Adapting a Lay Counselor Mental Health Intervention for Adolescents in Botswana

Aims When implementing interventions for adolescents, specific adolescent friendly adaptation from adult interventions is vital. The Friendship Bench is a lay counselor community therapy model that has been shown to have high efficacy in adult populations with adult lay counselors in Zimbabwe and other communities. Our objective was to understand the overall mental health needs and necessary adaptations for lay counselor based work for adolescents in Botswana.

Methods We used theory of change activities during stakeholder meetings to discuss necessary elements of the Friendship Bench for use with adolescents. We held four group sessions with stakeholders who were youth, parents, members of youth serving non-governmental organizations, members of government, and HIV clinic clinicians, and social workers. The meetings addressed root causes of poor mental health in youth in Botswana, overall structure of mental health services, ultimate outcomes we wished to achieve with a youth mental health intervention, and action steps and assumptions necessary to implement a lay counselor intervention.

Results Root causes of mental health in youth included lack of knowledge about these issues, family problems like abuse/neglect, and poor communication, low self-esteem, rapid growth of technology, and biology/genetics. Structurally barriers included: the stigma against mental illness, lack of psychosocial support, poor follow-up for mental health services, cultural beliefs about mental illness, and fragmented mental health services available. The stakeholders seek a program that empowers adolescents and youth counselors to address mental health concerns in order to create a healthier community. The group identified several major elements of an effective lay counselor intervention including age appropriate (youth) lay counselors, broad education and screening of youth at risk, creative and fun ways of engaging and maintaining them into the intervention, flexibility with schedules, and strong lay counselors with adequate training and personal skills that support thoughtful interpersonal engagement. Lay counselor pre-training qualifications were defined and included a preference for youth with similar diagnoses, a minimum of secondary school training, age of 18 to 35 and agreement to attend mandatory counseling.

Conclusion Stakeholders from multiple segments of the community can illustrate key elements of interventions being expanded to new populations and environments.