporting their HIV, TB or other long-term disease treatment. It can be hard for people with depression to talk about their experiences and so an important part of counselling is to involve and educate close contacts, but only if the patient consents to this. Confidentiality is very important.

Having identified the TS, then ask the patient whether they wish this person to be present for the HAP sessions. Discuss the benefits of involving a TS, but respect the patient’s decision if they prefer to receive counselling alone. If the TS attends, before you end the session ask them if they want to provide further information about the patient’s problem/s and if they have any questions.

Set an agenda

In the first session, it is important to orientate the patient to the process of agenda setting. Begin by making a list of items that you would like to cover in the first session such as:

1. Explain counselling and how it can help them
2. Ask about the patient’s problem/s.
3. Make a plan for future sessions and set the next session date.

Ask the patient if they agree with the list and whether there are any items they would like to add. In subsequent sessions, first invite the patient to list agenda items, then add yours to this list.

SPECIAL TASK 1: Get to know your patient

Having agreed the structure, aim to give your patient time to share thoughts and feelings so that you can understand their experience. When discussing the nature of the patient's stressful thoughts, it is helpful to be guided by the four questions from the Healthy Activity model of depression (Figure 1 – page 12):

1. What happened?
2. How did you feel?
3. What did you do (or not do)?
4. What is the connection between what you did (or didn't do) and how you feel and the problems/stressors in your life?

1. What happened?

Identify factors that either contributed to depression starting, or that are maintaining depression currently. Often, the most helpful factors to identify are events or stressors in the patient's life.

Examples of such events include:

- **Acute stress**: Defined as a difficult event that has just happened (e.g. death of a loved one, loss of a job, serious accident or injury).
- **Long-term stress**: Defined as problems that the patient has been dealing with for a long time (e.g. work-related or relationship problems; lack of safety in one's neighbourhood or home; long-term financial problems; or having to care for a sick family member).
- **Adverse childhood experience** in the past (e.g. abuse, neglect or trauma).

If the patient has difficulty identifying such factors, offer suggestions of these common factors:

> *"We think about depression as occurring in response to things that happen in your life. Did anything happen when you started feeling down (or stressed)?*
>
> *Has anything been going on in your life now that makes your life more stressful or harder (or that keeps you feeling down)?"*

Trauma or Adverse Childhood Experiences

HAP is not a psychological tool that is appropriate to manage the impact of serious trauma such as violence, abuse, sexual assault/rape or witnessing the death of a loved one. It is important that you recognise the negative impact of these experiences on the mental health of your patient and are empathetic and non-judgemental. However, recognise also that you may not have the psychological training to support them with these complicated feelings. Be empathetic and do not dismiss their experience. You can still offer them HAP, but discuss these cases with your mentor and supervisor. Consider referring them to the National Psychiatric Referral Hospital if their trauma is severe and they are able to attend. See also the **Mental Health Desk Guide** pages 33 and 49.

If your patient reports current abuse, sexual assault or violence, refer them urgently to a social worker, gender-based violence service or the police, with their consent. Encourage them to report this violence, but respect their wishes. They may be in danger.

If you think their or another's life is at risk, inform the police.

2. How did you feel?

Now work with the patient to explore how they felt in the context of what happened.

Examples of feelings that are common in patients under stress are:

- sadness and/or irritability;
- low interest or motivation;
- decreased energy – feeling tired and fatigued;
- lowered attention and concentration – inability to study or keep at one task for long;
- thoughts of hopelessness, worthlessness, and helplessness.

If the patient has difficulty in recounting these experiences, refer them to the items of the PHQ-9 that were scored positive and ask about these experiences. It is also very important to explain that these feelings are normal in the face of life's challenges, but do not belittle these feelings.

> *"When you experience such events (e.g., tension with your husband), how do you feel?"*

3. What did you do?

Work with the patient to identify how their actions changed in response to their experience of the events and subsequent feelings. This discussion focuses specifically on what the patient does (or does *not* do) when feeling down. This is the basis of HAP.

It can also be helpful to explain that it is very common for people to start or stop doing certain activities when feeling down. These can include:

- not meeting or talking to friends and family;
- not going to work;
- doing routine activities (e.g. sleeping, eating, hygiene routines) in disrupted ways;
- stopping or reducing physical activity (staying in bed, not exercising, etc.);
- increasing conflict with people close to them;
- thinking again and again about their problems.

> *"When you are feeling stressed (sad, tired, etc.), what do you do (or not do)?*
>
> *Are there activities you were doing that you have stopped since your stress began?"*

4. What is the connection between what you do (or don't do) and how you feel and the problems/stressors in your life?

It is important to discuss with patients the ways in which their actions (or lack of actions) may be keeping them stuck in depression. These activities may help them feel better temporarily, but over time make things worse – help them to understand this link. **Use the "8 steps to wellbeing" images (Figure 2 on page 23) to support this process.**

Also ask about actions that patients do (or used to do) to improve their mood. HAP counselling sessions work to reduce the frequency of negative activities and increase the frequency of positive activities.

Examples of activities which may worsen mood:

- watching TV for hours at a time;
- lying in bed for long periods;
- not attending work;
- neglecting personal appearance and hygiene.

Examples of activities which may improve mood:

- speaking to a friend;
- playing with a grandchild;
- spending time on hobbies;
- praying or reading religious or motivational books;
- going for a walk.

SPECIAL TASK 2: Elicit commitment for counselling

Before finishing the first session, it is important to confirm that the patient has understood what counselling involves and is willing to proceed with the treatment. Give the patient some time to talk about their understanding, clarify their doubts, and go over parts that they may not have understood.

Explore any **barriers to attending future sessions**. Common barriers include costs of transport, lack of time (especially for those in employment), care-giving responsibilities and lack of permission from a spouse. Discuss these with the patient and attempt to find solutions. Consider involving other agencies (e.g. the social welfare team) as necessary.

Agree 'homework'

HAP is an action-orientated intervention. As such, it places importance on patients practising key activities between sessions. Each session will have a simple "homework" task, designed to reinforce learning from the session. These tasks are **not** intended to be a burden for the patient and should be introduced as a way of supporting improvement. Consider involving the patient's treatment supporter so they can encourage the patient to complete the task. Be aware that not all patients can read. Sensitively advise homework that is appropriate for each patient.

For the first session, the homework focuses on **reviewing the '8 activities' card and the Patient Held Treatment Record.** Patients should be encouraged to reflect on the self-help component of the leaflet and ask to consider how they can add these activities to their daily schedule.

Close the session

Summarise

Summarising involves providing a brief description of the session and should include the key points that were discussed and any homework for the coming week. A good summary is short but comprehensive. Ask the patient to summarise the information that was provided, so that you can understand how effectively you have communicated the information and whether you need to correct any doubts/misconceptions. At the end of the first session, also explain what was not covered in the session. The patient should be reassured that this will be covered in the next session.

Set next session date

Agree a date and venue with the patient. The next session should typically occur at an interval of approximately 2-4 weeks. Ideally, HAP should coincide with other scheduled appointments as part of their ongoing healthcare.

Complete documentation

All necessary documentation should be completed. This includes:

- Patient record card: a brief record of PHQ-9 score and a summary of agreed action (e.g. activities to start/stop). The next appointment date should be documented, and this card should be given to the patient to bring to each subsequent appointment. Review the self-help information in the card to reinforce positive activities which may improve the patient's mood. The front of the card contains space to list activities you will discuss with the patient. Explain that you will fill this in **throughout the next sessions.**

- Clinic record card: this should be completed in full and held in a file within the clinic/department. At present, this is a paper record, but may electronic (e.g. part of CMIS) in the future. Check what is done in your clinic. This card contains an optional section where you can record key patient information. This is important information that may affect how you counsel your patient. In addition, you may pick up an alcohol use disorder. If you do, turn to the **Mental Health Desk Guide** page 26. In addition, this information could be useful to record for data collection purposes.

Copies of both of these documents should be available in your clinic. See the appendix for the templates and information on how to obtain further copies.

Chapter 6: Learning together (Phase 2a)

Once you have understood the patient's problem, it is important to select treatment targets by defining the patient's goals and then helping them move in the direction of achieving those goals. This is the main objective of Phase 2, which consists of two components, lasting two to six sessions in total:

- **Phase 2a: Learning together.**
- **Phase 2b: Getting active and solving problems.**

This chapter will focus on suggested content for Phase 2a. The main components are summarised in Table 9.

Table 9: Learning together – Phase 2a overview	
Duration	1 session.
Goals	Identify activation targets.
Actions	1. Open the session. 2. Set an agenda. 3. Review homework. 4. SPECIAL TASK 3: Encourage activation. 5. Agree homework. 6. Closing session.

Open the session

Introduction

Begin with a general introduction and recap what was discussed in the last session (reviewing the patient and clinic record cards as necessary).

Review progress

If you want/think necessary, use the PHQ-9 screening tool to measure how much the patient's symptoms have increased or decreased since the last session. Some counsellors and patients find it helpful to do every session, but some find it repetitive and tiring or that it takes up too much of the counselling time.

The PHQ-9 can give you an objective report of the patient's current state, help to guide the treatment focus, and allow you to provide feedback to the patient about how their condition is progressing therefore **we advise that you do the PHQ-9 score at least every 2-3 sessions**. The score should be compared with the previous score and feedback given. The PHQ-9 score **must** be done if:

- You suspect the patient is getting worse
- You or the patient are considering ending treatment

Even without the PHQ-9 score, **it is important that you assess the risk of suicide every session by asking question 9.** If the suicide question (Q9) is positive on the PHQ-9 screening tool, or you identify suicide risk during your assessment, then you must add this to the agenda and this becomes the immediate focus of the session. **Patients giving a positive answer to this question (regardless**

of PHQ-9 score) should be referred for urgent review by a doctor. Further information is outlined on page 18 of the Mental Health Desk Guide.

Examples of phrases which can be used to review progress based on PHQ-9 scores include:

> *"'From your answers to these questions, it sounds like you have been feeling a bit better. How does that fit your experience this past week?'*
>
> Or, if there is no significant improvement, you can say, *'Based on the feedback you are sharing with me, it seems that you have been feeling more or less the same as the last time we met. Is that correct?' You can then add, 'We will focus more on some of these issues today and see how we can help you further'."*

Set an agenda

As in Phase 1, an agenda for the session must be determined in collaboration with the patient.

An example of an agenda which could be used in Phase 2 is:

1. Go over the list of problems the patient described in session 1 and ask the patient which, if any, of these problems they would like to discuss in the session.
2. Go over any new problems that may have been identified while reviewing progress and ask the patient which, if any, of these they would like to discuss.
3. Based on the patient's responses, make a list of agenda items; add issues that you would like to discuss to the patient's list.
4. Record the various activities the patient performs and how they feel when doing these.
5. Make a plan to identify at least one activity that can help them feel better and encourage the patient to follow this activity at scheduled times till the next session.
6. Plan to set the next session date.

Review homework

In each session, it is important to review the patient's experience with the homework. The review of homework helps you identify the next steps for the patient to take.

Ask the patient to describe their understanding of the Healthy Activity Program. You may say, "*can you tell me what you have understood about the counselling treatment?"* This is an opportunity for you to fill in parts that the patient did not understand, or correct any misunderstanding.

It is important to encourage any progress that the patient has made with the homework and to review what was done (or not done) in detail. If the patient has not completed the homework, it is important to ask directly, *"what happened?"* or *"what got in the way?"* It is important to address this topic in a matter-of-fact and **non-judgmental** manner. Learning from what got in the way of completing the homework is important in understanding how to help the patient take the next steps.

SPECIAL TASK 3: Encourage activation

You need to identify the activities that help the patient feel better, and those that do not help the patient feel better, in order to build effective action plans. This is the focus of Phase 2a. A patient with depression is likely to report more activities that do not help them feel better in their routine. Thus, it is very important to assess a range of activities that the patient is doing, together with the effect of each activity on the patient's mood. You can then plan with the patient how the activities that help them feel better can be increased, by skilfully making them a part of the patient's routine, and how the effect of activities that do not help them feel better can be decreased through problem solving.

There are two main ways to identify activities:

- **Healthy Activity Program model (see Figure 1 on page 12)**
- **Activity 'calendar' (either on paper or verbally)**

Healthy Activity model

This is useful to assess the links between activity and mood and is a helpful tool to use during sessions. Often patients will come to sessions with concerns about the period since the previous session – such as arguments with friends or family, or times at which they felt particularly down. Use the copy in Figure 1 on page 12 of this guide with the patient to enquire about these situations, asking specifically about the elements of the Healthy Activity model:

1. **What happened?**
2. **How did you feel?**
3. **What did you do (or not do)?**
4. **What is the connection between what you did (or didn't do) and how you feel?**

Activity calendar

In the appendix at the back of this guide there are blank copies of an activity calendar. You can either photocopy this or draw your own with the patient on a piece of paper. Discuss with the patient whether they would use this or find it helpful. Not all patients are able to complete this, and be understanding and non-judgmental if this is the case. Offer to fill it in with them if that would help. Explain to the patient that it might help them to write it down, but that you can also do this same exercise verbally. Use your understanding of the patient to help choose which method is best.

It can help them to assess the relationships between activities and mood by recording or discussing activities that the patient has been engaged in during the day, together with the corresponding mood at the time of performing this activity. It is necessary to explain to the patient the reason why discussing this or filling in the calendar can be a helpful part of the counselling. First, remind them of the HAP model and how the activities they do (or don't do) can affect mood and stress. Then you can say:

> *"It is helpful for us to have a detailed picture of the different activities you perform during the day and to understand how you feel when you do these activities. We can then choose activities that make you feel better and discuss how you can increase these. Similarly, we can discuss how to reduce those activities that make you feel worse. What do you think about this?"*

Next, you can consider using the calendar with them in the session. **Even if they don't want to use the paper calendar, do this exercise verbally with the patient during the session.**

You can say:

> *'We can use this chart to help us understand what activities help you feel better. Is it OK for us to work on this together now? Could you please start by telling me what you did before coming in to the clinic today? How did you feel when you were doing that activity? Let's talk about what you did yesterday too ... Can you tell me what time you woke up yesterday?'* Pause for reply. *'What did you do after waking up?'* Pause. *'What did you do next?'*

Also ask about how the patient felt during these activities. How the patient feels when performing an activity is the key to knowing whether an activity made them feel good or did not make them feel good. Some patients do not describe feeling happy or sad but rather describe their mood in physical/somatic terms such as "tension" or "feeling well/unwell". It is important for you to use whatever terms the patient does when explaining mood rating.

Does the patient have a particular trend, for example, in which the patient reports better mood on Sundays than other days of the week? Or, does the patient feel better in the evening when the family is home rather than the rest of the day when they are alone?

Mood can be rated in different ways as shown in Table 10 below.

Table 10: Methods used to assess mood

Mood ladder	Using the printed copy in the appendix of this guide and ask the patient to rate their mood along the rungs of the ladder (1–10).
Good/bad	Some patients may not report in detail on the intensity of mood. For such patients, it may be helpful to ask them to choose one of two categories, such as: *"do you feel happy or sad?"* or *"do you feel good or bad?"*
Emoticons	For patients who cannot read or write, you or they can draw icons to identify how they are feeling, e.g. ☺ 😐 ☹.
Tick/cross	Use a tick mark (√) to indicate a positive mood and a cross (X) to indicate a negative mood.

Once completed, it is then important to review the calendar to identify any links between activity and mood with the patient. For example, you may observe that a patient felt better when socialising with friends than when lying in bed during the afternoon.

If there is no time to complete this during the second session then consider asking the patient to complete it as homework before the next session.

Agree homework

Based on the learning from the above session, there are two parts to the homework from session 2.

Identify one activity that helps the patient feel better.

Discuss with the patient a specific plan for doing this activity at home. Encourage the patient to follow this activity at scheduled times till the next session. This activity should be specific (e.g. what they are to do, with whom, for how long).

Encourage the patient to fill the activity plan, if they are able.

As with the activity calendar, not all patients will want to or be able to fill in the activity plan. Discuss this with the patient and decide with them what they would rather. If they are able, explain that it can be helpful to write it down, but if not, you can discuss these same issues instead.

The activity plan records when an activity was done and what the effect on overall mood was. It is completed as outlined in Table 11. Copies of the activity plan are available in the appendix of this guide. You can either photocopy them or copy a simple version out on paper by hand. Explain to the patient that noting the activity and rating the mood will help them see the relationship between doing activities and feeling better. List out the agreed activities in the activity plan and ask the patient to put a tick when they perform the activity during the week. They also record their mood when doing the activity, using their preferred rating system. If they are not using the paper plan, ask them to remember what activity they did and how they felt and to discuss it next time.

Table 11: Completing the activity plan	
1	List the agreed activities in the activity plan during the counselling session.
2	Patient puts a tick when they perform the activity during the week.
3	Patient also records their mood when doing the activity, using their preferred rating method.
4	Counsellor works with patient during next session to review links between performing activities and mood.

It is important to encourage the patient to anticipate possible barriers to completing this homework and to help the patient develop ways to overcome these. Some suggested approaches to helping patients complete the activity plan include:

- Link the activity and completing the chart to some other routine activity, such as meal time.
- Use reminders such as stickers in a prominent place or a phone alarm.
- Involve a treatment supporter to remind the patient.

Close the session

In the same way as at the end of the first session, help the patient to summarise what was discussed. Set the next session date and complete all necessary documentation.

Chapter 7: Getting active and solving problems (Phase 2b)

Having begun to identify activation targets in the first two sessions, Phase 2b is the time during which patients will learn most of the skills that they need to get active and address problems. The focus of this phase is on providing patients with opportunities for practise through the systematic planning of homework. The main components of this phase are outlined in Table 12.

Table 12: Getting active and solving problems – Phase 2b overview	
Duration	1–5 sessions
Goals	• Strengthen the patient's understanding of HAP • Encourage activation. • Identify barriers to activation and learning how to overcome these. • Help patients solve (or cope with) life problems.
Actions	1. Open the session. 2. Set an agenda. 3. Review homework. 4. Special task 4: Getting active. 5. Special task 5: Solving problems. 6. Agree homework. 7. Close the session.

These actions are described in more detail below:

Open the session

Introduction

Begin with a general introduction and recap what was discussed in the last session (reviewing the clinic record card as necessary).

Review progress

If you want/think necessary, use the PHQ-9 screening tool to measure how much the patient's symptoms have increased or decreased since the last session. Some counsellors and patients find it helpful to do every session, but some find it repetitive and tiring or that it takes up too much of the counselling time.

The PHQ-9 can give you an objective report of the patient's current state, help to guide the treatment focus, and allow you to provide feedback to the patient about how their condition is progressing therefore **we advise that you do the PHQ-9 score at least every 2-3 sessions**. The score should be compared with the previous score and feedback given. The PHQ-9 score **must** be done if:

- You suspect the patient is getting worse
- You or the patient are considering ending treatment

Even without the PHQ-9 score, **it is important that you assess the risk of suicide every session by asking question 9.** If the suicide question (Q9) is positive on the PHQ-9 screening tool, or you identify suicide risk during your assessment, then you must add this to the agenda and this becomes the immediate focus of the session. **Patients giving a positive answer to this question (regardless of PHQ-9 score) should be referred for urgent review by a doctor. Further information is outlined on page 18 of the Mental Health Desk Guide.**

Patients presenting with a score of **15 or more** at this point should be referred to a doctor for consideration of antidepressant medication. This is different from the original PHQ-9 (where we advise to refer with a PHQ-9 of 20 or more) because this indicates a persistent issue that may need additional treatment. Continue to offer HAP regardless.

Ask about any significant events since the previous sessions – both positive and negative. These may inform later discussions about how to choose activation targets.

Set an agenda

Ask the patient what they would like to discuss during this session, based on their goals or recent problems or stressors. Items to discuss may include:

1. Ask about the homework the patient was to do at home – i.e. filling in the activity plan and carrying out the activities that were identified as targets.
2. Review the Healthy Activities pictures together (in Figure 2 on page 23 or in their Patient Held Record Card) and discuss activities (or others ones) that can help the patient.
3. Review the activities you and the patient documented on the front of their Patient Held Record Card. Did they manage to do or avoid these activities? Be kind and non-judgmental. Add to these if appropriate
4. Make a plan to perform these activities until the next session.
5. Discuss ways to deal with problems that the patient is facing.
6. Set the next session date.

Review homework

This includes two parts:

Review activation target

In session 2, the patient was asked to identify one activity expected to have a positive effect on their mood. Ask the patient whether they were able to do the activity as planned, and how they felt while doing it and afterwards.

Review activity plan

The patient was asked to complete or discuss the **activity plan** following Session 2. If they have completed it, then review it with the patient. If they opted not to use the paper plan, discuss what their plan was and how they progressed instead. Identify any connections between the patient's activities and mood. Identify whether a patient shows improvement or worsening of mood following the performance of an activity. It is important for you to encourage any progress that the patient has made on the action plan and to review what was done (or not done) in detail.

If the patient has been unable to complete their activity plan, then explore the reasons for this. For example, it may be that their initial plan is too ambitious and a more realistic, achievable set of

activation targets is necessary. Discuss their plans again in this session and fill it in with the patient, if they have decided to use the paper copy of the plan.

SPECIAL TASK 4: Getting active

Having reviewed the homework from the previous session, the next objective is to develop the action plan, which is a vital part of Phase 2b. This may involve modifying the original activity, depending on whether the patient reports it as having a positive impact on their mood. Work with the patient to identify additional activities which can improve their mood.

Basic principles underpinning the selection of an activity include:

- **Collaborate with the patient.**
- **Start simple.**
- **Break down the activity.**
- **Schedule the activity.**

Collaborate with the patient

The target activity is identified through discussion with the patient, recognising that their priorities may differ from those of the counsellor. Always be prepared to review and change lists of activities based on the experiences of patients between sessions.

Start simple

Early on in the counselling process, it is often helpful to start with activities that will help the patient feel better and that the patient is most likely to do, even if such activities are small. These activities will have a greater chance of success and will encourage the patient to try other activities.

This should help the patient begin to feel more positive and thus more prepared to tackle bigger problems, in time. For example, a patient who does not have a job may come to you with complaints of sadness. Your long-term target may be to help them get a job, but it is helpful to start working on what is immediately helpful to the patient, e.g. to experience the benefits of speaking to a friend or of taking a morning walk.

Break down the activity

In HAP, we often focus on helping patients to break down more complex or challenging behaviours into steps. Patients may find activities overwhelming and not know how to begin. Or, they may wish to achieve a lot in a short period of time.

We need to remind patients, as well as ourselves, to start small and build on the achievements that are made at each step. We can explain to them that by doing so they can slowly build their confidence, which will go a long way in attempting to achieve bigger goals.

For example, if the patient wishes to spend more time with their family, you may wish to break this activity down as shown in Table 13.

Table 13: Breaking down an activity – spending more time with family	
1	Return home from work an hour earlier.
2	Sit and read a newspaper in the same room where their husband or wife and children are playing.
3	Watch them while they play.
4	Participate in play with them.

Schedule the activity

Help the patient choose a specific time to do the activity. It may not be possible to schedule all the activities, but when possible, help the patient identify the:

- Duration (when and how long),
- Intensity (how much) of the activity that they are scheduled to perform.

For example, if a patient wants to focus on doing housework such as cooking, it may be helpful to plan when they are going to do the activity (in the morning/evening), for how long (e.g. for 20 minutes or 40 minutes), and how much should be done (prepare one or two items of food).

Troubleshooting difficulties in doing an activity

Finally, it is extremely important to identify possible difficulties preventing the completion of activities. Help the patient understand that they may not accomplish all of the activity, despite their best efforts, because barriers may get in the way. Thinking ahead of the problems, and planning for how to overcome them, is an important part of developing effective action plans.

SPECIAL TASK 5: Solving problems

As you work with a patient to better understand their mood and identify helpful activities to perform, you will also encounter problems which the patient may be encountering. Patients with depression often report difficult life problems that triggered, or are maintaining, their depression. The problems may be in the form of financial difficulties, relationship issues, health concerns, or even difficulty in doing routine everyday activities – such as reaching the office on time.

Patients may also talk about multiple problems that they are facing in their lives. The patient's experience of these problems is often closely linked to their symptoms. Thus, problem solving is an important form of activation for many patients.

It is useful to start problem solving once you have a fair understanding of the problems and the activation has begun. However, if the patient is overwhelmed with their problems, it may be necessary to address the problems directly before the patient focuses on increasing pleasurable activities. Where possible and appropriate, involve their treatment supporter in this process.

If your patient expresses current violence, assault or abuse, refer to the box on page 28. This is very important and must be managed immediately. This 6-step approach does not apply to serious social issues such as this.

6-step approach

HAP uses a 6-step process to help the patient solve problems (Table 14). This can be used across a range of activities to address multiple problems. Some of the issues that patients face cannot be changed easily (such as financial problems or a natural calamity). However, their reactions to these events, and the way they cope with them, can often be addressed using problem solving in a stepwise manner.

Table 14: 6-step approach to problem solving

1. Problem definition	• define problems clearly, • be specific.
2. Solution generation	• develop a list of solutions, • state solutions in behavioural terms.
3. Choose the best solution	• discuss advantages and disadvantages of each solution, • choose solution that promises the best result.
4. Apply the solution	• practise applying the solution, • apply the solution.
5. Evaluate the solution	• use a time limit to test the solution, • assess the outcome.
6. Review the outcome	• CONGRATULATIONS if the solution works; • if it does not work, return to Step 2.

Although you may not follow each step strictly in each session, these general steps guide the counsellor in helping the patient to take an active, problem solving approach to challenges in their life.

> “ *'It seems like some of the problems you are dealing with are making you feel overwhelmed and preventing you from doing the activities that you enjoy. Is that correct?'* We can then add*, 'Let us discuss some of the problems and see how we can work together to help you solve these'.* ”

In addition to helping patients solve the current problem/s in their lives, it may be helpful to teach them these steps so that they can use them for problems that may arise in the future. You may say:

> “ *Can we go over the steps we have followed to help you with your problem of feeling sad and low (or stressed about money, etc.)? We first defined the actual problem you can work on (i.e. financial pressures), we then discussed a list of solutions, thought about the advantages and disadvantages of these solutions, identified the most promising one (i.e. looking at the monthly* ”

budget and assessing if you can save on unnecessary expenses), and developed an action plan (i.e. keeping a diary of daily expenses), which you will try out in the coming days.

This teaches the patient a new skill which they can use when faced with problems in the future.

Common problems and solutions

Sometimes, the patient's problems may be difficult and you may find it challenging to generate a list of solutions. Table 15 (on the next page) provides a list of some common problems that your patients might struggle with, along with some possible solutions.

Agree homework

Homework during Phase 2b will focus on encouraging the patient to practise doing activities that make them feel good and/or doing activities related to solving problems. You develop the specific homework collaboratively, based on an assessment of the links between activities and mood, and of the problems the patient is facing currently.

If the patient has decided to use it, make use of the activity plan to support this process. Although it is helpful if the patient can complete it independently, it can otherwise be done in the session. You can also measure the degree of activation by listing out the activity/activities and asking the patient to share feedback on the extent to which the activity/activities were performed.

It is important to plan for problems or barriers that may get in the way of the patient doing the activity. It is useful to help the patient understand the fact that they may not accomplish all of the activity despite their best efforts, because barriers may get in the way.

Close the session

Follow the same process used before:

- **Summarise the consultation** with the patient.
- **Set the next session date.** If this is the last session of Phase 2, it is important to remind the patient that the next session will be the last session of the treatment. This may make some patients worried about how they will cope without counselling – you need to reassure them by pointing out how they have learnt to deal with their problems through the counselling process.
- **Complete documentation.**

Table 15: Examples of problem solving for common scenarios	
Family member has drinking problem	• Encourage the family member to seek treatment. • Give the patient a leaflet about hazardous drinking that they can share with their family member. • Persons close to the family member, and whom they trust/respect, can encourage and support them to stop drinking. • See also **Mental Health Desk Guide** page 26
Husband is physically abusive towards the patient	• If the patient consents, discuss with a social worker/welfare, mental health nurse, gender-based violence service and/or the police. See box on page 28. • If you think the patient's (or another person's) life is in danger, call the police immediately. Remind them that violence is illegal • Discuss safety measures. • Assess whether they have a friend they can share this information with
Patient does not have a job	• Explore options of job opportunities – like ads for vacancies. • Ask friends and family to explore their network. • Share information about government employment schemes.
Illness in the family	• Encourage the family to seek the right treatment. • Refer to a specialist/agency/hospital • Seek support oneself to deal with the burden of care.
Relationship difficulties	• Identify ways of communicating better. • Ask the person close to the patient to come for a session. • Involve a third person who can help the patient.
Financial difficulties	• Look for better job opportunities. • Explore ways of saving, seek help from friends/family.
A person in the family with special needs	• Seek professional help to support the person with special needs. • Gather information and enhance skills to care for the person with special needs. • Seek support oneself to deal with the burden of care • Consider seeking consent to discuss with social welfare or home-based care
Difficulty in coping with work stress	• Learn effective ways to cope with stress, such as taking short breaks and improving time management. • Enhance skills that will help with work performance. • Advise to seek support from seniors/co-workers.
Living away from home and family	• Maintain regular communication with the family. • Create a support network of friends. • Join community activities.
Elderly patients with no family support	• Explore possibility of building a support network. • Provide information about government schemes, refer to agency.

Chapter 8: Ending well (Phase 3)

The last phase can occur at any point after session 4. You can end treatment if both of the following criteria are fulfilled:

- **The last two PHQ-9 scores have been 9 or less.**
- **The goals of treatment have been met.** (For example, the patient is active, the patient has begun to take steps to solve problems etc. as agreed upon by the patient, the counsellor, and the supervisor.) Counsellors are expected to discuss patients with their supervisor before completing treatment.

“Ending well” aims at identifying potential triggers that may increase the risk of having another depressive episode in the future and effectively addressing these by reviewing what has helped during counselling; it also includes considering how such actions can continue to be taken in the future. The main components are summarised in Table 16.

If a patient remains unwell at the end of eight sessions, refer them to a doctor for consideration of antidepressant medication.

Table 16: Ending well – Overview of Phase 3	
Duration	05 - 1 session
Goals	• Help the patient review the HAP model in general, together with specific actions that support the patient’s mood. • Help patient identify possible challenging future situations. • Help patients make a plan to deal with such situations using the skills they have learnt. • Ensure the Patient Held Record Card front cover is filled in, so that patients can refer to this if they feel low in the future.
Actions	1. Open the session. 2. Set an agenda. 3. Review homework. 4. Special task 6: Review new skills. 5. Special task 7: Prepare to stay well. 6. Close the session.

Open the session

In addition to the approach outlined previously, ensure that the patient and their treatment supporter (if present) understand that this is the final session of treatment.

Review progress

As this may be the last session, you **must** complete the PHQ-9 tool. Interpret this as previously and outlined in Table 4 on page 20. If the score is 15 or over, refer to a doctor. If questions 9 is positive, you must **refer urgently to a doctor.** If a patient continues to score 10 or over after **8 sessions**, this indicates persistent depression and that they are not improving sufficiently and should be referred to a doctor. We advise you do not offer more than 8 sessions to each patient.

Ask about any significant events since the previous sessions – both positive and negative. These may inform later discussions about how to choose activation targets.

Set an agenda

Work with the patient to make a list of items that you would like to cover in the session such as:

1. Asking about the homework– i.e. activation, solving problems.
2. Reviewing what skills the patient has learnt and activities that can make them feel better.
3. Review the activities you and the patient documented on the front of their Patient Record Card. Did they manage to do or avoid these activities? Be kind and non-judgmental.
4. Summarising steps to help support the patient in staying well over time.

Review homework

For the final time, review any homework set at the previous session. This will include a focus on maintaining specific activities as part of their schedule, agreed during previous sessions.

SPECIAL TASK 6: Review new skills

It is important to review and consolidate learning from the process to support the patient's ongoing recovery. The following points should be covered:

1. **Review what the patient has learned from the sessions.**
2. **Highlight specific actions that the patient has used to overcome depression.**
3. **Emphasise the patient's role in getting better.**
4. **Motivate the patient to use their new strategies in other settings.**

Review what the patient has learned from the sessions

Ask the patient to identify key learning points from the HAP counselling process. For example:

> *"As this is our last session, I would like to know from you what it is that you have learnt from these sessions that we have had together? Can you tell me in your own words what are the most important things you have learned?"*

Highlight specific actions that the patient has used to overcome depression

It is very useful for you to highlight specific actions that the patient used to overcome depression that may not be clear in the patient's memory. For example:

> *"When you felt down, we noticed that taking a walk in the morning was very helpful for your mood. Do you agree?"*

Emphasise the patient's role in getting better

The patient may fail to recognise the efforts they have made. It is important to remind them of this:

> *"You have made a lot of effort towards recovering from your stress. Despite feeling like you didn't want to get out of bed in the morning, you gradually managed to not only wake up early but also to do all you needed to prepare your children for school. One of the ways you did this was by starting with a single step (waking up every day) and then building on that with harder steps (like making breakfast). You also asked your sister to help you with some of the household tasks until you felt well enough to do these yourself."*

Motivate the patient to use their new strategies in other settings

A patient may often believe that skills learnt to solve a particular problem may apply to that problem only. In such a case, it can be helpful to encourage the patient to identify and apply the skills across different situations. For example, a patient who has learnt to help solve quarrels with a spouse may be encouraged to use these in other contexts, such as interactions with colleagues in the workplace.

> *"Do you recall how you approached your friend for help in dealing with the problems you were facing with your wife? Talking with him was very helpful to you in feeling encouraged and in practising how to make your wishes known to your wife. Do you think that taking this same action could be helpful in dealing with your current problem of how to tell your boss that you need some time off work to attend to family matters?"*

SPECIAL TASK 7: Preparing to stay well

Work with the patient to agree a plan which will help them to stay well in the future. Try to involve the treatment supporter in this process if possible. This should involve completing the End of Treatment form, which can be handed to the patient at the end of the HAP treatment course and used as an asset to maintain the positive activities made to improve mental health.

Ensure documentation on their Patient Held Record Card

Ensure the activities and actions that helped the patient get better, and those that made the patient feel worse are documented on the front of their Record Card. Encourage the patient to review these if they feel down again, and consider how these activities make them feel. Encourage them to think about focussing on those that make them feel better, and reducing those that make them feel worse. Remind them to employ the lessons they have learnt through HAP counselling.

Close the session

It is important for you to summarise the patient's efforts during the counselling, thank them for their participation and ask about any remaining questions or concerns. **Remind them how to seek help in future should their symptoms worsen again**

Chapter 9: Useful strategies for specific problems

HAP is a practical form of counselling with a focus on solving problems and improving behaviours. As such, it is useful for a counsellor to have a number of simple strategies which they can employ to support patients presenting with some of the most common problems/scenarios which can act as a barrier to making progress in treatment, including:

- Thinking too much.
- Feeling anxious or tense.
- Interpersonal problems.
- Sleep difficulties.
- Drug and alcohol problems.
- Grief.
- History of rape.

Thinking too much

People suffering from depression often focus on thinking about themselves and how they feel, the condition in which they find themselves, and the reasons for their struggles. Often patients describe this experience – repeating thoughts about these topics over and over again in their mind – as *thinking too much*. Thinking is certainly not always a negative thing, and do no discourage the patient from thinking as this is a very important aspect of life. Thinking *too much* about negative things, especially repetitive negative or fearful thoughts, however, can be difficult for the patient.

The problem of thinking too much can make it hard for some patients to do activities. At times, their main activity might be just that – thinking too much. Others do activities but they report that they do not feel any better. When you ask more about their activities, you learn that they were thinking too much while engaged in activity.

How can you help patients who are caught in thinking too much? You can use activities to decrease it. This is a process that requires time and effort both from the patient and you.

1. Identify and highlight the effects of thinking too much:

Thinking too much may be such an automatic behaviour that patients may engage in it without awareness of its impact. You can help patients see the effects of thinking too much on how they feel. You may say,

> *“Lindiwe, when you are in bed thinking again and again about the pains in your back and the demands at your job, how do you feel? What about when you get up to prepare dinner for the family? Do you feel more or less tired?”*

In these ways, you can begin to help patients understand the impact of thinking too much on how they feel.

Patients may also believe that thinking too much is helpful in overcoming their problems. You can help patients see the effects of thinking too much about the problems in their lives. You may say,

> *“Lindiwe, we have talked about how you stay on your own and think again and again about your husband. It does not appear that this is helping you to solve the problems you and he face. Would you agree with that? I know it is hard to change the habit of thinking too much, but one of the first steps is noticing that it does not often solve your problems – even though it seems like it will.”*

It may be important to help patients learn to “catch” themselves when thinking too much and notice its effects in that moment. You may say,

> *“Lindiwe, the first step in changing the problem of thinking too much is realising when it is happening. This week, I would like to suggest that you notice one time each afternoon when you are thinking too much and how you feel in that moment. Would you be willing to practise with this?”*

2. Guide the patient in alternative actions to take when they find they are thinking too much.

There are three main options in dealing with thinking too much:

Help the patient solve the problem

It is often valuable to help define the problem that the patient is thinking too much about and then outline steps towards active problem solving. For example, you may teach Lindiwe to define the problems that she thinks about over and over, and work on solving these problems in your sessions, focusing on how to talk with her husband in more useful ways, how to get support from her neighbour, and how to reduce demands at work.

Teach the patient to attend closely to sensory experience

Thinking too much automatically shifts the patient’s focus from the present moment to the mental tape that is going on in their mind. You can teach the patient to refocus attention to the present moment by attending to a specific sensory experience in the present moment – such as sounds, smells, visuals, tastes, or touch.

To teach this strategy to the patient, do the following:

1. Explain the purpose of this strategy: “*We will be learning some homework today that can be helpful when thinking too much is a problem. It is a way for you to practise keeping your mind focused in the present moment by directing your attention to what you feel, see, smell, hear, etc.*”
2. Ask the patient to focus on one sensation as you guide them in practising the strategy. For example, you may ask the patient to focus on the room in which you are sitting, and to describe all of the colours that they see in the room.
3. Ask the patient about what they experienced and answer any questions or clear any confusion.
4. Ask patients to practise at home by developing a plan for when and for how long they will practise. The time and place can be linked to the settings in which the patient is most likely to be thinking too much, but it can also be helpful if the patient starts to practise at less challenging times, in order to build their basic skill. Also, remember to ask about what might get in the way of practising, and solutions that might help.

Distraction

Distracting oneself from thinking too much helps shift the focus to something new or different in the environment. This helps to distract the patient's attention from thinking too much. Some helpful activities to explore with the patient include: physical activities (brisk walking, fast-paced household chores), activities that shift location (visit a neighbour, walk outside), activities that are engaging (watching a funny movie, talking with someone who is close).

It is possible to plan in advance for such activities by identifying the context in which patients commonly think too much.

Many patients report using distraction activities at some point during their days. Your role in the session would then focus on guiding them to use this strategy as an alternative to thinking too much.

Feeling anxious or tense

Many patients with depression report feeling anxious, tense, or stressed, or that they have difficulty relaxing. These experiences are common among people who are depressed. Sometimes people experience a lot of tension as they begin to get active. Excessive stress or worry can be a barrier to getting active and reaching out to others in one's life.

Different people find different techniques useful for coping with anxious/tense feelings on a daily basis. Some people report benefits from regular meditation, some find benefits from prayer, and so forth. It is helpful to review in detail what coping methods have been useful for them in the past during stressful times. One strategy that can help patients overcome this barrier is to practise specific relaxation strategies.

In this chapter you will focus on a type of relaxation training that involves deep breathing.

Your role is to teach the practice of deep breathing during the session, correct any mistakes that the patient may be making while doing the breathing exercise, assign deep breathing for homework, and review the patient's home experience during the next session, again providing feedback as needed.

It is important to note, however, that some types of anxiety require additional intervention and are not likely to be helped only by teaching relaxation. If the patient's anxiety is severe and persistent, or occurs in brief sudden episodes, then it is important to refer the patient to a specialist for further management.

1. Assess the need for relaxation training

To determine if relaxation training would be helpful, you can ask these questions:

- *How long have you been experiencing these symptoms* (such as: bodily tension, palpitations, etc*.)? How much trouble do they give you?*
- *When and where do these symptoms become most severe* (in the morning/evening; at the office)?
- *What did you do to deal with these problems earlier? How helpful were these methods?*
- *Are you interested in learning a new method that focuses on breathing?*

Answers to these questions will help you structure and schedule the breathing exercise in the patient's routine.

2. Teach the breathing exercise

- Guide the patient through each step during the session.
- Let the patient continue the breathing exercise in silence for about three to five minutes.
- Ask the patient about what they experienced in order to identify questions, problems, or confusion. If necessary, you should guide the patient in the practice again.
- Once the patient has learned the exercise in the session, you should assign it for regular home exercise. While doing this, you can discuss with the patient, the duration, frequency, place, and possible difficulties in doing the exercise.

3. Posture for the exercise:

- There is no special position; any position that the patient finds comfortable is the right one. The patient can therefore sit or lie down (if there is space in the room).
- Give the patient a choice of doing the exercise either with eyes open or shut.
- Generally, the exercise is practised with the eyes closed, but some patients may feel uncomfortable and can leave their eyes open.

4. Breathing:

- After about ten seconds, the patient should start concentrating their mind on the rhythm of their breathing. Tell them to concentrate on breathing slow, regular, steady breaths through the nose.
- If a patient asks how “slow” the rhythm should be, you can suggest that they should breathe in until they have counted slowly to three, breathe out to the count of three, and then pause for the count of three till they breathe in again.
- As the exercise progresses, the rhythm can be slowed even further, according to the comfort level of the patient.
- You can suggest that each time the patient breathes out, they could say in their mind, “relax” or an equivalent thought in the local language. Patients who are religious can use a word that has some importance to their faith e.g. a Christian may say “Praise the Lord”.
- Continue the breathing for at least ten minutes, until the anxiety has reduced.
- If a patient complains of palpitation, tingling/numbness in fingers or mouth, chest pain, or any other physical discomfort during the exercise, it may mean that they are breathing too fast; slow down the rhythm to one that they find more comfortable.

Interpersonal problems

One source of tension for many patients with depression is the challenge of communicating effectively with other people in their lives. Some depressed patients have difficulty asking other people for help and this makes them feel isolated or overwhelmed by their problems. Others have difficulty saying no to other people’s demands or requests and thus find themselves doing things they do not want to do, feeling pressured, or overwhelmed.

If a patient lacks the skills in communicating effectively with others, one activity to practise at home is communicating with close family or friends. You can teach the patient the steps in the session and then ask if they are willing to practise at home. There are four steps:

1. Problem solve

The first step is helping the patient to identify clearly what they want or do not want. Thus, the patient who is feeling hopeless about a conflict with her daughter may be encouraged to identify what she would like from her daughter (e.g., wanting her to visit more often).

2. Communicate

The second step is teaching the patient how to communicate this clearly and effectively. This can be done by remembering the acronym "DEAR":

- **D**escribe the situation briefly – what is happening? Example: "*You have been arguing so much lately about how rarely you come to see me*".
- **E**xpress feelings about the situation – don't expect the other person to read your mind. Example: "*I feel very unhappy about our quarrels and am also worried that our relationship will just keep getting worse*".
- **A**ssert – Ask for what you want (or don't want) clearly. Example: "*I want you to come and have lunch with me every Sunday*".
- **R**einforce – encourage the other person to support you. Example: "*This will make a big difference to how I feel. It would give me a chance to speak to you about what is bothering me and make me feel less lonely*".

In order for DEAR to be effective, the following tips may be useful to improve the patient's communication skills:

- Focus on the current quarrel and don't talk about all the mistakes the other person has made in the past.
- Separate the other person from their behaviour. Using the words "*Your words were very hurtful"* leads to more constructive discussion than using the words "*You are an unkind person*".
- Acknowledge the other party's expectations. They could say: "*I know you feel like I am not paying attention to you*".
- Use "I" statements about how the patient feels and what they want. For example, you could say "*I feel angry when you behave like this*" rather than "*You make me angry*".
- Avoid using words such as "always" and "never". For example "*you never listen to me*" or "*you always shout when things don't go your way*".

3. Practise

The third step is creating opportunities to practise these skills in action. You can do this in the session using role play. For example, saying, *"I will be your daughter, OK? I'm calling you on the phone now. Hello mother, I can't visit you this weekend. We're really busy. Maybe I will come next weekend, OK?"* The patient is then asked to respond in the way described above. If the patient doesn't respond, she may require more coaching. *"So what if you were to say..."* and then continue the role play with the patient so they have an opportunity to practise saying those words.

4. Schedule a session with the person concerned

Ask the patient to find a good time to talk, when the other person is more receptive to the conversation. It is easier to practise if neither person is angry or upset or in a hurry. Also, if the patient prefers, a session can be scheduled where the person concerned is invited to join and the patient is encouraged to communicate on the basis of the above steps. The patient may feel more confident and supported while in the session, and you can assist as the need arises. It is also possible to discuss finding

another helper if they cannot communicate directly with the other person. This can be someone both of them have trust and respect for.

Sleep difficulties

Many patients with depression will have poor sleep. This may take many forms:

- Inability to fall asleep leading to lying awake in bed for hours at night.
- Frequently waking up during the night, and being unable to sleep again.
- Waking up much earlier than one's usual time and being unable to fall asleep again.

Inadequate sleep leads to the patient feeling even more tired, can interfere with activities, and further worsen the mood.

There are simple methods the patient can use in order to sleep better. You can advise the patient to:

- Keep to regular hours for going to bed and waking up. If the patient sleeps at 10:00 in the night and wake up at 6:00 in the morning, they must try to keep to the same timing every day.
- Avoid daytime naps.
- Avoid using sleeping tablets or alcohol to fall asleep.
- Avoid tea or coffee after 5 p.m.
- Finish any toilet needs just before sleeping.

If the patient cannot fall asleep easily, they must not lie in bed. The patient should get out of bed; try out some activity (e.g. walking, reading a book/religious book or newspaper, listening to some pleasant music, etc.) and then try to sleep later when feeling really sleepy.

If thinking too much is interfering with sleep, then follow the steps described above. Similarly, if feeling fearful, or worrying, is the reason for poor sleep, practising the breathing exercise when going to bed will help.

Grief

Many patients responded to loss in different ways. Conventionally the focus is on emotional responses, but grief affects people in the following ways:

- physical;
- cognitive;
- behavioural;
- social;
- cultural.

If a patient suffers from grief, they feel emotional suffering because someone has been taken away. Individuals grieve in connection with a variety of losses throughout their lives, such as:

- unemployment;
- ill health;
- the end of a relationship.

The counsellor should help the patient to go through the five stages of Grief as indicated by Kubler-Ross (see the **Mental Health Desk Guide** page 28).

Drug and alcohol problems

These should be managed in accordance with the guidance on page 49 of the **Mental Health Desk Guide**.

Rape

Disclosure of rape during a counselling session should be managed in accordance with the guidance on page 49 of the **Mental Health Desk Guide**. See also the box on ‘Trauma and Adverse Childhood Experiences’ on page 28.

Appendix 1: Summary of helpful documents

This page provides a summary of the documents that have been provided to support your clinic delivering HAP. This includes which languages they are available in and details of when and how to use them. It can also be used to audit supplies within a clinic or department. Before supplies run low, consider how you will be able to re-stock your clinic with these resources. Contact your HAP mentor or gshpublichealth@gmail.com or Lubombo.hru@gmail.com for soft copies of the resources.

Document	English	SiSwati	Details
Depression patient information leaflet	✓	✓	From the National Psychiatric Referral Hospital. Can be provided to patients following initial diagnosis or during Phase 1.
Suicide patient information leaflet	✓	✓	From the National Psychiatric Referral Hospital. Can be provided to patients following initial diagnosis or during Phase 1.
Healthy Activities Poster	✓	✓	This should be put on your clinic wall or shown to patients when discussing Healthy Activities
HAP Structure Poster	✓	✘	This should be put on your clinic wall or kept somewhere where you can refer to it to prompt your memory
Patient record card	✓	✘	Give this to the patient after diagnosis. Review self-help content with them and ensure understanding. Use the healthy activities in the central part to discuss with the patients. In appendix 5.
Clinic record card	✓	✘	Complete this after each appointment and file in register. Use continuation card if needed. In appendix 5.
PHQ-9 form	✓	✓	Screening tool. Can be completed by the patient or administered by a trained staff member. In appendix 5.
Activity Calendar	✓	✓	Useful to help the patient structure their health activities. In appendix 5.
Activity Plan	✓	✓	Useful to help the patient plan their health activities. In appendix 5.

Appendix 2: Dealing with difficult scenarios

If you are unsure what to do in a difficult situation, discuss this with your HAP mentor, who should be a trained mental health nurse in your regional hospital. See page 25 on mentoring/supervision.

Problem	Possible solution
Patient expects financial assistance	Inform patient that you work together to identify how financial support can be generated. Emphasise that your role is to offer counselling support.
Patient talking too much and not letting the counsellor speak	Set the agenda after introduction and explaining confidentiality, so that the patient is reassured that they will get a chance to share.
Patient crying excessively during the session	Allow space for the patient to express their feelings. Do not interrupt or ask too many questions. Provide minimal encouragement and offer a glass of water.
Patient talks about distress/worry related to sexual problems	Be comfortable and objective. Discuss with supervisor and role play in order to learn how to respond to such issues
Patient is grieving over the loss of a loved one	Allow space for the patient to talk. Help the patient understand that grieving is a natural response to loss. Then encourage the patient to return to the agenda and complete all sessions. See Mental Health Desk Guide page 28
Patient worried about confidentiality	Reassure the patient about privacy during session and confidentiality. Remind the patient you will only refer or discuss their case with their consent
Patient is angry or agitated	Allow the patient to express their feelings. Reflect and suggest that the issues can be discussed in a planned way in the session.
Patient accompanied by small child/children	Suggest that the child/children engage in an activity like drawing that will engage them and allow for a session with fewer interruptions.
Patient is not engaged with the treatment	Focus on the emotions and use skills like reflection. Allow the patient time and space to share thoughts. Encourage the patient to talk about their concerns and address these.
Counsellor identifies symptoms of other mental health conditions	These should be dealt with by reference to the Mental Health Desk Guide which will advise on necessary treatment (e.g. immediate review by a doctor). If you are unsure, discuss with your HAP mentor.
Patient does not recover at end of 8 sessions	Refer the patient to the doctor. Discuss this patient with your HAP mentor.
If a patient who has dropped out returns	Offer counselling and continue from the last session.
A discharged patient returns seeking help	Encourage them to consult the doctor for their difficulties or refer to a local mental health nurse or psychologist. No further session is offered.

Appendix 3: HAP Summary

This page provides a summary of:

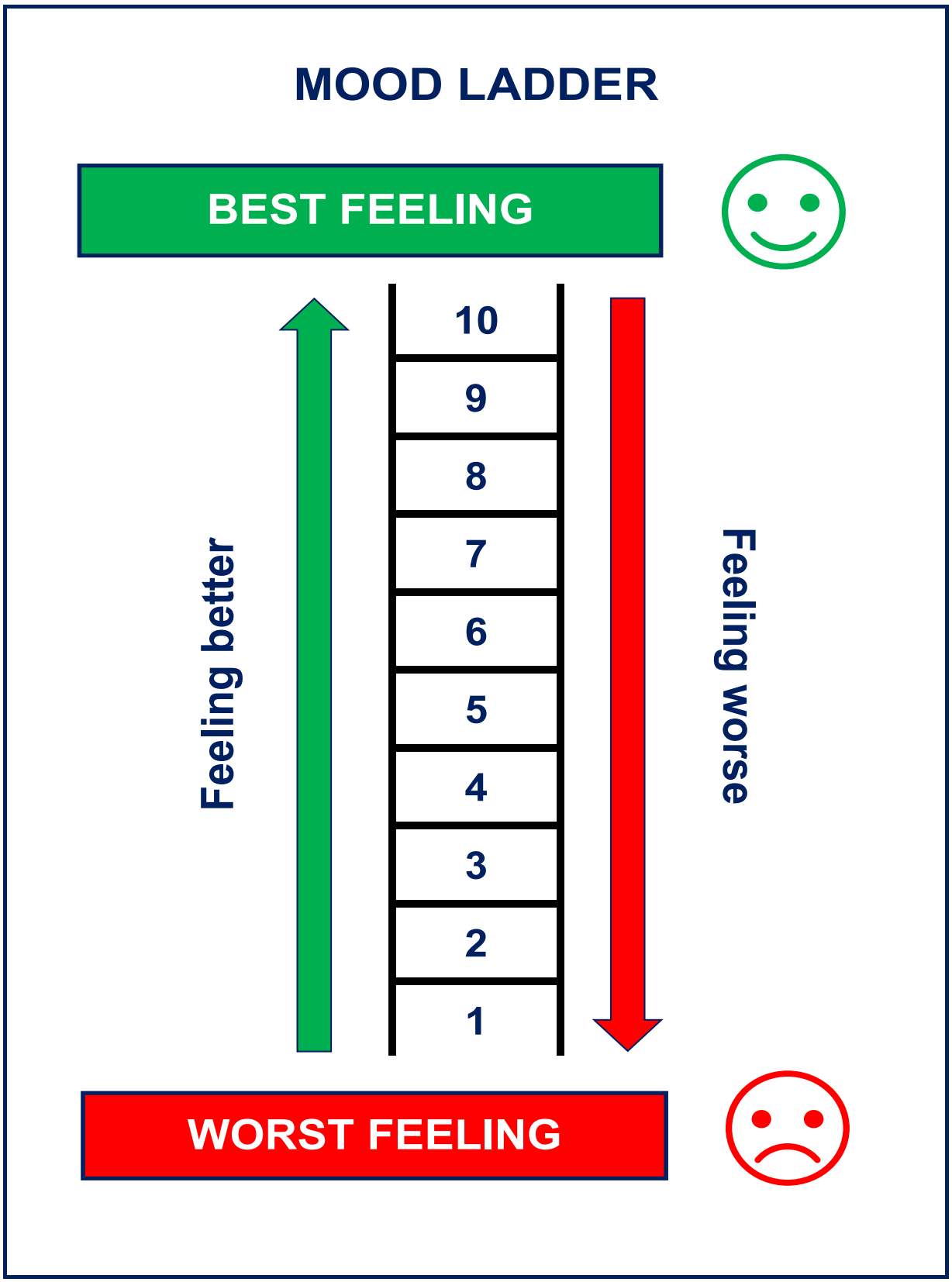
- How to structure any individual HAP session using the 6-step approach.
- How to structure a course of HAP treatment (including special tasks required at each stage).

It can be used as a quick reference by HAP counsellors.

General structure of individual HAP sessions	
1. **Open the session**	Introductions. Review progress and assess suicide risk. Involve the treatment supporter.
2. **Set the agenda**	Agree in collaboration with patient.
3. **Review homework**	As agreed in previous session.
4. **Complete special tasks**	Phase-specific: See below.
5. **Agree homework**	Examples include: • complete activity calendar, • complete activity plan, • practise activation.
6. **Close the session**	Summarise. Set the next session date. Complete documentation.

Overall HAP course structure (5 – 8 sessions in total)		
Phase 1 Getting started	**Duration**	0-5 - 2 sessions.
	Goals	Engage and establish an effective counselling relationship (rapport), help clients understand HAP. Obtain commitment for counselling.
	Special tasks	1: Get to know your patient (page 28). 2: Elicit commitment for counselling (page 30).
Phase 2	**Duration**	2 - 6 sessions.
	Goals	Judge activation targets and encouraging activation. Identify barriers and how to overcome them. Help patients solve or cope with life problems.
	Special tasks	3: Encourage activation (page 34).
		4: Getting active (page 39). 5: Solving problems (page 40).
Phase 3	**Duration**	0.5 - 1 session.
	Goals	Review and strengthen gains the patient has made to prevent relapse.
	Special tasks	6: Review new skills (page 45). 7: Preparing to stay well (page 46).

Appendix 4: Mood Ladder



Appendix 5: Helpful Documents to copy/photocopy

If you would like soft copies of these documents to print, please contact your HAP mentor or gshpublichealth@gmail.com or lubombo.hru@gmail.com

Contents:

Activity Calendar

Activity Plan

Clinic Record Card (Print double-sided – pages 64 and 65)

Patient Held Record Card (Print double-sided – pages 62 and 63)

PHQ-9

ACTIVITY CALENDAR[5] NAME:_____ DATE:_____

TIME OF DAY	MONDAY		TUESDAY		WEDNESDAY		THURSDAY	
	What did you do?	Score (1-10)	What did you do?	Score (1-10)	What did you do?	Score (1-10)	What did you do?	Score (1-10)
Morning								
Afternoon								
Evening/ Night								

How to fill this form:

For each part of the day, record your activities.

Rate how you felt when you did each activity using a number between 1-10.

1 means the worst possible feeling and 10 means the best possible feeling.

TIME OF DAY	FRIDAY		SATURDAY		SUNDAY	
	What did you do?	Score (1-10)	What did you do?	Score (1-10)	What did you do?	Score (1-10)
Morning						
Afternoon						
Evening/ Night						

[5] Adapted from resources originally created by Sangath for the PREMIUM Health Activity Program

ACTIVITY PLAN[6]

NAME:_____ **DATE:**_____

How to complete this form:

This is a list of activities that you and your counsellor agreed you would do this week. For each day place a check mark (✓) if you did the activity or x mark (✖) if you did not do the activity. Rate how you felt when you did this activity using a number between 1-10, with 1 meaning the worst possible feeling and 10 meaning the best possible feeling.

ACTIVITY	MON		TUES		WED		THURS		FRI		SAT		SUN	
	Did you do it? ✓or ✖	Score (1-10)	Did you do it? ✓or ✖	Score (1-10)	Did you do it? ✓or ✖	Score (1-10)	Did you do it? ✓or ✖	Score (1-10)	Did you do it? ✓or ✖	Score (1-10)	Did you do it? ✓or ✖	Score (1-10)	Did you do it? ✓or ✖	Score (1-10)
Activity 1 _____														
Activity 2 _____														
Activity 3 _____														
Activity 4 _____														
Activity 5 _____														

[6] Adapted from resources originally created by Sangath for the PREMIUM Health Activity Program

Health Activity Program - Clinic Record Card – to be kept in patient notes

Facility name		Counsellor name		Patient name	

Age	Sex	DOB	Physical Address	Telephone number	Treatment supporter (TS): Name/telephone number

This information may be useful to record, as it may affect how you deliver counselling.

Occupation	Household size	Education level	Marital status	Alcohol (Y/N – if Y then average weekly amount)	Smoking status (Y/N – if Y then average daily amount)

Diagnosis (tick all that apply)							Previous mental health care
Depression	Anxiety	Epilepsy	TB-drug sensitive	TB-drug resistant	HIV	Other (please state)	

This information needs to be recorded to monitor progress and document the sessions.

Date: _____	Session number		Next appt		Notes (including agreed homework)	
	PHQ-9 score		Homework done (Y/N)			
	Referrals made					
	Medication					

Date: _____	Session number		Next appt		Notes (including agreed homework)	
	PHQ-9 score (if done)		Homework done (Y/N)			
	Referrals made					
	Medication					

Date: ____________	Session number		Next appt		Notes (including agreed homework)	
	PHQ-9 score (if done)		Homework done (Y/N)			
	Referrals made					
	Medication					

Date: ____________	Session number		Next appt		Notes (including agreed homework)	
	PHQ-9 score (if done)		Homework done (Y/N)			
	Referrals made					
	Medication					

Date: ____________	Session number		Next appt		Notes (including agreed homework)	
	PHQ-9 score (if done)		Homework done (Y/N)			
	Referrals made					
	Medication					

Continue on new patient record card if necessary

Date Attended	Action Plan	Next Session

Patient Held Record Card

Healthy Activity Program

Patient Name	
Clinic or Hospital Name	
Telephone	

Activities that help:

Activities that don't help:

HEALTHY ACTIVITIES

Take regular exercise

Shukumisa umtimba njalo njalo

Spend time socialising with friends

Citsa sikhatsi uhlanganyela ne-bangani

Have a regular sleeping habit

Tetayete kuphumula ngalokwenele

Avoid drugs and alcohol

Gwema tjwala netidzakamiva

IMISEBENTI LENEMPILO

Make time for spiritual health

Tinikete sikhatsi ngempilo yakho yakamoya

Have healthy eating habits

Kudla lokunemphilo

Share your feelings with a friend

Cocisana nebantu lobatsembako ngetindzaba takho

Seek help if you feel worse

Funa lusito um utiva ungalungi

LUHLA LWEMIBUTO NGEMPHILO YAKHO

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Kulamaviki lamabili lendlulile, ukhatsateke kanganani nganati tinkinga letilandzelako:

	Sebentisa nalu luphawu √ kuphendvula			
	Akukake kwenteka	**Emalanga lambalwa**	**Lokungetulu kweliviki (7 days)**	**Cishe onkhe emalanga**
1. Kuncipha kwemdlandla/inshisekelo ekwenteni tintfo letikuchazako/letikujabulisako	0	1	2	3
2. Kutiva uphansi emoyeni, ukhatsatekile noma ute litsemba	0	1	2	3
3. Kungakhoni kulala noma kulala kakhulu	0	1	2	3
4. Kutiva udziniwe noma uphelelwa ngemandla	0	1	2	3
5. Kungakhanuki kudla (inhlitiyo imnyama) noma kudla kakhulu	0	1	2	3
6. Kuva utisola/utenyanya noma usehluleki noma utentele phansi noma wentele phansi umndeni wakho	0	1	2	3
7. Kuba nebulukhuni / kulandzelela etintfweni lotentako njenge kufundza liphepha ndzaba	0	1	2	3
8. Kukhuluma wedwa noma wehle wenyuka ungati kutsi wentani	0	1	2	3
9. Kuba nemicabango yekutsi kuncono kufa, noma ucabange kutilimata.	0	1	2	3
	Balalokungenhla			
	SEKUKONKHE			

Was the patient referred to a Doctor? Refer if **initial** PHQ-9 = 20+ *or* if **subsequent** PHQ-9 = 15+ *or* if Q9 is positive (i.e. scoring 1,2 or 3)	**YES**	
	NO	

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?:

	Circle the correct answer			
	Not at all	**Several days**	**More than half the days**	**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 are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper?	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
	Add columns			
	TOTAL SCORE			

Was the patient referred to a Doctor? Refer if **initial** PHQ-9 = 20+ *or* if **subsequent** PHQ-9 = 15+ *or* if Q9 is positive (i.e. scoring 1,2 or 3)	**YES**	
	NO	

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