# WORKSHOP FOR INTEGRATING MENTAL HEALTH INTO HIV SERVICES IN ZIMBABWE
## TRAINING OF TRAINERS

### TRAINER'S MANUAL

*"THERE IS NO HEALTH WITHOUT MENTAL HEALTH"*

# AIDSTAR-One
## AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

# WORKSHOP FOR INTEGRATING MENTAL HEALTH INTO HIV SERVICES IN ZIMBABWE

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# Contents

# Foreword

AIDSTAR-One is USAID's global HIV and AIDS project providing technical assistance services to the Office of HIV/AIDS and U.S. Government (USG) country teams in U.S. President's Emergency Plan for AIDS Relief (PEPFAR)-supported countries in knowledge management, technical leadership, program sustainability, strategic planning, and program implementation support. In collaboration with USAID's Care and Support and Treatment Technical Working Groups and with the Ministry of Health and Child Welfare (MOHCW) in Zimbabwe, AIDSTAR-One implemented a pilot activity to integrate mental health (MH) screening services into HIV treatment and care sites in Zimbabwe. Screening and referring for MH can improve the quality of life, treatment adherence, and retention in care and support programs for people living with HIV (PLHIV) in Zimbabwe (Gutmann and Fullem 2009). MH is a critical component of care necessary for PLHIV, and services are often limited in resource-poor settings.

The World Health Organization (WHO) reports that HIV seroprevalence among people with MH problems is significantly greater than that of the general population. In addition, approximately 75 percent of the burden of neuropsychiatric disorders is estimated to be found in persons living in low- and middle-income countries (WHO 2008a). Those suffering from MH problems and harmful alcohol and substance use are more likely to contract HIV. This is largely due to the inherent vulnerability of those living with MH problems as well as the great psychological burden that living with HIV places on the HIV-positive person. Harmful alcohol and substance use may develop as a coping mechanism to deal with this psychological burden of being HIV positive (WHO 2008a). In addition, persons suffering from MH problems are more vulnerable to exploitation, have greater difficulties advocating for safer sexual practices, and may be less likely to remain in long-term, monogamous relationships (Tegegn, Wissow, Jerene et al. 2010). Self-care, including adherence to antiretroviral therapy (ART) and other medications, optimal nutrition, sleep, exercise, and making and following through with clinic appointments, is more difficult in the presence of MH problems (WHO 2008a).

Integration of MH and HIV programs has the potential to significantly improve health outcomes for PLHIV. This training-of-trainers manual was written to support a pilot project for MH and HIV integration at the community level such that health facilities, community-based organizations (CBOs), and traditional medical practitioners (TMPs) can collaborate to support MH screening and service provision for PLHIV in Zimbabwe. The findings from this pilot project have informed a standard operating procedure (SOP) that should be used in tandem with this manual to inform HIV and MH integration. This training manual may be used as an important step to engage HIV and MH stakeholders and train health and community workers to screen for MH problems and harmful alcohol and substance use within the community. This manual encourages and plans for strong linkages at the community level to provide simple interventions and identify clear referral pathways to address MH needs, resulting in improved health and quality-of-life outcomes for those living with HIV.

# About the Workshop

## Goal of the Workshop and Workshop Manual

The goal of the *Workshop for Integrating Mental Health Services into HIV Services* is to provide health and community care providers and TMPs with basic information and a stepped therapeutic care protocol to integrate MH into HIV services and to create a system of referrals such that there is a strong system of support and linkages for MH and HIV integration. This workshop is a training-of-trainers format, such that participants who attend this workshop will be able to return to their site of employment and train fellow colleagues on MH and HIV integration.

This goal of this manual is to provide the facilitator with the necessary information to implement the workshop. In order to effectively prepare, the facilitator should refer to the "Trainer's Toolkit," which provides detailed information on the tasks to accomplish prior to the workshop. In addition, each module within this manual also contains information that will assist the facilitator to plan and implement the training in a coordinated and effective manner.

## Acronyms

| | |
|---|---|
| ART | antiretroviral therapy |
| CBO | community-based organization |
| HIV | human immunodeficiency virus |
| MH | mental health |
| MOHCW | Ministry of Health and Child Welfare |
| PLHIV | people living with HIV |
| SOP | standard operating procedure |
| SSQ | Shona Symptom Questionnaire |
| TMP | Traditional Medical Practitioner |
| WHO | World Health Organization |
| WRAP | Wellness Recovery Action Plan |

# Symbols and Colors Used in this Trainer's Manual

This manual uses symbols and color-coding to make the facilitator's job easier.

<div style="border:1px solid #4472C4; padding:20px;">

✎    This symbol alerts you to prepare a flipchart or ask participants to write.

📖    This symbol alerts you to an activity that requires use of the *Standard Operating Procedures Manual*.

❓    This symbol alerts you to a question that you should ask the participants.

🕐    This symbol shows you a suggested session activity time limit.

✋    This concludes Session 4. This symbol marks the end of each session.

🍸    Time for a Break. This symbol shows suggested points for a morning or afternoon break in the workshop schedule.

Ⓟ    This symbol refers to the "Parking Lot" flipchart, which is a sheet of paper where you record participant questions to be answered later (e.g., questions not directly related to the current session or discussions that will detract from the ongoing session's focus).

Accompanying this manual is one set of PowerPoint slides. This manual highlights ***slide numbers*** in green.

This training uses several techniques, such as group activities, group presentations, lectures/lecturettes, and small group discussions. In this manual, we highlight **activity types** in blue.

</div>

# Training Materials Components

Please make sure that as the Training Facilitator you have the three resources that together make up the set of training materials for this workshop:

1. *Workshop for Integrating Mental Health into HIV Services in Zimbabwe Training of Trainers: Trainer's Manual* (includes the Integration Leader's Training Manual).

2. Workshop PowerPoint Slides. These slides are referred to throughout this guide. (The training has been written such that PowerPoint slides are not required if materials are not available.)

3. *Standard Operating Procedures for Integration of Mental Health and HIV in Zimbabwean Communities*.

# Trainer's Toolkit

Materials:

        Name tags

        Markers

        Tape

        Flipcharts (minimum 20 sheets)

        Scissors

        Prizes for game winners

Several copies of the *Standard Operating Procedures Manual*

Laptop computer, projector and screen, and PowerPoint slides

Sufficient copies for all sites of the following materials (*found in the 'Annex 2: Training Materials' section of this manual*):

        **Integration Leader's Training Manual**, page 77

        **Interview Questionnaire**, page 109

        **Values, Thoughts, and Perceptions Worksheet**, page 111

        **Counseling Tip Sheet for Harmful Alcohol and Substance Use**, page 113

        **Motivational Interviewing**, page 115

        **Mental Health and HIV Integration Workplan**, page 117

        **Pre-Test/Post-Test**, page 123

        **Mental Health/HIV Integration Post-Training Workshop Evaluation**, page 127

# Workshop Goals and Objectives

**Goal:**
By the end of this workshop, participants will understand the principles of MH and how to integrate designated MH screening tools into the services that they currently provide. Participants will understand how to apply a stepped-care approach through creating and supporting linkages and referrals for integrated MH and HIV services between health facilities and community organizations. Participants will plan for sharing the information learned at this workshop so that they may provide instruction for their colleagues to integrate MH screenings into daily practice.

**Objectives:**
By the end of this workshop, participants will be able to:

1. Define and explain basic principles of mental health.
    a. Describe symptoms associated with various mental health problems and how they may impact HIV/AIDS outcomes.

2. Define and explain basic principles of alcohol and substance use.
    a. Describe symptoms of harmful alcohol and substance use and the potential impact on HIV/AIDS outcomes.

3. Describe and practice utilization of the Shona Symptom Questionnaire, CAGE-AID, and Abbreviated Community Screen tools.
    a. Describe the designated referral protocol for clients who have additional mental health and substance use needs.

4. Describe various therapeutic communication techniques to utilize in practice.
    a. Utilize a therapeutic communication tool for mental health problems.
    b. Utilize a therapeutic communication tool for alcohol and substance use.

5. Create a system of linkages utilizing a referral protocol for mental health integration at the community level.

6. Create a plan to train colleagues at their facility on integration activities.
    a. Practice facilitating a session on mental health integration in small groups during the workshop.

7. Carry out mental health integration in practice with supportive supervision following the workshop.

8. Provide feedback post-pilot to AIDSTAR-One on mental health and HIV integration protocols, referral protocols, and perceived impact on clients.

9. Previously trained Integration Leaders will be able to provide leadership for mental health/HIV integration within their communities.

# Suggested Workshop Schedule

**Day One**

| | |
|---|---|
| 9:00-10:15 | Welcome, Introductions, and Pre-Test |
| 10:15-10:30 | BREAK |
| 10:30-11:40 | The Basics of Mental Health |
| 11:40-12:30 | The Basics of Alcohol and Substance Use |
| 12:30-1:30 | LUNCH |
| 1:30-3:20 | Introduction to the Screening Tools and Protocol Practice |
| 3:20-3:35 | BREAK |
| 3:35-4:30 | Preparation for Facilitation Session / Breakout Community Integration Leader |
| 4:30-5:00 | Day One Wrap-Up |

**Day Two**

| | |
|---|---|
| 8:30-9:00 | Day Two Introductions |
| 9:00-10:10 | Linkages for Community Level Integration |
| 10:10-10:30 | BREAK |
| 10:30-12:00 | Therapeutic Communication Skills |
| 12:00-1:00 | LUNCH |
| 1:00-2:00 | Practice Facilitation Sessions |
| 2:00-3:00 | Logistics |
| 3:00-4:30 | Game, Q&A, Post-Test, and Closing |

# Module 1:
## The Mental Health/HIV Integration Pilot Activity

**Session Objectives:**

By the end of the session participants will:

      1. Identify other participants in the workshop

      2. Cite the goals and objectives of the workshop

      3. Decide upon and agree to group norms

      4. Find and refer to the workshop schedule

      5. Describe the structure of the pilot activity

      6. Identify potential learning needs through the pre-test.

**Time Needed:** 🕐 *Total session time is 75 minutes*

**Materials:**

- ☐ *Standard Operating Procedures Manual*, one copy for each participant
- ☐ Name tags
- ☐ Card stock paper for name tents
- ☐ Markers
- ☐ Blank flipchart for group norms
- ☐ Blank flipchart for Parking Lot
- ☐ **Interview Questionnaire**, one copy for each participant (page 109 of this manual)
- ☐ **Pre-Test/Post-Test**, one copy for each participant (page 123 of this manual)
- ☐ PowerPoint slides: Introduction to Day One (*Slides 1-10*)

**Techniques:** Group introduction, Large group brainstorm, and Short lecture

**Facilitator Notes:**

Provide the *Standard Operating Procedures Manual* as participants arrive. Prepare sufficient copies of the interview questionnaire and pre-test in advance.

*Slide 1:* Workshop Title Slide

> **Workshop for Integrating Mental Health into HIV Services in Zimbabwean Communities**
>
> *"There is no health without mental health"*
>
> **AIDSTAR-One**
>
> Produced by the AIDS Support and Technical Assistance Resources Project, Sector 1, Task Order 1 (AIDSTAR-One), USAID Contract# GHH-I-00-07-00059-00, funded January 31, 2008.
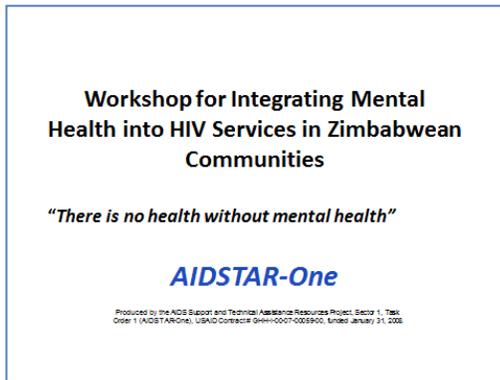
**Learning Activities:**

**1. Ice Breaker** (Partner interviews and Class introductions) – 🕐 *20 minutes*

*Slide 2:* Module 1 Title Slide

> **MODULE 1**
>
> Introductory Activities
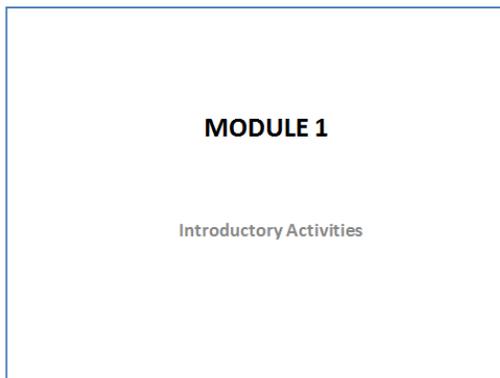
Welcome the participants.

As Integration Leaders, they will lead their site throughout the duration of this activity. It will be important to get to know each other as they will be working closely in groups throughout the day.

Request that participants pair off into groups of two, preferably with someone they do not know, and distribute an Interview Questionnaire to each participant (found on page 109 of this manual). Tell the groups that they have 🕐 *5 minutes* to talk with their partner and that each participant should take turns interviewing their partner.

After 10 minutes have passed, bring the participants together and request that each pair briefly introduce their partner to the group. Trainers should introduce themselves as well.

*Slide 3:* Objectives for Module 1

> **Objectives for Module 1**
>
> 1. Identify other participants in the workshop
> 2. Cite the goals and objectives of the workshop
> 3. Decide upon and agree to group norms
> 4. Find and refer to the workshop schedule
> 5. Describe the structure of the pilot activity
> 6. Identify potential learning needs through pre-test
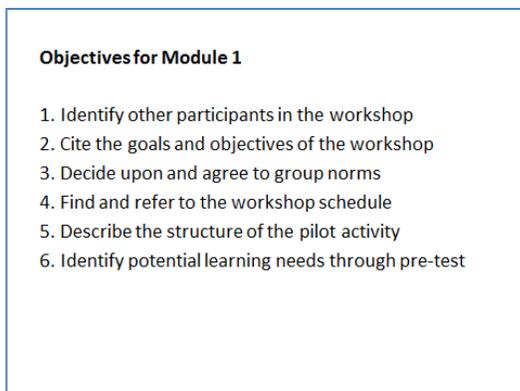
Briefly review the objectives for this module.

**2. Workshop Logistics** (Lecture) - ⏱ *5 minutes*

Take a few minutes to review the following logistics for the workshop:

- Location for tea/coffee breaks and lunch
- Location of washrooms
- Mobile phone policy.

**3. Goals, Objectives, and Schedule** (Interactive Lecturette) **-** ⏱ *15 minutes*

*Slide 4:* Goal of the Mental Health and HIV Integration Pilot Activity

**Goal of the Mental Health and HIV Integration Pilot Activity**

- To integrate mental health screens into HIV services creating a network of referrals and linkages at the community level to support a stepped-care approach to meet the mental health needs of PLHIV in targeted communities in Zimbabwe.

- To develop a Standard Operating Procedure so that other communities interested in mental health integration can follow the model of this pilot activity

Review the goals of the pilot activity.

*Slide 5:* Goals of the Workshop

**Goals of the Workshop**

- Participants will understand the principles of mental health and how to integrate designated mental health screening tools into the services that they currently provide.

- Participants will understand how to create a strong network of referrals and linkages for mental health within their communities.

- Participants will plan for sharing the information learned at this workshop so that they may provide instruction for their colleagues to integrate mental health screenings into daily practice.

Review the goals of the workshop.

*Slide 6:* Objectives

**Objectives**

1. Define and explain basic principles of mental health
    a. Describe symptoms associated with various mental health problems and how they may impact HIV/AIDS outcomes

2. Define and explain basic principles of alcohol and substance use
    b. Describe symptoms of harmful alcohol and substance use and the potential impact on HIV/AIDS outcomes

Review the objectives of the workshop.

3

*Slide 7:* Objectives

**Objectives**

3. Describe and practice utilization of the Shona Symptom Questionnaire (SSQ), CAGE-AID and Abbreviated Community screenings tools
    a. Describe the designated referral protocol for clients who have additional mental health and substance use needs

4. Describe various therapeutic communication techniques to utilize in practice
    a. Utilize a therapeutic communication tool for mental health problems
    b. Utilize a therapeutic communication tool for alcohol and substance use

*Slide 8:* Objectives

**Objectives**

5. Create a system of linkages utilizing referral protocols for mental health integration at the community level

6. Create a plan to train colleagues at their facility on integration activities
    a. Practice facilitating a session on mental health integration in small groups during the workshop

7. Carry out mental health integration in practice with supportive supervision following the workshop

Be sure to point out:

- Beginning and ending time for the day
- Breaks and lunch time.

Note the intensity of the workshop and that each participant is expected to fully participate in every session**. Remind participants that they should pay close attention as they will be participating in a practice facilitation session and will go on to provide instruction for integration of mental health and HIV at their respective site to their colleagues.**

- Participants will be informally assessed during their facilitation sessions.

- There is a more formal final assessment at the end of the training workshop.

- Assessments or review activities are informal and designed to help the trainers understand how well participants have learned the knowledge and skills necessary throughout the workshop.

Ⓟ Point out the flipchart entitled "Parking Lot" and mention that you will use this flipchart to keep track of any topics that are raised outside of the topic of discussion and that can be discussed during the workshop when there is time available.

**5. Establishing Group Norms** (Brainstorm) **-** ⏱ *5 minutes*

Because participants will be working closely together during the workshop, it is important to agree on behaviors all participants will follow. Explain that these behaviors are known as "group norms."

🖉 Write "Group Norms" on the top of a piece of flipchart paper. State that an example of a group norm is "everyone participates equally" or "observe punctuality."

- Ask participants and trainers to think about norms or behaviors they want everyone to follow during the workshop. As an idea is presented, the trainer should quickly check with everyone to be sure that the majority agrees with the norm. If so, add it to the list.

- Spend no more than ⏱ *5 minutes* developing the list. When it is completed, post it on the wall (by the entrance if possible) where it can be easily seen when participants enter and exit the room. The list of norms should remain on the wall throughout the workshop.

**6. Pre-test** (Individual exercise) **-** ⏱ *15 minutes*

Hand out pre-tests (found on page 123 of this manual). Remind participants that the pre-test will be compared with a post-test that will be administered at the end of the workshop to determine if the workshop was successful in meeting its goals and objectives.

**1.    Introduction to the Mental Health/HIV Integration Pilot** (Lecturette) **-** ⏱ *15 minutes*

To build a strong system of linkages and referrals within communities, it will be important to create a network between the health facilities, CBOs, and TMPs that provide HIV and/or psychosocial services within each community. It is expected that once participants complete this training, they will return to their respective site to train their fellow colleagues how to carry out mental health and HIV integration.

*Slide 9:* Integration Leaders

**Integration Leaders**

- Provide expert guidance for the community on integration
- Provide oversight for the referral system (to be discussed tomorrow)
- Provide oversight on integration protocol within their sites and for all sites in catchment area
- Communicate with AIDSTAR-One with questions/issues
- Lead the agenda for mental health integration in their communities and advocate for clients

Integration Leader responsibilities will be clearly explained throughout this workshop.

*Slide 10:* Why Integrate Mental Health and HIV?

**Why Integrate Mental Health and HIV?**

- Integration of mental health and HIV has the potential to improve health and social outcomes for PLHIV
    - CD4 count
    - Weight
    - Adherence
    - Retention
    - Mental health status

Close the session by describing the potential benefits of mental health and HIV integration.

🍸 Time for a Break.

# Module 2:
# The Basics of Mental Health

**Session Objectives:**

By the end of the session participants will:

1. Explore their values, thoughts, and perceptions surrounding mental health

2. Explain how HIV and mental health may be associated

3. Describe various signs and symptoms of mental health problems

4. Discuss case studies to identify potential mental health problems.

**Time Needed:** ◔ *Total session time is 1 hour 10 minutes*

**Materials:**

☐ PowerPoint slides: The Basics of Mental Health (*Slides 11-26*)

☐ **Values, Thoughts, and Perceptions Worksheet**, on page 111 of this manual

**Techniques:** Activity, Discussion, Lecturette, and Case Studies

**Facilitator Notes:**
This module is extensive; prepare participants before beginning the module by explaining that you will be sharing a great deal of information about mental health and that discussions should be short due to the amount of information that will be covered. Make sure to cover each topic within the activity adequately, but be sure to monitor the time as these discussions can be lengthy. Prepare sufficient copies of the Values, Thoughts and Perceptions Worksheet in advance.

**Learning Activities:**

*Slide 11:* Module 2 Title Slide

MODULE 2

The Basics of Mental Health
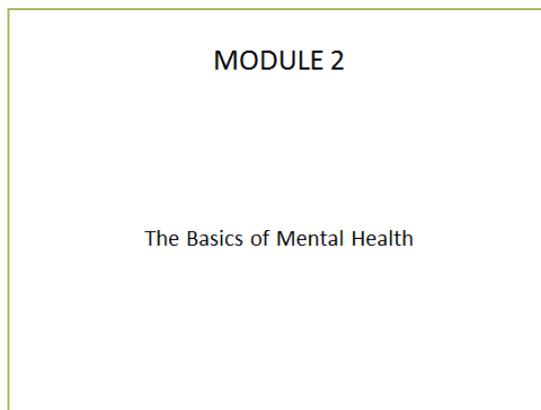
Although this pilot is limited to assessments for the most common mental health problems, such as anxiety and depression, this module contains information surrounding additional mental health problems in order to build the capacity of Integration Leaders to truly become "leaders."

The site staff training that the Integration Leaders will be providing in the upcoming week will only include information surrounding basic mental health problems.

*Slide 12:* Objectives for Module 2

**Objectives for Module 2**

1. Explore their values, thoughts and perceptions surrounding mental health
2. Explain how HIV and mental health may be associated
3. Describe various signs and symptoms of mental health problems
4. Discuss case studies to identify potential mental health problems

Briefly review the objectives for this module.

**1. Values, Thoughts, and Perceptions** (Activity and Discussion) - ⏲ *10 minutes*

It is important for participants to explore their own values, thoughts, and perceptions about mental health to understand how best to communicate with clients who may be experiencing some difficulties. Pass out the **Values, Thoughts, and Perceptions Worksheet** (located on page 111 of this manual) and have participants choose a partner and review the top half of the activity sheet (the second half will be covered in the next module). They should discuss each phrase and complete the phrase by writing down their response. Tell participants that they have ⏲ *5 minutes* to complete the activity.

You may circulate the room during the activity to listen to the conversations and gain an idea of what the general attitudes about mental health are among the group. After ⏲ *5 minutes* have passed, bring the group back together and ask for volunteers to read their responses. After each response, ask if the rest of the group agrees or disagrees or if it has something else to add.

At the completion of the activity, summarize the general values, thoughts, and perceptions about mental health problems among the participants. Highlight the importance of understanding one's own ideas about mental health problems so that participants can be sure to provide high-quality mental health services to their clients.

**2. Mental Health and HIV** (Lecturette and Discussion) - ⏲ *45 minutes*

Why is it important to consider mental health when working with an HIV-positive client, and what effect does mental health or the absence of it have on HIV outcomes?

*Slide 13:* Mental Health and HIV; what is the connection?

**Mental Health and HIV; what is the connection?**

• Persons suffering from mental illness are more likely to contract HIV

• An HIV + diagnosis poses a significant psychological burden, increasing the risk of mental illness

WHO, 2008

Those suffering from mental health problems and substance use are more vulnerable to contracting HIV.

The prevalence of mental health problems is much higher among PLHIV than in the general population; this is due to:
- The vulnerability of those living with mental health problems
- The great psychological burden that living with HIV places on the infected person.

**Slide 14:** Mental Health and HIV; what is the connection?

**Mental Health and HIV; what is the connection?**

- Decreased adherence with mental illness

- Decreased HIV care and treatment seeking behaviors in persons with mental illness and substance use

- Greater HIV-related mortality with chronic depression

WHO 2008

Persons suffering from mental health problems are more vulnerable to sexual exploitation and gender-based violence.

They may have difficulties advocating for safe sex and may be less likely to stay in long-term monogamous relationships (Tegegn, Wissow, Jerene et al. 2010).

Self-care such as adherence to treatment, nutrition, sleep, exercise, and making and completing clinic appointments are also much more difficult in the presence of mental health problems (WHO 2008a).

There are various points during the course of HIV that can cause the infected person to become more vulnerable to experiencing mental health problems.

**Slide 15:** HIV and Mental Health Problem Vulnerability

**HIV and Mental Health Problem Vulnerability**
Diagnosis
- Reactions to diagnosis are varied and may change over time
- May include anger, shock, denial

Disclosure
- Fear surrounding tell others
- Hiding status can lead to stress, avoidance of relationships, and interfere with treatment adherence

Stigma and Shame
- Internal
- External

Tegegn & Wissow, 2010

Stressors due to HIV can come about at any point during the illness; however, the time surrounding diagnosis, disclosure, and perceived stigma can bring about increased stress resulting in depression and anxiety symptoms.

Reactions to diagnosis may vary greatly among persons. It is important to speak with people following a positive diagnosis to perceive their reaction, express compassion, and encourage them to find a support person or group on whom they may rely.

Disclosure is also a very stressful period. Clients may feel ashamed and fear losing a loved one if they disclose.

Stigma, both internal (negative feelings and attitudes that clients place on themselves) and external (attitudes coming from society), may be an enormous source of stress that can cause clients to reduce care-seeking behaviors in an effort to hide their HIV status. This may include missing clinic appointments and not taking medicine (Tegegn, Wissow, Jerene et al. 2010).

**Slide 16:** Definitions

**Definitions**
Health:
- ""A state of complete physical, mental and social well-being, and not merely the absence of disease". (WHO)

Mental Health:
- The psychological or mental state of an individual

Mental Disorder:
- When a problem or symptom disrupts daily functioning in 1) home, 2) school, and/or 3) community.

Mental Illness:
- Any disease or condition affecting the brain that significantly influences or disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning.

Review definitions with participants.

Depression:

[?] Describe how a client with depression might behave and appear.

Depression can range from mild symptoms that are episodic and terminate after a stressful period to persistent feelings of sadness and "feeling low" that may last for a period of several years and to the point that suicidal thoughts may exist (WHO 2010a).

### Slide 17: Depression

**Depression**
- Low energy, fatigue, sleep and appetite changes
- Persistent sad or anxious mood; irritability
- Low interest or pleasure in activities that used to be interesting or enjoyable
- Multiple symptoms with no clear physical cause (aches, pains, palpitations, numbness)
- Difficulties in carrying out usual work, school, domestic or social activities

WHO mhGAP

[?] Are there any cultural differences between the symptoms on this slide and the symptoms of depression that are seen in practice?

[?] Why may a client with HIV be at an increased risk for depression?

— Clients may experience depression due to feeling overwhelmed by the diagnosis, social isolation, and stigmatization. Depression can also be genetically predisposed.

[?] What are some periods during the course of HIV care when a client may want to talk to someone more deeply about his or her feelings? Do these services exist in your setting?
— The time surrounding the initial diagnosis can be emotionally difficult for a client, as can disclosing to others, changes in health status, and the loss of loved ones living with HIV.

[?] What are some very serious symptoms that are associated with severe depression when an immediate higher-level referral for MH care may be necessary?
— This may include suicidal ideation, constant feelings of no or low self-worth, and difficulty carrying out activities of daily living.

[?] What symptoms are associated with less severe depression?
— Symptoms may include low energy and decreased self-worth, but the client is still able to carry out activities of daily living.

[?] What can a provider do if the client states that he or she is thinking about hurting him- or herself, and what is an appropriate referral pathway in your setting?

### Slide 18: Suicide

**Suicide**
Most common during crisis:
- At the time of initial HIV diagnosis
- When the CD4 count first declines and medication begins
- Complications in the course of the illness
- Chronic pain
- Rejection by a loved one
- Loss of a loved one

Increased risk to carry out an attempt:
- Severe depression and /or psychosis
- Drug or alcohol use

Tegegn & Wissow 2010

Certain points during the course of the illness may cause a severely depressed client to consider suicide, such as:

- The period of initial diagnosis
- When the CD4 cell count first declines and medication begins
- Medical complications
- Periods of chronic pain
- Rejection or death of a loved one (Tegegn, Wissow, Jerene et al. 2010).

Clients who have severe depression and/or psychosis and those who use drugs and/or alcohol are also more likely to carry out a suicide attempt (International Center for AIDS Care and Treatment Programs 2011).

*Slide 19:* Suicidal Clients

**Suicidal Clients**
- Ask the client if they are thinking of hurting themself
- Ask if they have ever attempted suicide in the past
- Ask if they have a plan
  - Ask for more information as the client is willing to share
  - Bring the client to a provider who can carry out the necessary mental health referral to receive additional services
  - Involve the family and psychosocial services for additional support where appropriate and as the client agrees

*If the client is cleared to go home, make an agreement with the client to notify a trusted individual immediately if the suicidal thoughts return!!*

When depression is suspected, the client should be screened for suicidal thoughts.

If a client indicates that he or she is suicidal, supervision should begin immediately until the client is no longer a risk to him- or herself.

If the client indicates that he or she plans to hurt him- or herself, remove any weapon that the client intends to use to carry out the suicide, such as poison or a firearm (Zimbabwe MOHCW WHO).

Action plans will be created in a later session to address mental health emergencies.

- If the suicidal thoughts can be attributed to worsening illness, provide treatment as appropriate.
- If the thoughts can be attributed to a loss or rejection, connect the client to mental health or counseling services as available. If no service is available, ask the client to whom he or she can talk about these feelings and explore ways to provide this social support for the client.
- Providing listening and some therapeutic counseling and support may also help the client to reframe negative thought processes (Tegegn, Wissow, Jerene et al. 2010).
- Make an agreement that the client will follow up or notify someone immediately if the suicidal thoughts return.

Anxiety:

Describe someone with anxiety. How does this person appear? How does he or she behave?

*Slide 20:* Anxiety

**Anxiety**
- Excessive fear and/or nervousness
- Commonly occurs in the setting of depression
- Characterized by physical and mental symptoms
- Results in specific behaviors manifested by the anxiety
- May be associated with past trauma

Anxiety can be manifested in three ways:

- Physical: somatic symptoms such as headaches and abdominal pain.
- Mental: inability to fall asleep or stay asleep due to racing thoughts. The client may also feel excessively worried, be unable to concentrate, or fear that something bad will happen. Hyper-vigilance and quick startle reflexes may also occur.
- Behavioral: fear of leaving their home, avoidance of stress-inducing triggers/situations, and irritability (WHO 2010a).

*Slide 21:* Anxiety, Trauma, and Gender

**Anxiety, Trauma, and Gender**
- 57% of women in Zimbabwe experience some form of violence in their lifetime
  - Emotional, physical, sexual
- 25% of women in Zimbabwe experience sexual violence
  - Places the woman at risk for contracting HIV
  - Result in anxiety
  - Complaints of genital pain is a common symptom among women experiencing anxiety with a past history of sexual trauma

It is also important to consider the effect of gender-based violence and its contribution to anxiety and depression.
- Over half of women have been the victims of some form of violence in Zimbabwe, with one out of four being the victim of sexual violence.
- Violence can increase women's risk of experiencing anxiety.
- Trauma and sexual violence also increase women's risk of contracting HIV. Women who have a history of sexual violence may report multiple somatic complaints that often include genital pain (Nyamayemombe, Mishra, Rusakaniko et al. 2010).

If you suspect that the client is a victim of violence:
- Provide an opportunity to speak to the client alone so that the partner is not in the room (if the partner is, or is suspected of being, the perpetrator) and other clients and staff cannot overhear
- If the client is a woman, if possible make sure that the person doing the assessment is also a female to encourage sharing and help the client feel safe
- Listen to the client without judgment
- Offer additional appointments to return to the clinic for more help and check-ins
- Help the client to identify a trusted individual with whom he or she can speak
- Refer the client to psychosocial services in the area for additional support (Nyamayemombe, Mishra, Rusakaniko et al. 2010).

Psychosis:

Describe someone with psychosis. How does this person appear? How does he or she behave?

*Slide 22:* Psychosis

**Psychosis**
- Abnormal or disorganized behavior (incoherent or irrelevant speech, unusual appearance, self-neglect, unkempt appearance)
- Delusions (a false firmly held belief or suspicion)
- Hallucinations (hearing voices or seeing things that are not there)
- Neglecting usual responsibilities related to work, school, domestic or social activities
- Manic symptoms (several days of being abnormally happy, too energetic, too talkative, very irritable, not sleeping or reckless behavior) WHO mhGAP

Are there any cultural differences between the symptoms on this slide and the symptoms of psychosis that they see in practice?

What are some reasons that a client may experience psychosis?
- Chemical imbalances, brain trauma, aggression, lack of inhibitions, and inheriting the illness from parents are potential causes of psychosis (WHO 2010a).

There may be a variety of opinions as to what causes psychosis, but all clients with psychosis should be referred for further clinical assessment and treatment as the psychosis can directly affect the client's health status.

Epilepsy:

**?** Why is epilepsy or seizures often considered to be a mental health problem?

- A high prevalence of mental health problems is found among those who also have epilepsy. Additionally, epilepsy is sometimes attributed to possession by evil spirits or insanity due to the abnormal involuntary movements and loss of memory and consciousness that sometimes can occur (Tegegn, Wissow, Jerene et al. 2010).

- Seizures are often mistakenly seen as a form of mental illness, which they are not, but they can be very disabling and there is a high rate of co-occurrence of seizures and depression (Tegegn, Wissow, Jerene et al. 2010).

- Seizures are a result of abnormal neurologic function in the brain resulting in abnormal involuntary movements, loss of consciousness, urinary incontinence, temporary memory loss, and confusion. A variety of types of seizures exist, and they vary in degree of severity and duration of the episode.

*Slide 23:* Epilepsy

**Epilepsy**
- Epilepsy causes seizures
- More common among PLHIV
- People with epilepsy have a higher prevalence of mental illness BUT epilepsy is NOT a mental illness
- Caused by brain tumor, head injury, stroke, brain infection, alcohol chronic intoxication and withdrawal, genetics and low blood sugar
- Traditional beliefs sometimes attribute epilepsy to insanity, evil spirits and sorcery
  Tegegn & Wissow, 2010

Seizures are more common among PLHIV because those who are immune-compromised are more susceptible to infection, including infection of the brain, which can lead to seizures. Seizures always warrant a medical evaluation.

**4. Mental Health Case Studies** (Discussion) - ⏱ *15 minutes*
*Slide 24:* The Case of Miriam

**The Case of Miriam**

Miriam, a 25 year old married mother of three was diagnosed with HIV six months ago. She has been relatively healthy, however she has not been attending her appointments as scheduled. When she does attend, she appears withdrawn, impatient with her children who accompany her, and complains of generalized aches and headache.
- What do you suspect?
- Why?

**?** What is Miriam suffering from and why is this suspected?

Ask participants if they have noted clients with similar symptoms in practice. What signs and symptoms were present that indicated that the clients might be depressed?

- The period surrounding initial diagnosis is a particularly vulnerable period for mental health problems. Miriam has not been routinely attending appointments; she appears withdrawn and irritable and has multiple somatic complaints,

which should lead the assessor to suspect that she is suffering from depression.

*Slide 25:* The Case of Maureen

**The Case of Maureen**

Maureen, a 20 year old HIV positive female is brought to the traditional healer by her mother. Her mother states that recently Maureen has begun to have conversations with someone who is not there and that she has not been going to work as usual. Maureen appears unkempt and is speaking very rapidly about someone who is "out to get her".
- What do you suspect?
- Why?

**What is Maureen suffering from and why is this suspected?**

Ask participants if they have noted clients with similar symptoms in practice. What signs and symptoms were present that indicated that the clients might be having a psychotic episode?

— Maureen is a young adult, which is a particularly vulnerable age for these symptoms to emerge. Her mother's report that she has been having conversations with someone who is not there and that she has not been able to maintain her activities of daily living, along with the fact that

she is paranoid with pressured speech, indicate that she is experiencing a psychotic episode. The cause of the psychotic symptoms is not clear, and it may be due to an infection stemming from her compromised immune system. Maureen should be directly referred to a mental health care provider for further investigation.

Although these case studies are relatively straightforward in terms of symptoms, signs and symptoms of mental health problems are often very subtle and clients might be unlikely to share how they are feeling. For these reasons a mental health and substance use screen should be routinely carried out. These screens will be introduced later in the workshop.

*Slide 26:* Why is it Important to Recognize Symptoms of Mental Health Problems?

**Why is it Important to Recognize Symptoms of Mental Health Problems**
- To carry out a formal screen and refer immediately
- Improve the emotional quality of health for the client
- Link the client to services within the community to provide additional emotional and psychosocial support
- Help improve self-care including medication adherence, routine clinic attendance
- Open dialogue surrounding mental health may serve to decrease stigma and improve communication surrounding future symptoms

**Why is it important to recognize symptoms of mental illness in an HIV-positive client?**

— MH screens are a key part of caring for your client. Even if you do not think your client has a mental illness, a formal screen can open up the potential for a referral so your client can obtain more support. Assessing mental illness, or conducting a brief intervention and/or referral, can significantly improve the client's emotional quality of life. Referrals can also link the client to a number of services that he or she may not have accessed.

Strong mental health can improve the client's ability to care for him- or herself. Open and routine discussions with all clients will help to improve their comfort with discussing their emotional status over time.

✋This concludes Module 2

# Module 3:
# The Basics of Alcohol and Substance Use

**Session Objectives:**

By the end of the session participants will:

1. Explore their values, thoughts, and perceptions surrounding alcohol and substance use

2. Explain how HIV and mental health problems are related to alcohol and substance use

3. Increase their comfort level in discussing alcohol and substance use

4. Discuss case studies to identify potential alcohol and substance.

**Time Needed:** ☉ Total session time is 50 minutes

**Materials:**

☐ PowerPoint slides: The Basics of Alcohol and Substance Use (*Slides 27-39*)

☐ **Values, Thoughts, and Perceptions Worksheet** (bottom half), on page 111 of this manual

**Techniques:** Activity, Discussion, Lecturette, and Case Studies

**Facilitator Notes:**

This is a critical module for the participants to identify their own values and perceptions surrounding alcohol and substance use and stigma surrounding these topics. Allow sufficient time for participants to discuss these sensitive topics to increase their comfort level and understanding of the importance in addressing these topics with clients. Prepare sufficient copies of the Values, Thoughts, and Perceptions Worksheet in advance.

**Learning Activities:**

*Slide 27:* Module 3 Title Slide



MODULE 3

The Basics of Alcohol and Substance Use
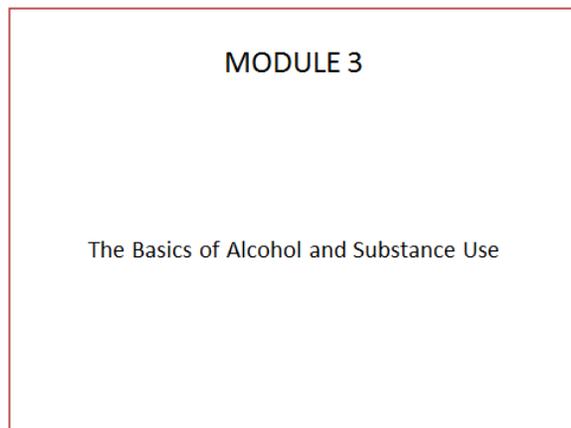
**Objectives for Module 3**

1. Explore their values, thoughts and perceptions surrounding alcohol and substance use
2. Explain how HIV and mental health problems are related to alcohol and substance use
3. Increase their comfort level in discussing alcohol and substance use
4. Discuss case studies to identify potential alcohol and substance use

Briefly review the objectives for this module.

**1. Values, Thoughts, and Perceptions** (Activity and Discussion) - ☉ *15 minutes*

It is important for participants to explore their own values, thoughts, and perceptions about alcohol and substance use to understand how best to communicate with clients who may be experiencing some difficulties. Have participants return to the bottom half of the **Values, Thoughts, and Perceptions Worksheet** (located on page 111 of this manual). Participants should choose a different partner and review the bottom half of the activity sheet. They should discuss each phrase and complete the phrase by writing down their response. Tell participants that they have ☉ *5 minutes* to complete the activity.

Circulate the room again. After ☉ *5 minutes* have passed, bring the group back together and ask for volunteers to read their responses. After each response, ask if the rest of the group agrees or disagrees or if it has something else to add.

At the completion of the activity summarize the discussion:

Do you think that assessing a client for alcohol and substance use is important? Why?

Sometimes it can be difficult to ask a patient about alcohol and substance use. Why do you think this is?

What are some ways to overcome this initial discomfort to ask about alcohol and substance use?

**2. Alcohol and Substance Use and HIV** (Lecturette and Discussion) - ⏱ *20 minutes*

*Slide 29:* Alcohol and Substance Use in Zimbabwe

**Alcohol and Substance Use in Zimbabwe**

Lifetime alcohol abstinence: 58% men, 91% women

Among drinkers >15 years old
- 39% of men and 20% of women are heavy episodic drinkers (>60 grams of pure alcohol at least once in the last week) (WHO, 2011)

Less evidence available on other substances, but anecdotally, rates are increasing

While most women and just over 50 percent of men abstain from alcohol in Zimbabwe, there remains a significant issue among those who drink, with studies indicating that 39 percent of men and 20 percent of women who drink are heavy episodic drinkers (WHO 2010b.

*Slide 30:* Why Is Alcohol and Substance Use of Concern?

**Why is Alcohol and Substance Use of Concern?**
- Substance use on the rise
- Sharing needles may cause HIV transmission
- Having unprotected intercourse with an IV drug user can increase risk of HIV
- Alcohol and substance use may be a means to escape from the stress of living with HIV
- Alcohol and substance use may lead to decreased adherence and care seeking behaviors
- Alcohol and substance use may lower economic status

In the setting of drug use, HIV may be transmitted through sharing needles or having sexual relations with an injection drug user. Risk-taking behaviors also increase with drug and alcohol use, resulting in unprotected sexual relations and non-monogamous relationships.

A client may use a substance as a means to deal with the stress of living with HIV or a common mental health problem. However, substance use may interfere with adherence and care-seeking behaviors and may lower the client's economic status.

Substance use, which may be a coping mechanism to deal with the psychological burden of HIV, can negatively affect the progression of HIV, including non-adherence, care-seeking behaviors, and response to treatment (WHO 2008a).

*Slide 31:* Stigma Towards Substance Users

**Stigma Towards Alcoholics and Substance Users Decreases Access to Treatment**

Substance users (and their families) do not seek help due to social stigma
- Keep the problem hidden by avoiding treatment
- Deny that substance use is a problem and that treatment is needed

Women are more stigmatized than men
- Hide substance use due to fear of having children removed, and fear that she will be judged by health care providers

(Myers et al., 2009)

A study in South Africa found that negative social perceptions of substance use and the stigma surrounding substance use are major barriers in accessing treatment. To maintain social acceptance and avoid judgment by the community and by health care workers, substance users may deny that there is a problem, which prevents them from accessing much-needed treatment (Myers, Fakier, and Louw 2009).

## Addiction

- Physical and mental dependence upon a substance to the point that stopping or cutting down is difficult

- Stopping may lead to mental agitation and physical illness that lead the person to continue using the substance

- Often need more of the substance to experience the same effect over time.

Although it may be difficult to understand why a client continues to use a substance when it is harmful to his or her health, it is important to understand the power of an addiction. Addiction causes physical and mental dependence to the point that the client is mentally fixated on the substance and may become physically ill when cutting down or stopping its use.

In addition, the client may build a tolerance, requiring more of the substance over time to experience the same sensation (Tegegn, Wissow, Jerene et al. 2010).

Harmful Alcohol Use:

It is important to discuss substance use because it is becoming an increasingly serious public health issue (Zimbabwe MOHCW WHO).

**Alcohol**
*Early detection is effective to prevent clients from becoming dependent*
- Hazardous use: risk to physical or mental health by making other conditions worse and impairing judgment
- Harmful use: physical and mental health damage evident
- Dependence/addiction: strong urge to drink, inability to control the quantity of intake, drinking becomes prioritized, increased tolerance and alcohol withdrawal

Hasin, 2003

Screening clients for alcohol is extremely important because early recognition of a problem can have a positive impact.

Alcohol use can be categorized into three categories (Hasin 2003, Zimbabwe MOHCW):
- Hazardous use, where the client may negatively affect his or her physical and mental health and make poor decisions such as having unprotected sex.
- Harmful use, where damage from intake is already evident.
- Dependence/addiction, where the client's thought processes are often fixated on

alcohol and he or she is unable to control the quantity of intake, requires more to reach the same level of intoxication, and may experience acute alcohol withdrawal resulting in tremulousness, fever, headache, nausea, vomiting, irritability, hallucinations, seizures, and even death.

Describe how a client who has a drinking problem might appear and behave.

*Slide 34:* Signs and Symptoms of Alcohol Use

**Signs and Symptoms of Harmful Alcohol Use**
- Appearing to be under the influence of alcohol (smell, appears intoxicated, hangover)

- Presenting with an injury

- Somatic symptoms associated with alcohol use (insomnia, fatigue, anorexia, nausea, vomiting, indigestion, diarrhea, headaches)

- Difficulties in carrying out usual work, school, domestic or social activities

WHO mhGAP

A client who is suspected of alcohol dependence should never stop alcohol use abruptly without medical attention. Alcohol depresses the nervous system. Abrupt cessation of alcohol use can cause a hyper-stimulation of the nervous system, resulting in a variety of symptoms (WHO 2010a).

*Slide 35:* Acute Alcohol Withdrawal

**Acute Alcohol Withdrawal**

- Headache, hand and body tremors, sweating, nausea, vomiting, auditory or visual hallucinations, marked irritability, and confusion, increased pulse and blood pressure, and seizures
- Occur 24 - 48 hours after last drink
- Encourage fluids, provide immediate referral for medication
- Acute alcohol withdrawal is a life-threatening emergency

Signs and symptoms of acute alcohol withdrawal include headache, hand and body tremors, sweating, nausea, vomiting, auditory, or visual hallucinations, marked irritability and confusion, increased pulse and blood pressure, and seizures.

- Withdrawal symptoms typically begin 24 to 48 hours after the client's last alcoholic drink
- Fluids should be encouraged and immediate emergency care or a referral should be provided to appropriately medicate the client
- Acute alcohol withdrawal is a life-threatening emergency and the client should be closely monitored.

Action plans for acute alcohol withdrawal will be created in a later session.

Harmful Substance Use:

Substances other than alcohol are also very common.

What are the most common substances that are used?

- Also note that substances may include petrol, cannabis, glue, and so on.

Describe how a client who has a drug problem might appear and behave.

**Slide 36:** Substance Use Disorders

**Substance Use Disorders**

Drug Use
- Appearing drug-affected (low energy, agitated, fidgeting, slurred speech)
- Signs of drug use (injection marks, skin infection, unkempt appearance)
- Requesting prescriptions for sedative medication (sleeping pills, opioids)
- Financial difficulties or crime related legal problems
- Difficulties in carrying out usual work, domestic or social activities

WHO mhGAP

It should always be noted when a client may be affected by drugs in order to intervene appropriately. Signs of drug use include:

- Appearing sedated, agitated, and fidgety, or with slurred speech
- Marks on the skin from injecting or skin infections at injection points
- Requesting prescriptions for sedatives often
- Financial hardships due to drug use and difficulty carrying out routine activities (WHO 2010a).

## 3. Alcohol and Substance Use Case Studies (Discussion) - ⏱ *15 minutes*

**Slide 37:** The Case of Joseph

**The Case of Joseph**

Joseph, a 54 year old who is a recent widow has been on ART for 5 years with good adherence. He accesses services within the community for psychosocial support. When he presents to the community health worker this visit, he appears disheveled, has slurred speech, appears to have lost weight and is markedly uninhibited. He shares that he does not remember the last time he filled his prescription for ART.
- What do you suspect?
- Why?

What is Joseph suffering from and why is this suspected? Ask participants if they have noted clients with similar symptoms in practice.

- Joseph is a recent widower. A red flag is that Joseph has been adherent with his medication for five years until recently. In addition, the weight loss, poor hygiene, slurred speech, and uninhibited behavior indicate alcohol use.

**Slide 38:** The Case of Jacoline

**The Case of Jacoline**

Jacoline is a 32 year old mother of 4 who was diagnosed with HIV 3 years ago and recently learned that 2 of her 4 children are also HIV positive. Jacoline has been attending appointments irregularly, and when she does come in, appears that she has been drinking alcohol. You have encouraged her in the past to stop drinking. Today Jacoline appears very uncomfortable. She is shaking and sweaty and reports nausea and a bad headache.
- What do you suspect?

What is Jacoline experiencing and why is this suspected?

- Jacoline is sweating, shaking, has a headache, and is nauseous. These symptoms with her long history of alcohol consumption and the possibility that she abruptly stopped drinking indicate that she is likely experiencing acute alcohol withdrawal. Because this is a medical emergency, Jacoline should receive immediate medical attention.

*Slide 39:* Why Is It Important to Recognize Symptoms?

**Why is it important to recognize symptoms of Alcohol and Substance Use?**

- To carry out a formal screen and refer appropriately.
- Improve the health and quality of life for the client
- Identify a mental health problem which may be disguised by alcohol or substance use
- Link the client to services within the community to provide additional support
- Help to improve self-care including medication adherence, routine clinic attendance and decreased mortality
- Open dialogue may help to decrease stigma and improve communication surrounding future symptoms

It is important to be aware of alcohol and substance use symptoms in order to screen clients and connect them to the treatment and support that is needed to improve their health and quality of life as well as their ability to take care of themselves.

- Abrupt withdrawal from alcohol and some drugs can be dangerous for the client and should be carried out under the supervision of a clinician. Alcohol and drug use may also be masking a client's other emotional health issues (WHO 2010a).

Allowing for open dialogue and displaying a nonjudgmental attitude toward clients with harmful alcohol and substance use can decrease perceived stigma and increase the likelihood that clients will respond honestly and be more likely to access services and speak with the provider openly in the future.

This concludes Module 3

# Module 4:
# Introduction to the Screening Tools and Protocols

**Session Objectives:**

By the end of the session participants will:

1. Identify the appropriate screening tools to use at their site

2. Explain the purpose of each screen

3. Practice utilizing each of the screening tools

4. Practice the integration protocol utilizing various scenarios.

**Time Needed:** ⏱ *Total session time is 1 hour and 40 minutes.*

**Materials:**

☐ PowerPoint slides: Introduction to the Screening Tools and Protocols (*Slides 40-61*)

☐ Handouts: *Standard Operating Procedures Manual*

**Techniques:** Lecturette, Activity, Observation, and Discussion

**Facilitator Notes:**

This module introduces each screen that will be used. Make sure that each individual understands the screen(s) that they will be responsible for and the correct protocol for a positive screen.

**Learning Activities:**

**1. Introduction to the Screening Tools** (Lecturette and Activity) **-** ⏱ *50 minutes*

*Slide 40:* Module 4 Title Slide

**MODULE 4**

Introduction to the Screening Tools and Protocols
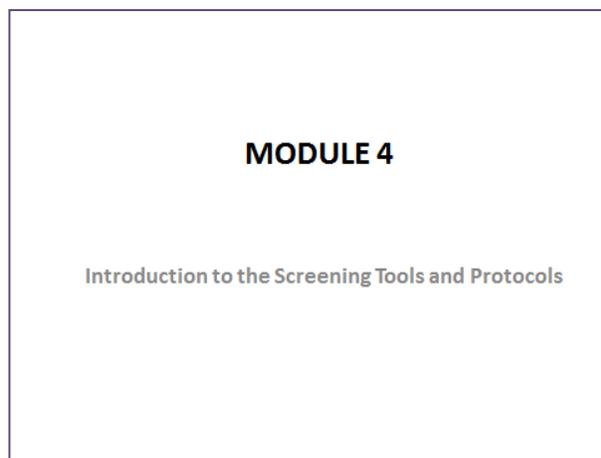
**Slide 41:** Objectives for Module 4

**Objectives for Module 4**

1. Identify the appropriate screening tool(s) to use at their site
2. Explain the purpose of each screen
3. Practice utilizing each of the screening tools
4. Practice the integration protocol utilizing various scenarios

Briefly review the objectives for this module.

**Slide 42:** Introduction to the Screening Tools

**Introduction to the Screening Tools**

- Health Facility
    - Shona Symptom Questionnaire (SSQ)
    - CAGE-AID

- Community Based Organizations and TMPs
    - Abbreviated Community Screen

Three different screening tools will be introduced in this module. For the purposes of this pilot, the Health Facility will utilize the Shona Symptom Questionnaire (SSQ) and the CAGE-AID.

CBOs and traditional practitioners will be utilizing the Abbreviated Community Screen, which is a simplified tool.

Integration Leaders will train their colleagues on how to utilize these tools.

**Ensure that each individual knows which screen(s) he or she will be responsible for.**

**Slide 43:** The Shona Symptom Questionnaire

**The Shona Symptom Questionnaire (SSQ)**
- The first indigenous screening tool in Africa to detect anxiety and depression.
- Fourteen item questionnaire developed by nurses and traditional healers.
- May be used within health facilities and within the community identify potential mental illness cases.
- Available in English and Shona.
- Does not screen for psychosis.

Patel, 1995

The SSQ is the screening tool that will be used to identify common mental health problems. The SSQ was created in Africa by nurses and traditional healers to screen for emotional health symptoms. Although the SSQ may help identify hallucinations, it does not specifically screen for psychosis (Patel, Fungisai, Simunyu et al. 1995).

Review each question on the SSQ with participants.

The screen is available here in English and Shona. There are a total of 14 questions on this screen. The client should be asked if he or she has experienced any of the symptoms during the past week.

At the completion of the screen, the "yes" responses should be totaled. A score of 8 or greater indicates that the client may be experiencing symptoms of depression or anxiety and is in need of a referral (Patel, Fungisai, Simunyu et al. 1995). An SSQ score of 10 or greater warrants a same-day immediate referral for additional mental health screening. **If a client is suspected of having mental health problems despite a negative screen, the screen should be considered positive regardless of the score.**

Integration Leaders from health facilities should turn to the SSQ screening tool in the *Standard Operating Procedure Manual*. Each participant should identify a partner and practice using the SSQ. Give participants ⏱ *5 minutes* to complete the screen.

The CAGE-AID is a tool that screens for alcohol and substance use; it has been used throughout the world. This screen has been validated for use with persons aged 16 and above and has been translated into Shona for the purposes of this pilot project (Lanier and Ko 2008).

Review each question on the CAGE-AID with participants.

Any "yes" responses should be totaled after administering the screening tool.

Any "yes" response warrants further investigation and a referral, and a score of 3 or 4 indicates alcohol or substance use dependence unless proven otherwise (Lanier and Ko 2008). **If a client is suspected of harmful alcohol and substance use despite a negative screen, the screen should be considered positive regardless of the score.**

Integration Leaders from health facilities should turn to the CAGE-AID screening tool in the *Standard Operating Procedure Manual*. Each participant should identify a different partner and practice using the CAGE-AID. Give participants ☺ *5 minutes* to complete the screen.

> **A note on the community:** CBOs and TMPs are responsible for carrying out the Abbreviated Community Screen and are *not* responsible for the SSQ or the CAGE-AID. Positive Community Screens should be referred to a health facility for SSQ and CAGE-AID screens.

***Slide 47:*** Introduction to the Abbreviated Community Screen



This tool consists of three questions to screen for mental health, alcohol, and substance use issues. The first question asks the client to rate his or her feelings of sadness, the second asks the client to rate his or her feelings of worry, and the third inquires about potentially harmful alcohol and substance use.

***Slide 48:*** The Abbreviated Community Screen
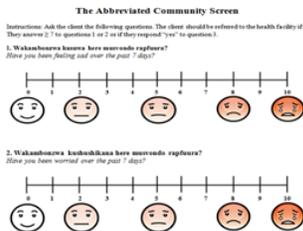


A rating of 7 or greater to the questions on being sad or worrying or a positive response to the question on alcohol and substance use warrants a direct referral to the health facility. **If a client is suspected of having mental health problems or harmful alcohol or substance use despite a negative screen, the screen should be considered positive regardless of the score.**

This requires a strong system of communication, referrals, and linkages between CBOs and health facilities to ensure that the client has followed through on the referral and that the CBO is able to continually provide support to the client if a mental health problem is identified at the health facility level.

Integration Leaders from CBOs and TMPs should turn to the Abbreviated Community Screen screening tool in the *Standard Operating Procedure Manual*. Each participant should identify a different partner and practice using the Abbreviated Community Screen. Give participants ☺ *5 minutes* to complete the screen.

## 2. Screening, Referral, and Management Protocols (Lecturette) - ⏱ 25 minutes

*Slide 49:* The Stepped-Care Model
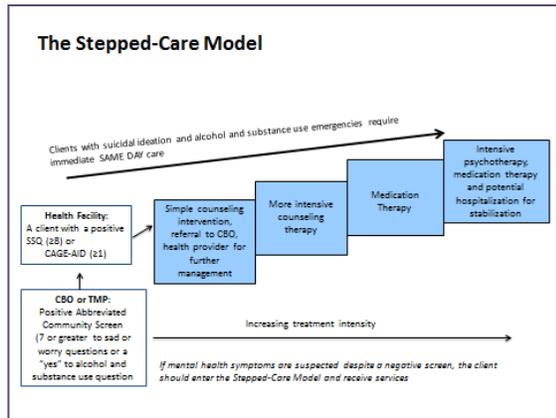


Have participants turn to the Stepped-Care Model in the *Standard Operating Procedure Manual.* A stepped-care model is a model of care in which simple interventions are first utilized and more complicated interventions are reserved for clients who have not improved through simple interventions.

Although the stepped-care model is appropriate for most clients, there will be some clients with severe mental health problems and/or harmful substance use that may require immediate referral to a mental health professional or specialized care.

*Slide 50:* Mental Health and HIV Integration Protocol
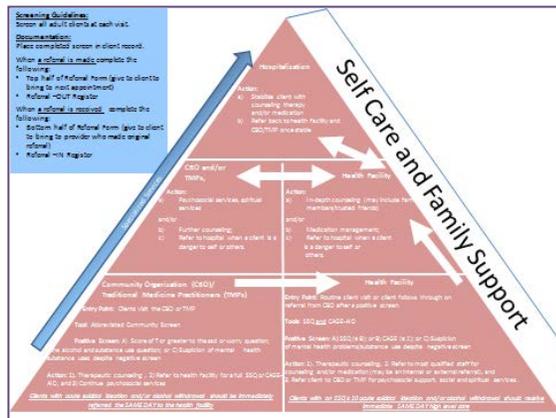


Have participants turn to the Mental Health and HIV Integration Protocol in the *Standard Operating Procedure Manual.* Review step 7 under Program Planning together with participants.

*Slide 51:* Protocol at the CBO or TMP



At the CBO or TMP, all adult clients should be screened at each visit. When a client screens positive, he or she should be given a basic counseling intervention and be referred to the health facility for more in-depth screening.

All screens should be documented in the Data Collection Sheet. Each client who receives a referral should be given a Referral Form, and the referral should be documented in the Referral Register. The referral process will be discussed more in depth in a later session.

***Slide 52:*** Protocol at the Health Facility

**Protocol at the Health Facility**

- Screen each client annually
  - Rescreen positive clients every 3 months until negative
- For a positive screen
  - Provide a basic counseling intervention
  - Refer the client for higher level counseling and /or medication management as needed (internal or external)
  - Refer the client to a CBO for psychosocial services
- Documentation (to be discussed further tomorrow)
  - Record all screens on the Data Collection Sheet
  - Provide client with a completed Referral Form
  - Record referral in the Referral Register

At the health facility, all adult clients should receive SSQ and CAGE-AID screens at each visit. **Note that these screens should be carried out at the same time.** Oftentimes, a primary care counselor at the health facility will carry out the screens.

For a positive SSQ or CAGE-AID, a basic counseling intervention should be provided along with two referrals. The first referral will be for more in-depth counseling and/or medication management as needed. This may be internal to the health facility or external, depending on who is able to provide this level of service. The second referral will be to a CBO for psychosocial services.

All screens should be documented in the Data Collection Sheet. Each client who receives referrals should be given a Referral Form for each referral, and the referrals should be documented in the Referral Register. The referral process will be discussed more in depth in a later session.

Clients who did not obtain relief from psychosocial support, counseling, and/or medication management or who might be violent or a danger to themselves should receive intensive psychotherapy and medication management and may require hospitalization until they are stable.

Once the clients have been stabilized during hospitalization, they should be referred directly back to the health care facility and CBO for ongoing support.

***Building the client's capacity for self-care and involving the family for additional support where appropriate are also key interventions throughout all levels of the system.***

***Slide 53:*** Job Aid for the Health Facility



Participants should turn to the job aids for the health facility and for the CBO and TMP in the *Standard Operating Procedure Manual*. Review each box in the job aids to ensure that each participant understands his or her responsibilities given his or her specific cadre.

*Slide 54:* Job Aid for the CBO and TMP



Clarify any remaining questions before moving on to the next activity.

## 3. Mental Health Protocol Practice (Group Activity) - ⏱ *35 minutes*

Participants will now be participating in a series of practice protocols where they will be presented with specific scenarios. The facilitator will present each scenario to the group and lead a discussion with participants ensuring that the correct protocol to be followed is understood by everyone. Each scenario should last no longer than ⏱ *5 minutes.*

*Slide 55:* Protocol at the CBO or Traditional Healer



### Protocol at the CBO or Traditional Healer

Rudo receives an Abbreviated Community Screen during a routine visit and scores an 8 on the sad question, a 3 on the worry question and a 0 on the alcohol and substance use question.

- What should you do?
- Where should you make a referral?
  - What type of documentation is required to make a referral?
- Where should you document information about Rudo?
- When should he receive another screen?

**The next four slides should be considered by participants from CBOs and Traditional Healers.**

Rudo scored positive on the sad question.
- Determine if he is suicidal; if he is, he should be emergently referred to a health facility.
- He should receive a basic counseling intervention (to be discussed later).
- If he is not suicidal, he should receive a referral to the health facility for a full SSQ screen.
- The top half of the Referral Form should be completed and given to Rudo along with instructions to bring the form to his appointment and return it to you once the bottom half has been completed at his next appointment that he attends. Also explain how to arrive to his appointment and why he should go. Help problem solve if there are any transportation issues.
- The data should be recorded in the Data Collection Sheet and the Referral Register (to be discussed later).
- Rudo should be re-screened during his next visit.
- Rudo should receive a Referral Form along with instructions to bring the form to the health facility and return it to you once it has been completed at his next appointment.

**Slide 56:** Protocol at the CBO or Traditional Healer

**Protocol at the CBO or Traditional Healer**

Maiba receives an Abbreviated Community Screen during her visit with the Traditional Healer and scores a 10 on the sad question, a 7 on the worry question and a 0 on the alcohol and substance use question.
- What additional questions should you ask?
- Where and when should you make a referral?
- Where should you document information about Maiba?
- What additional actions can you take to make sure that she arrives at the health facility today?

Maiba scored very high on the sad question and should immediately be assessed for suicidal ideation.
- If she states that she is having thoughts of harming herself, she should be emergently referred to the health facility the same day.
- Any assistance in assuring that she arrives to the health facility—through arranging transport with a family member or friend and through calling the health facility to make sure that she arrived—is critical.
- Maiba should receive a Referral Form along with instructions to bring the form to the health facility and return it to you once it has been completed at her next appointment.
- This information should be documented in the Data Collection Sheet and the Referral Register.
- She should be re-screened during her next visit.

**Slide 57:** Protocol at the CBO or Traditional Healer

**Protocol at the CBO or Traditional Healer**

Farai visits the CBO and during a routine Abbreviated Community Screen and scores a 2 on the alcohol and substance use question, a 3 on the sad question and a 4 on the worry question.
- What should you do?
- Where should you make a referral?
  - What type of documentation is required to make a referral?
- Where should you document information about Farai?
- When should he receive another screen?

Farai scored positive to the alcohol and substance use question.
- Assess for acute alcohol withdrawal, if he is withdrawing; refer him emergently to the health facility for clinical attention.
- If he is not acutely withdrawing, he should receive a simple counseling intervention.
- Refer him to the health facility and continue CBO services and link to any other services that might be helpful. The top half of the Referral Form should be completed and given to Farai along with instructions to bring the form to his referral appointment where the provider will complete the bottom half and return it to Farai to return to you when he follows up again.. Also explain how to arrive to his appointment and why he should go. Help problem solve if there are any transportation issues.
- This information should be documented in the Data Collection Sheet and the Referral Register.
- He should be re-screened during his next visit.

**Slide 58:** Protocol at the CBO or Traditional Healer

**Protocol at the CBO or Traditional Healer**

Nyasha visits the Traditional Healer and receives a routine Abbreviated Community Screen. She scores a 5 on both the sad and worry questions and a 0 on the alcohol and substance use question. While she does not meet the cut-off for a positive screen, you suspect that she might be experiencing depression and anxiety.
- What should you do?
- Where should you make a referral?
  - What type of documentation is required to make a referral?
- Where should you document information about Nyasha?
- When should she receive another screen?

Nyasha did not score positive on the Abbreviated Community Screen but is still suspected of mental health symptoms.
- She should be treated as if she had a positive screen, assessed for suicidal ideation, given a brief counseling intervention, and referred per the protocol to the health facility.
- Complete the top half of the Referral Form which should be given to Nyasha along with instructions to bring the form to her referral appointment

where the provider will complete the bottom half and return it to Nyasha, who will bring the Referral Form back to you at her next appointment. Also explain how to arrive to her appointment and why she should go. Help problem solve if there are any transportation issues.

- Information about this encounter should be documented in the Data Collection Sheet and the Referral Register.
- She should be re-screened during her next visit.

*Slide 59:* Protocol at the Health Facility

**Protocol at the Health Facility**

Moyo received a positive Abbreviated Community Screen at the CBO and has been referred for a full screen at the health facility. Today he scores an 8 on the SSQ and a 0 on the CAGE-AID.

- What should you do?
- Where should you make a referral?
  - What type of documentation is required to make a referral?
- Where should you document information about Moyo?
- When should he receive another screen?

**The next four slides should be considered by participants from health facilities.**
Moyo scored positive on the SSQ.

- Determine if he is suicidal; if he is, take immediate action by referring him to the most qualified person on-site.
- If he is not suicidal, provide a brief counseling intervention.
- Refer Moyo (either to yourself for a follow-up appointment or to a more qualified health care provider) for further counseling and/or medication management using the Referral Form.
- Refer him to a CBO for supplementary

support services using the Referral Form.
- Record the information on the Data Collection Sheet and both referrals in the Referral Register.
- He should be re-screened during his next visit.

*Slide 60:* Protocol at the Health Facility

**Protocol at the Health Facility**

Zuka receives routine SSQ and CAGE-AID screens during a routine HIV visit. He scores a 4 on the CAGE-AID and a 3 on the SSQ.

- What should you do?
- What else should you determine during this visit?
- Where should you make a referral?
  - What type of documentation is required to make a referral?
- Where should you document information about Rudo?
- When should he receive another screen?

Zuka scored positive on the CAGE-AID.
- Determine if he is experiencing acute alcohol withdrawal; if he is, provide emergent clinical services.
- If he is not, provide a brief counseling intervention.
- Refer Zuka (either to yourself for a follow-up appointment or to a more qualified health provider) for further counseling.
- Refer him to a CBO for supplementary support services using the Referral Form.
- Record the information on the Data Collection Sheet and both referrals in the Referral Register.
- He should be re-screened during his next visit.

**_Slide 61:_** Protocol at the Health Facility

**Protocol at the Health Facility**

Cynthia receives an SSQ and CAGE-AID screen during a routine HIV visit. She scores a 6 on the SSQ and a 0 on the CAGE-AID. While she does not meet the criteria for a positive SSQ, you still suspect that she is depressed.

- What should you do?
- Where should you make a referral?
  - What type of documentation is required to make a referral?
- Where should you document information about Cynthia?
- When should she receive another screen?

Cynthia did not score positive on either the SSQ or the CAGE-AID screen; however, depression is still suspected.

- She should be treated as if she had scored positive on the SSQ.
- Assess for suicidal ideation.
- Provide a brief counseling intervention.
- Provide a referral (either to yourself for a follow-up appointment or to a more qualified health provider) for further counseling and medication management using the Referral Form.
- Refer her to a CBO for supplementary support services using the Referral Form.
- Document the information in the Data Collection Sheet and record both referrals in the Referral Register.
- She should be re-screened during her next visit.

Ⴧ Time for a Break.

# Module 5:
# Facilitation Preparation

Ask if there are any questions regarding how to follow the protocol. ***Notify participants that the job aids will be available in poster form and will be available on-site for assistance as needed.***

**Session Objectives:**

By the end of the session participants will:

1. Prepare to facilitate a practice session to get ready to train colleagues

2. Become acquainted with the Integration Leader's Training Manual within the *Standard Operating Procedure Manual*.

**Time Needed:** ⏲ *Total session time is 50 minutes*

**Materials:**

☐ <u>PowerPoint slides:</u> Facilitation Preparation (***Slides 62-64***)

☐ <u>Handouts:</u> **Integration Leader's Training Manual**, found on page 77 of this manual

**Techniques:** Group Work

**Facilitator Notes:**

This activity is intended to acquaint participants with the materials they will be presenting at sites and using in the follow-on training for their colleagues. It will also make them accustomed to giving presentations to groups of professionals. The Integration Leader's Training Manual can be found on page 77 of this manual; ensure that sufficient copies are prepared in advance for each participant.

Once this activity is introduced, the Community Integration Leaders should be separated to do Module 6 separately from the other participants. Because Module 6 is short in length, the Community Integration Leaders may return and also prepare for a brief facilitation session for the following day.

**Learning Activities:**

**1. Introduction to Facilitation Responsibilities** (Lecturette) - ⏲ *50 minutes*

*Slide 62:* Module 5 Title Slide



**MODULE 5**

Facilitation Preparation

As Integration Leaders, participants will be expected to return to their site and carry out a follow-on training for all staff who provide direct client services. To assist in preparing for this site staff training, participants will be given the opportunity to practice facilitating the materials that they will be presenting to their colleagues during this workshop the next day.

**Slide 63:** Objectives for Module 5

**Objectives for Module 5**

1. Prepare to facilitate a session for Day 2 of the workshop
2. Become acquainted with the Site Staff Training Manual within the Mental Health/HIV Integration Workbook

Briefly review the objectives for this module.

**Slide 64:** Facilitation Responsibilities

**Facilitation Responsibilities**

- Review the Training Manual and:
    - Choose a session to facilitate
    - The session should be approximately 5 minutes in length

- Begin to consider how you plan to train your colleagues at your own site

Participants should review the Integration Leader's Training Manual and select a component of a session (of which they have already participated in today) that they will facilitate on Day Two. Each participant will only facilitate for ⏲ *5 minutes* to allow time for each Integration Leader's presentation. After all the participants have selected the session that they will present Day Two, allow time for them to review the training manual in its entirety, concentrating on the session that they will be presenting.

Any extra time should be spent planning the logistics of the training that they will be providing at their own sites.

Participants will have approximately ⏲ *50 minutes* to review the Integration Leader's Training Manual.

During this time participants should:

- Become acquainted with the Site Staff Training Manual
- Review the tasks necessary to prepare to teach the session
- Prepare for the practice facilitation session
- Begin to consider how the actual site staff training will be carried out at their site in the following week.

Circulate the room as participants are preparing and answer any questions that they may have. After ⏲ *50 minutes*, bring the participants back together. Ask if there are any remaining questions.

Encourage them to take time during the evening of Day One to review the Integration Leader's Training Manual and to prepare for their practice facilitation session on Day Two.

✋ This concludes Module 5

**Session Objectives:**

By the end of the session participants will:

      1. Understand the characteristics of effective leaders

      2. Describe the responsibilities of Integration Leaders

      3. Be prepared to provide leadership and guidance for integration in their communities.

**Time Needed:** ⏱ *Total session time is 50 minutes*

**Materials:**

      ☐ PowerPoint slides: Facilitation Preparation (***Slides 65-69)***

**Techniques:** Group Work

**Facilitator Notes:**

This activity is intended to build the leadership capacity of the Integration Leaders. Due to the leadership and guidance that they will provide for mental health and HIV integration, they are well positioned to serve as leaders and mentors and as a visible face of the mental health and HIV integration within the community.

**Learning Activities:**

**1.   Building Leadership Capacity** (Lecturette) **-** ⏱ *35 minutes*

***Slide 65:*** Module 6 Title Slide



**MODULE 6**

BUILDING LEADERSHIP CAPACITY
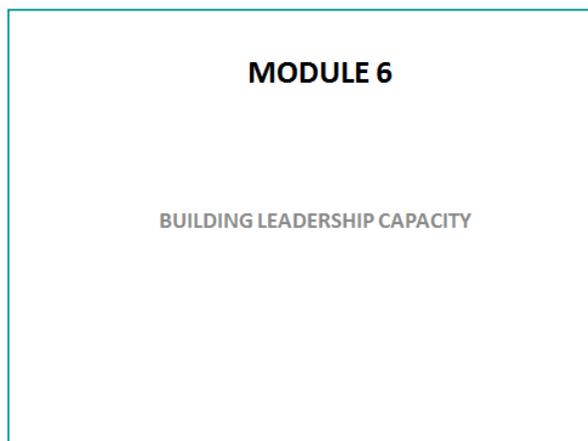
**Slide 66:** Objectives for Module 6

**Objectives for Module 6**

1. Understand characteristics of effective leaders
2. Describe responsibilities as Integration Leaders
3. Be prepared to provide leadership and guidance for integration in their communities

Because Integration Leaders have demonstrated skills and experience in mental health and HIV integration, they are well positioned to provide leadership at the community level for integration activities and to advocate for building a continuum of services for mental health.

Review Module 6 objectives

What are the qualities of an effective leader?

**Slide 67:** Characteristics of Effective Leaders

**Characteristics of Effective Leaders**

- A good leader is enthusiastic about their work or cause and also about their role as leader.
- A good leader is confident.
- A leader also needs to function in an orderly and purposeful manner in situations of uncertainty.
- A good leader is committed to excellence

Colleagues and community members will be more responsive to a passionate and dedicated person.

Leaders need to be a source of inspiration to their colleagues and the community and motivate others to do their best work. Integration Leaders are also in the position to effect positive change within the community for mental health and can advocate for mental health services and on behalf of clients to ensure that they receive the most appropriate care possible.

As an Integration Leader, you will need to be seen as part of the team within the community working toward the goal of integrated mental health services. To provide leadership and guidance for the activity, you will need to set the direction to follow integration protocols and encourage others to do the same.

A leader needs to appear confident as a person and in the leadership role to inspire confidence in others and help the team put forth its best efforts for the integration activities. A leader who conveys confidence and skills for integration will inspire his or her colleagues and community members to put forth their best efforts. During times of uncertainty and unfamiliarity, people look to the leader; when the leader portrays confidence and a positive demeanor, people find reassurance and security. An effective leader will maintain high standards throughout the activity and inspire others to do the same (Javitch 2013).

**Slide 68:** Integration Leaders

**Integration Leaders**

- Provide expert guidance for the community on integration
- Provide oversight for the referral system (to be discussed tomorrow)
- Provide oversight on integration protocol within their sites and for all sites in catchment area
- Communicate with AIDSTAR-One with questions/issues
- Lead the agenda for mental health integration in their communities and advocate for clients

Using their leadership skills, Integration Leaders will provide expert guidance to their colleagues and to the community for the integration activity. They should be available for other integration sites when questions arise.

They should also provide oversight to the referral system and ensure that protocols are followed within the community. When questions arise, Integration Leaders should contact the lead supervisor for this program.

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*Slide 69:* Introducing Integration to Other Leaders

**Introducing Integration to Other Leaders**

Who are your community leaders?
- Traditional healers, spiritual leaders, government officials, informal leaders within the community

Introduce the pilot activity to the leaders and request
- Encouraging at-risk community members to visit health facility, CBO or traditional healers for screenings
- Encourage follow-up of clients who are known to be receiving services to minimize defaulters
- De-stigmatize mental health by acknowledging in the community that mental health problems are common and can be treated

As a component of advocating for mental health integration, Integration Leaders should approach other leaders in the community before the activity begins to introduce and build support and acceptance for the activity.

In doing so, they can build momentum within the community to address mental health issues by requesting that other Community Leaders identify at-risk community members and encourage them to be screened and promote follow-up of services for clients who are known to be receiving care. They can also de-stigmatize mental health in the community by speaking openly about mental health problems and building knowledge that mental health problems are common and treatable.

During monthly check-ins, any gaps in protocols and the referral system should be identified and corrected. Integration Leaders should also act as the lead to provide oversight to the referral system for the community.

🖐 This concludes Module 6

# Module 7:
# Day One Wrap-up

**Session Objectives:**

By the end of the session participants will:

        1. Discuss lessons learned in Day One

        2. Review objectives.

**Time Needed:** ⏱ *Total session time is 30 minutes*

**Materials:**

    ☐  <u>PowerPoint slides:</u> Day One Wrap-up *(70-72)*

**Techniques:** Group Discussion

**Facilitator Notes:**
Review each point for Day One and make sure to respond to any remaining questions before finishing for the day. Remind participants that Day Two will begin at 8:30 am.

**Learning Activities:**
**1. Lessons Learned** (Group Discussion) - ⏱ *30 minutes*

*Slide 70:* Day One Wrap Up

**MODULE 7**

Day One Wrap-Up

Thank participants for their cooperation and participation during the day. Tell them that you would like to conclude the day with a brief wrap-up discussion.

*Slide 71:* Objectives for Module 7

**Objectives for Module 7**

1. Discuss lessons learned in Day One
2. Review

Briefly review the objectives for this module.

*Slide 72:* Day One Activities

**Day One Activities**
- Basics of Mental Health
  - Define Mental Illness
  - Define Depression
  - Define Alcohol and Substance use

- Describe each of the Screening Tools
  - Explain the protocol for a positive screen at each level

- List the tips for creating strong community linkages

Lead a discussion surrounding Day One activities.

Define mental health, depression, and alcohol and substance use.

Describe the SSQ. What score is considered a positive screen, and what is the protocol for a positive screen?

Describe the CAGE-AID. What score is considered a positive screen and what is the protocol for a positive screen?

Describe the Abbreviated Community Screen. What scores are considered a positive screen and what is the protocol for a positive screen?

Share and discuss:

- Lessons learned
- What they already knew
- What surprised them
- If they have any remaining questions.

Ⓟ Answer any remaining questions in the Parking Lot.

🖐This concludes Module 7

**Session Objectives:**

By the end of the session participants will:

  1. Discuss lessons learned in Day One

  2. Review objectives.

**Time Needed:** ⏲ *Total session time is 30 minutes*

**Materials:**
  ☐ PowerPoint slides: Day Two Introduction (***73-77)***

**Techniques:** Group Discussion

**Facilitator Notes:**

**Learning Activities:**
**1. Day Two Introduction** (Group Discussion) **-** ⏲ *30 minutes*

**Materials:**
*Slide 73:* Day Two Introduction
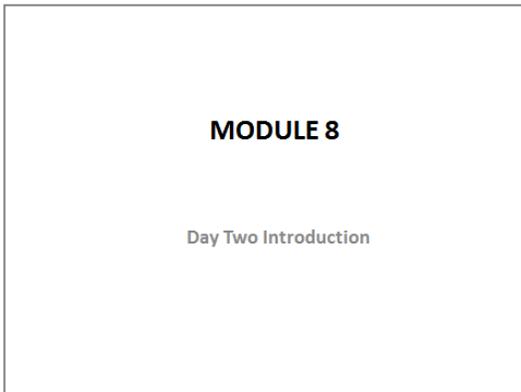
Welcome participants to Day Two of the workshop.

*Slide 74:* Objectives for Module 8
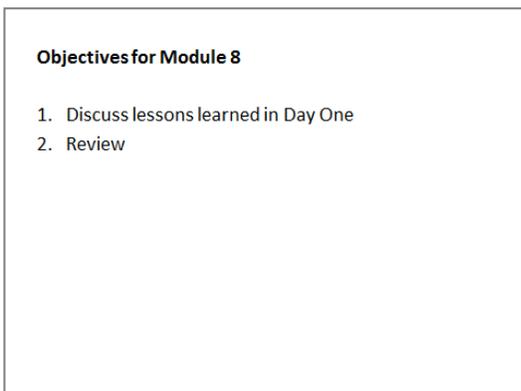
Briefly review the objectives for this module.

*Slide 75:* Review of Day One Activities

**Review of Day One Activities**

- Basics of Mental Health
  - Define Mental Illness
  - Define Depression
  - Define Alcohol and Substance use

- Describe each screening tool
  - Where each tool is used (health facility or community)
  - What is the protocol for a positive screen for each

Lead a review discussion of Day One activities.

Define mental health, depression, and alcohol and substance use.

Describe the SSQ. Where will this tool be used? What score is considered a positive screen, and what is the protocol for a positive screen?

Describe the CAGE-AID. Where will this tool be used? What score is considered a positive screen and what is the protocol for a positive screen?

Describe the Abbreviated Community Screen. Where will this tool be used? What scores are considered a positive screen and what is the protocol for a positive screen?

*Slide 76:* Day Two Activities

**Day Two Activities**

- Understand best practices for internal and community referrals and linkages within an integrated program
- Plan for a referral program in catchment area groups
- Review therapeutic communication techniques for mental health problems
- Review therapeutic communication techniques for alcohol and substance use

Review the Day Two activities.

*Slide 77:* Day Two Activities (continued)

**Day Two Activities (continued)**

- Review logistics for integration
  - Considerations to prepare and carry out the pilot
  - Data Collection
  - Supportive Supervision

- Practice Facilitation Sessions

- Closing Activities

This concludes Module 8

# Module 9:
# Building Linkages for an Integrated Community Network

**Session Objectives:**

By the end of the session participants will:

1. Explain why community linkages are important

2. Explain the key elements of linkages for the integrated network

3. Explain how to use the Integration Referral Form and Registers

4. Plan for an integrated referral network in catchment area groups.

**Time Needed:** ⏲ *Total session time is 70 minutes*

**Materials:**

☐ PowerPoint slides: Linkages for Community-Based Support *(Slides 78-90)*

☐ Handouts: *Standard Operating Procedures Manual*

**Techniques:** Lecturette, Brainstorm, and Activity

**Learning Activities:**

**1. Benefits of Community-Based Services** (Lecturette) **-** ⏲ *30 minutes*

*Slide 78:* Module 9 Title Slide

**MODULE 9**

Building Linkages for an Integrated Community Network

**Slide 79:** Objectives for Module 9

**Objectives for Module 9**

1. Explain why community linkages are important
2. Explain the key elements of linkages for the integrated network
3. Explain how to use the integration Referral Form and Referral Register
4. Plan for an integrated referral network in catchment area groups

Briefly review the objectives for this module.

**Slide 80:** Linking Community-Based and Health Facility Services



**Linking Community-Based and Health Facility Services**

Improved mental health and HIV outcomes for clients
- Improved retention, improved adherence, self-reported well-being, decreased substance use

Community-based opportunities
- Screening
- Counseling
- Spiritual support
- Support groups
- Substance use
- Disclosure
- Child protection
- Domestic violence support and advocacy
- Skills training
- Livelihoods

Integration

HIV Health facility services
- Screening
- Higher level counseling
- Medication management
- Linkages for referrals with hospitals

Bi-directional referrals

In the left-hand column are potential services that may be provided by a CBO and/or a TMP. In the right-hand column are services offered at the health facility. A strong bi-directional integrated referral network between the health facility and the community will build the foundation to provide integrated mental health and HIV services at the community level.

**Slide 81:** Why Are Linkages Important

**Why are linkages important**

- Provide continuity of care
- Reinforce messages at multiple levels
- Provide case-management for particularly vulnerable clients
- Supplement services that other organizations and services do not have the capacity to provide
  - No cost
  - Very easy and simple intervention

Through building bi-directional linkages at the community level, the integrated network is able to provide continuity of care for clients, meaning that after they leave the health facility, they will continue to be offered services to provide further support.

A network of linkages also offers the opportunity to receive healthy living messages at multiple services points in the community.

Each organization most likely does not have the capacity to provide all the services clients might need; creating a network of linkages is a simple way to ensure that clients receive the services they need while not adding additional costs.

**Slide 82:** WHO Guidance

**WHO Guidance-Referral Networks for Integrated Programs**

- All organizations within the network should meet and agree on referral procedures
  - Clarify services offered by each organization
  - Identify a referral point person at each organization
  - Identify a lead organization to lead and track referrals within the network
  - Identify and utilize case managers, volunteers to ensure that clients are following through with referrals

Review the WHO guidance for referral networks.

**Slide 83:** WHO Guidance (continued)

**WHO Guidance (continued)**

- Create and maintain an up to date contact list of all organizations within the network

- Create a system to record, track and monitor for referral completion

- Use a standardized referral form throughout the network that allows for a feedback loop of communication between organizations

**Slide 84:** Creating a Health and Community Services Directory

**Creating a Health and Community Services Directory**

Health and Community Services Directory

| Name of Organization | Type of Services Provided | Contact Person | Contact Information (Telephone and Address) |
|---|---|---|---|
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

Shortly, participants will be working in catchment area groups to plan for their integrated referral network.

The first step will be to create an updated Health and Community Services Directory, which can be found in the *Standard Operating Procedures Manual.* This will be created during Day Two and should be updated regularly to include new organizations within the network or any other changes that may occur.

**Slide 85:** The Referral Form

**The Referral Form**

A referral form will be used to establish a strong network of communication and linkages.

The *Standard Operating Procedures Manual* contains the referral form that will be used for this pilot. Participants should turn to this page. The provider that is originating the referral should complete the top half of this form and give it to the client to bring to the appointment to which he or she is being referred. The organization receiving the client should cut along the dotted line, keep the top half of the referral form for its records, and complete the bottom half to give to the client, who can provide it during his or her next appointment to the original referring organization. This will provide proof that the client completed the referral and will also provide a mechanism for bi-directional communication and linkages in the community.

*Slide 86:* Register of Referrals – IN

**Register of Referrals - IN**

In order to keep track of referrals, each organization should maintain a register of referrals that are made to and from the facility. The Register of Referrals has two separate sections: a Register of Referrals – IN and a Register of Referrals – OUT, which can be found in the *Standard Operating Procedures Manual.*

The <u>first</u> section keeps track of referrals IN to the organization. Each time that a referral is received to take a client, it will be documented here.

Review the Register of Referrals – IN form.

*Slide 87:* Register of Referrals – OUT

**Register of Referrals- OUT**

The <u>second </u>section keeps track of referrals that are made OUT of the facility to other organizations. Each time a referral is made, it should be documented here.

Review the Register of Referrals – OUT form.

**Slide 88:** Referral Protocol

**Referral Protocol**

- Each time a referral is made:
  - Document in Register of Referrals - OUT Form
  - Complete the top half of the Referral Form and instruct client to bring it to their appointment
  - Provide an explanation and instructions to complete the referral
- Each time a referral is received:
  - Document in Register of Referrals – IN Form
  - Ask for Referral Form
  - Complete second half of referral form and instruct client to return it to original organization at their next appointment

Review the referral protocol.

**2. Creating an Integrated Referral Network Brainstorm and Activity** (Group Discussion and Activity) - ⏱ *40 minutes*

**Slide 89:** Creating Your Referral Network – Group Work

**Creating Your Referral Network – Group Work**

- Meet in catchment area groups
  - Create an updated Health and Community Services Directory
  - Clarify the roles of each organization in your network
  - Identify a referral point person at each organization
  - Identify a lead organization in the network
  - Brainstorm ideas for who can service as case managers to ensure referral follow through
  - Review as a team the Referral Form and Referral Registers
  - Identify where each organization will keep the Referral Register and Referral Forms
  - Establish a follow-up date to meet and review progress once pilot is underway

Now that participants have reviewed the WHO Guidelines for an integrated referral network, as well as the referral documentation that will be used for the pilot, participants should meet in catchment area groups and carry out the tasks listed in the slide.

Give participants ⏱ *30 minutes* to complete the activities. After ⏱ *20 minutes* have passed, review each group's plan for its referral network (which organization will lead, what are possibilities for case managers, plans for follow-up).

**Slide 90:** The Referral Checklist

**Referral Checklist**
- ☐ Explain reason for referral to the client
- ☐ Prepare the client referral form
- ☐ Provide client with:
  - ☐ Contact and name of information
  - ☐ The client referral form
  - ☐ Information on how to make the appointment (or make the appointment (provide card with appointment date and time).
- ☐ Remind what client should bring to the appointment (client referral form, medications, etc.)
- ☐ Follow-up appointment to determine follow through.

When referring a client for services, it should be explained to the client why the referral is being made. The client should also be given oral and written directions on how to arrive to the appointment and instructed to bring the Referral Form. If necessary, a follow-up appointment may be made with the client as well.

What is the required documentation to make a referral?

- Referral Form (top half), Referral Register – OUT

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When a client referral is received, where should this be documented?

– Referral Form (bottom half), Referral Register – IN

What information should be given to a client when a referral is made?

– Reason why the referral is made, oral and written instructions on how to arrive to the appointment, instruction to bring the Referral Form to the appointment, instructions for a follow-up appointment.

When should a referral be made and to where?

– From the CBO or TMP, a referral should be made to the health facility when the Abbreviated Community Screen is positive.

– At the health facility, a referral should be made for higher-level counseling and/or medication management (internal or external) when an SSQ or CAGE-AID is positive. A second referral should also be made to the CBO for psychosocial support.

Time for a Break.

**Session Objectives:**

By the end of the session participants will:

1. Describe how to set up a therapeutic environment for a mental health screen
2. Practice mental health counseling skills
3. Practice alcohol and substance use counseling skills
4. Carry out therapeutic communication surrounding mental health and substance use screening in the clinical and community settings.

**Time Needed:** ⏱ *Total session time is 90 minutes*

**Materials:**

☐ PowerPoint slides: Therapeutic Communication Skills (***Slides 91-116***)

☐ Handouts: **Counseling Tip Sheet for Harmful Alcohol and Substance Use**, on page 113 of this manual

***Standard Operating Procedures Manual***

**Techniques:** Lecturette, Discussion, and Role Play

**Learning Activities:**

**1. Therapeutic Communication Skills** (Lecturette and Discussion) - ⏱ *25 minutes*

***Slide 91:*** Module 10 Title Slide

**MODULE 10**

Therapeutic Communication Techniques and
Motivational Interviewing
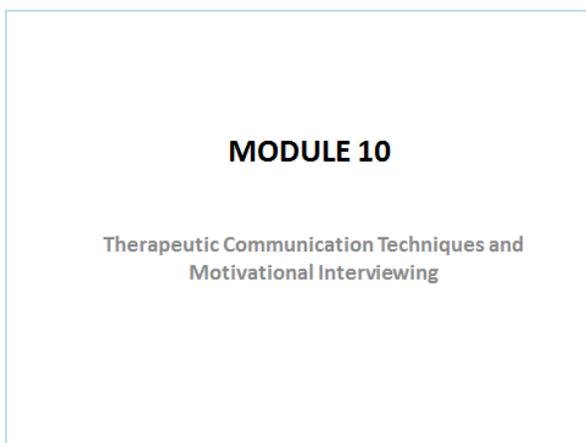
**Slide 92:** Objectives for Module 10

**Objectives for Module 10**

1. Describe how to set up a therapeutic environment for a mental health screen
2. Practice mental health counseling skills
3. Practice alcohol and substance use counseling skills
3. Carry out therapeutic communication surrounding mental health and substance use screening in the clinical and community setting

Review the objectives for this module.

Communication skills are very important in providing quality services; this is particularly true when carrying out mental health and substance use screens.

**Slide 93:** Why Are Communication Skills Important?

**Why are Communication Skills Important?**

- So that clients will share their mental health concerns
- So that communication takes place in a therapeutic manner
- To build a therapeutic connection with the client and their family
- To help the client and their family share information in a more efficient manner
- So that the client and their family will be more likely to accept advice

Tegegn & Wissow, 2010

Therapeutic communication is the first step of care with all clients; it is critical so that clients will feel that they can safely share personal information about their emotional state. Clients may also be more likely to take advice and information from a provider who is expressing empathy and a nonjudgmental attitude. Good communication can also help build a strong connection with each client and his or her family so that the client will be more likely to access care and share information when issues arise (Tegegn, Wissow, Jerene et al. 2010).

There are a number of interviewing techniques that facilitate open communication between a client and provider.

**Slide 94:** Interviewing Techniques

**Interviewing Techniques**

- Open–ended versus Close–ended questions

- Reflective Listening

- Empathetic Comments

Tegegn & Wissow, 2010

An open-ended question requires the client to express how he or she is feeling, whereas a close-ended question only requires the client to respond "yes" or "no," which will not provide sufficient information to the interviewer.

Reflective listening helps the client to focus on his or her own thoughts and feelings. This can be done by providing encouragement throughout the interview, such as by nodding the head and actively listening. Reflective listening may also include repeating part of what the client has stated to demonstrate that you are actively listening or pointing out something that the client may not have stated.

- For example, if a client appears stressed when discussing a topic, you can point out that he or she appears more nervous when discussing the topic and probe further as to why (Tegegn, Wissow, Jerene et al. 2010).

Empathetic comments demonstrate that you as the provider understand how the client is feeling, which can help build a relationship of trust and provide encouragement for the client to share information about personal topics. Examples of empathetic comments include:

- "That must be difficult for you."
- "I am sorry that you are experiencing this right now."
- "I can imagine that that must make you feel very sad"(Tegegn, Wissow, Jerene et al. 2010).

Setting up a therapeutic environment is crucial to helping the client feel at ease and may also help gather important information from the client (Tegegn, Wissow, Jerene et al. 2010).

How can a provider make a client feel at ease and comfortable during an interview?

*Slide 95:* Setting up a Therapeutic Environment

**Setting up a Therapeutic Environment**

- Let the client know that you are interested in what they have to share
  - Eye contact, sitting down, closing the door, allowing them time to and actively listening

- Open up the visit with an open ended greeting
  - How have you been? How can I help you today?

- Do not ignore "hints"
  - Lack of enthusiasm, poor eye contact, change in demeanor

Tegegn & Wissow, 2010

It is important to let the client know that you are interested in what he or she has to share. Sit down, place your hands in your lap, and give the client your undivided attention. Make sure there is privacy by shutting the door and give the client an opportunity to speak in confidence.

If the client states that he or she is fine, but does not appear so by not maintaining eye contact, speaking quietly, or appearing sad, be sure to enquire further by making a statement, such as, "I hear that you are saying that everything is fine, but you seem to be withdrawn this visit. Is there anything else that you would like to share?" (Tegegn, Wissow, Jerene et al. 2010).

*Slide 96:* Routine Mental Health Screening Tips

**Routine Mental Health Screening Tips**

- Make sure that the client feels comfortable prior to carrying out the screen

- Preface the screen by explaining to the client that it is important to understand how they are doing emotionally so that you can provide them with the best care possible.

An additional way to maximize the quality of a mental health screen is to ensure that the client feels comfortable during the screen.

- If possible, carry out the screen as the last task of the visit so that the client has had sufficient time to become comfortable during the visit.
- Before carrying out the screen, explain that all patients receive this screen as a method to ensure that they are receiving the best care possible. This will help the client to not feel "singled out" or self-conscious during the screen.

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*Slide 97:* Routine Mental Health Screening Tips (continued)

**Routine Mental Health Screening Tips (continued)**

- Reassure the client that what they share is confidential unless they share that they intend to hurt themselves or someone else
- Do not judge the client and provide verbal support when given the opportunity
- Thank the client for sharing after the screening is complete
- Make sure to follow through with referrals when it is indicated

- Additional screening tips include reassuring the client of confidentiality unless the client expresses the intent to harm him- or herself or someone else.

- Refrain from judging the client, regardless of what is shared during the interview, and provide verbal support and encouragement when the opportunity arises.

- After the screen is complete, thank the client for sharing the information with you and make sure to follow through on each referral wherever it is indicated.

*Slide 98:* Additional Helpful Hints

**Additional Helpful Hints**

- When the client has multiple concerns
  - Provide a synopsis of the client's concerns and help them to focus on their greatest concern

- When the client talks for too long
  - Gently interrupt and help the client to focus on their primary concern

- When multiple family members are present
  - Address each family member individually
  - If appropriate, involve family members to gain information

  Tegegn & Wissow, 2010

It can be very difficult in a busy setting to attend to all of the client's needs during one visit.

When a client has multiple complaints, provide a brief synopsis of what he or she has shared with you and help to prioritize and focus on the greatest concern during the visit.

Some clients may be in need of someone to speak with and may take advantage of the opportunity to speak with you for a prolonged period of time. In these cases, try to gently interrupt the client during a brief pause and bring him or her back to focus on the primary concern for that visit. You may phrase this as, "Let's make sure that we have sufficient time to focus on…"

There may be visits during which multiple family members are present. When this happens, you should greet each family member individually. If the client appears comfortable with their presence and involvement, you may also involve the family members in the interview to gain additional information and understanding of the client's concerns (Tegegn, Wissow, Jerene et al. 2010).

*Slide 99:* A Note on Confidentiality

**A Note on Confidentiality**

- Reassure the client that the information that they share is private and will not be shared
- Take action to maintain the client's privacy at all times
  - Shut the door during the client interview
  - Do not leave client information in public areas
  - Do not discuss clients with colleagues unless it will directly benefit the client
  - Do not discuss the client in public areas

Reassuring the client of confidentiality is important and can help build trust and maximize information sharing. Be aware that the client's privacy is maintained at all times by allowing a private space during the interview, guarding client information, and only sharing with colleagues when absolutely necessary and with the client's permission.

**2. Simple Therapeutic Interventions for Mental Health Problems** (Lecturette) - ⏱ *30 minutes*

*Slide 100:* WHO Service Organization Pyramid
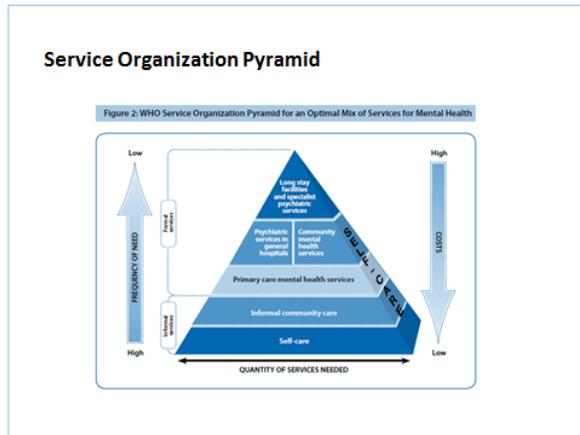


Recognizing the often limited capacity of countries to address mental health and alcohol and substance use issues, the WHO recommends concentrating efforts to build the individual's capacity to take care of him- or herself. The majority of interventions should entail action within the individual through self-care behaviors, at the community level through traditional practitioners and CBOs, and at the community health facility level wherever possible (WHO 2009).

Simple interventions at the community and health facility levels that build the capacity of the client to care for him- or herself are essential. Building the client's capacity to improve emotional health and to reduce alcohol and drug use can occur through a number of methods.

*Slide 101:* Simple Therapeutic Interventions for Depression—Education



Providing the client with education regarding his or her illness can help offer perspective and reinforce that depression is common, treatable, and temporary. Emphasizing that the client can take action to address feelings of depression is crucial (Markowitz and Wiseman 2004; Tegegn, Wissow, Jerene et al. 2010).

*Slide 102:* Simple Therapeutic Interventions for Depression—Advice



In addition, providing the client with simple talk therapy to help him or her identify the principal sources of stress so that he or she can brainstorm methods to take action to reduce the stress is helpful. Encouraging a healthy lifestyle and accessing additional support from CBOs and supportive friends and family may also be helpful (Markowitz and Wiseman 2004; Tegegn, Wissow, Jerene et al. 2010).

*Slide 103:* The Wellness Recovery Action Plan

**The Wellness Recovery Action Plan (WRAP)**

**Daily Maintenance**
- Describe yourself when you are feeling all right
- List what you need to do daily to keep yourself feeling all right

**Things are Breaking Down or Getting Worse**
- Describe how you feel when things have gotten worse
- List the things you have done in the past or could do when you notice that things are getting worse that will help avoid a crisis

**Crisis Planning**
- What are the symptoms that indicate that you need others to take action to help you
- Individual(s) who you want to help you
- Actions that others can take that would be helpful
- Actions that should be avoided

The Wellness Recovery Action Plan (WRAP) may be found in the *Standard Operating Procedure Manual.*

A common counseling technique for mental health symptoms is the WRAP in which counselors allow clients to explore:

- How they feel when things are okay, and how they might maintain this level of well-being.

- How they feel when things are getting worse, and what actions they might take to help feel better.

- How they feel when they are experiencing a crisis

and the actions that should be taken to return them to an improved well-being. The WRAP also contains a toolkit (see the second page of the handout) to help the client identify which actions might be helpful.

*Slide 104:* Mental Health Role Play

**Mental Health Role Play**

Watch the role play and observe:
- How did the counselor make sure that the environment was therapeutic?
- Which interviewing techniques are used?
- Which intervention(s) were offered (ie: advice, education)?
- What else could the counselor have done?

It is now time for the trainers to role model a mental health role play. Make sure to establish a therapeutic environment, and use motivational interviewing techniques. The **Example Mental Health Counseling Role Play** can be found on page 105 of this manual.

**3. Simple Therapeutic Interventions for Alcohol and Substance Use** (Lecturette) - ⏱ 30 minutes

When working with a client who is suspected of alcohol or substance use, it is important to consider the linkage between mental health and alcohol and substance use. To differentiate between mental health problems and alcohol and substance use problems, each time a client has a positive screen for alcohol or substance use the provider should consider:

    a.   Is the client self-medicating with alcohol and/or substances because he or she is depressed?

    b.   Is the client depressed because he or she is drinking and/or using substances?

**Slide 105:** Motivational Interviewing for Alcohol and Substance Use

**Motivational Interviewing for Alcohol and Substance Use**

A directive, client-centered counseling style that enhances motivation for change by helping clients clarify and resolve ambivalence about behavior change.

– Brief interactions can be effective when client needs/concerns are gathered with health messages specifically tailored to address those concerns

– Empowers the client to take ownership over their health by working in partnership with the provider so that they feel capable of reaching their health goals

Motivational interviewing is utilized to motivate clients to create positive behavior change through health messages and taking opportunities to empower themselves.

**Slide 106:** Motivational Interviewing

**Motivational Interviewing**

• Each client is powerful and capable of change

• When the provider also believes that the client can change, it also helps the client to believe in themselves

• Setting high expectations of the client to achieve their goals can help them work harder to do so.

*Your job is to provide hope, belief in the client, and express confidence that the client can make positive changes!!*

Motivational interviewing is most successful when the client implicitly knows that he or she is powerful and can create positive change. The provider should reinforce these messages by providing them to the client and setting high expectation of them.

**Slide 107:** OARS

**OARS: Therapeutic Counseling Tips**

• **O**pen-ended questions
– "How much do you drink in the evening?"
– "Do you think that you should cut down?"

• **A**ffirmations
– "That was a smart decision."
– "I am glad you came in today."

• **R**eflections
– "Am I correct in hearing you…"
– "It sounds like you are saying…"

• **S**ummaries
– "To recap you say you are ready to reduce your alcohol intake starting this week. Is this correct?"

When providing therapeutic communication, keep in mind that asking the client open-ended questions requires more of a response than a yes/no answer. Providing affirmations to the client, reflecting on what the client is saying, and summarizing the conversation may also be helpful for the client.

*Slide 108:* Steps in Motivational Interviewing

**Steps in Motivational Interviewing**

- Assessing the client
  – Establish rapport, show empathy, carry out a CAGE-AID, provide <u>objective</u> results and feedback
- Explore the good and problematic parts of substance use
  – What are some good things? How have they helped you?
  – What is the downside? What parts are you not happy about?

The first step in motivational interviewing is to establish a relationship or rapport with the client by demonstrating empathy and good listening skills. Once a CAGE-AID has been completed, provide objective results.

- An example of an objective result is providing factual statements. "You are drinking 12 beers daily," or "You have missed work twice this week due to substance use, this seems to be interfering with your professional life."

The second step in motivational interviewing is to explore the positive and negative elements of alcohol or substance use for the clients.

*Slide 109:* Steps in Motivational Interviewing

**Steps in Motivational Interviewing**

- Summarizing
  – Summarize the good and problematic components of substance use
  – Summarize how substance use impacts life goals
- Decisions and goals setting
  – After this discussion, are you more clear about what you will do?
  – What is your first step?
  – What will you do in the next few weeks?
  – How confident are you on a scale of 1-10?

The third step in motivational interviewing is to summarize what the client has described as the good and problematic parts of his or her substance use and compare this to how it impacts his or her life goals.

The last step in motivational interviewing is to assist the client in decision making and goal setting. Identify any changes that the client would like to make and determine what his or her first step will be, such as lessening the amount of substance used or completely stopping by establishing a "quit date" and support plan.

A tool that is often used to assess readiness to change with alcohol and substance use is the Readiness to Change Rulers. It is a quick assessment that can be used to determine a client's readiness to change a specific behavior. The Readiness to Change Rulers can assist you in assessing the client on two levels: 1) the client states how important he or she thinks the desired change is and then ranks the level of importance, and 2) the client ranks how likely he or she is to make that change.

This can help you work with the client to identify and address barriers to healthy behavior changes. Utilize this tool to determine the client's readiness and motivation to change a behavior and as a discussion piece to promote healthy behavior change.

*Slide 110:* The Readiness to Change Rulers
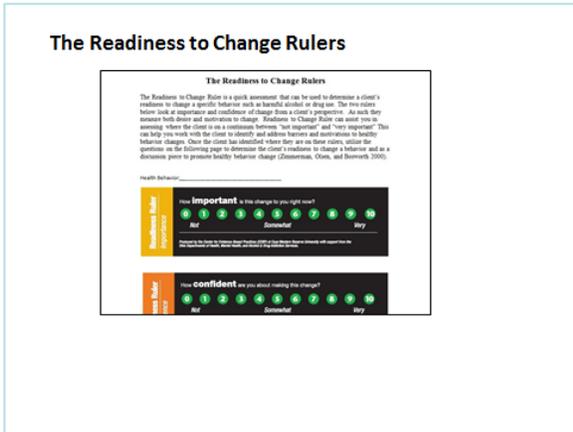
The Readiness to Change Rulers can be found in the *Standard Operating Procedure Manual*. This will also be provided as a job aid so that you can have it on hand to use with clients.

To utilize the Readiness to Change Rulers, the care provider should ask the client about the desired behavior to change.

- "How important is decreasing your alcohol use to you on a scale of 0 to 10?"

- "How likely are you to actually reduce your alcohol intake this week?" This helps to examine the client's desire and motivation to change. The provider can then lead a discussion based on the client's readiness with the guidance that is provided on this page.

*Slide 111:* Simple Therapeutic Interventions for Alcohol and Substance Use

Providing a brief counseling intervention that reduces judgment and focuses on where clients are along the continuum of change has proven to be effective to help clients cut down or stop substance use.

Hand out the **Counseling Tip Sheet for Harmful Alcohol and Substance Use** (on page 107 of this manual). This may be utilized in practice to assist with clients with suspected substance use (Tegegn, Wissow, Jerene et al. 2010).

*Slide 112:* Motivational Interviewing Techniques

Hand out the **Motivational Interviewing** sheet (on page 115 of this manual), which provides in-depth information about this technique. Motivational interviewing is a collaborative approach that is client led. A common framework for motivational interviewing includes the following steps:

- Expressing empathy; relating to the client that what he or she is experiencing must be difficult.

- Providing choices; helping the client determine a difference between his or her current state and what he or she would like it to be.

- Empowering the client; the client leads the process, which supports self-efficacy and builds his or her confidence that he or she will be able to

reach the stated goal by identifying previous successes. Highlight areas where the client has overcome barriers to change in the past.

- Providing feedback; reflect what the client is saying to you and provide some feedback that focuses on how he or she has moved forward. It is important not to interfere if the client is resistant to change. Do not argue with the client (Miller 2011; Walsh 2010).

- Clarifying goals; end the session by recapping the goals the client has stated and work to create a plan for change that reflects what the client wants.

*Slide 113:* Alcohol and Substance Use Role Play

**Alcohol and Substance Use Role Play**

Watch the role play and observe:
- How did the counselor set up a therapeutic environment?
- Which motivational interviewing techniques were used?
- What else could the counselor have done?

It is now time for the trainers to role model an alcohol and substance use role play. Make sure to establish a therapeutic environment, and use motivational interviewing techniques. The **Example Alcohol Counseling Role Play** can be found on page 107 of this manual.

**4. Practice Therapeutic Communication Skills and Basic Interventions** (Role Play) - ⏱ *35 minutes*

Practicing therapeutic communication skills is important for successfully interviewing clients in practice. Let participants know that they will be participating in three different role plays. They should read the information provided in the slide, but it is okay if they want to elaborate on their role.

Participants should select a partner; each partner should alternate roles for each role play, taking turns as provider and client.

Tell participants that they should conduct an interview based on the information provided in the slide. They should practice utilizing therapeutic communication techniques and basic interventions, including motivational interviewing techniques and the Readiness to Change Rulers.

After the partners have had an opportunity to play each role, review the therapeutic techniques that the providers used during their interviews and make suggestions for additional therapeutic communication techniques that may also be used.

Repeat this protocol for Role Plays 2 and 3. Allow a total of ⏱ *10 minutes* for each role play.

**Role Play with Japera**

Japera comes to the clinic today for her first visit following a positive diagnosis that she received one month ago. She is clearly withdrawn and appears sad. She feels overwhelmed by the diagnosis and does not have very much knowledge surrounding HIV.

Obtain information from the client regarding her physical and emotional health using therapeutic communication techniques and basic interventions.

*Slide 115:* Role Play 2

**Role Play with Mudiwa**

Mudiwa, an elderly woman seeks care from the Traditional Healer who she knows well because she has been having difficulties sleeping at night due to "too many thoughts". She appears withdrawn and is irritable when asked about her physical health. She states that she would rather just not be alive.

Interview Mudiwa to determine if there are any recent changes in her status that would cause her to feel this way utilizing therapeutic communication techniques and basic interventions.

*Slide 116:* Role Play 3

**Role Play with Gamba**

Gamba, a 17 year old man has been accessing services at the CBO for several years and is well known to the organization. He has always been responsible about taking care of himself and has performed well in school. He recently had to start medication due to a decline in his CD4 count. He comes in today and receives a CAGE-AID Screen result of 2.

Carry out an interview with Gamba utilizing motivational interviewing techniques and assess his readiness to change.

This concludes Module 10

# Module 11:
# Practice Facilitation

**Session Objectives:**

By the end of the session participants will:

1. Practice and present a component of the training
2. Be prepared to provide training to colleagues at their respective site.

**Time Needed:** ☉ *Total session time is 60 minutes*

**Materials:**

☐  <u>PowerPoint slides:</u> Slide Set Day Two: Practice Co-Facilitation (*Slides 117-119*)

**Techniques:** Co-Facilitation Presentations

**Facilitator Notes:**
The facilitator should split the participants into two separate groups for practice facilitation to guarantee that they have sufficient time to present. Allow ☉ *5 minutes* for each participant to facilitate a session and respond to any questions that may arise.

**Learning Activities:**
**1. Practice Facilitation Sessions**- (Facilitation Presentations) - ☉ *60 minutes*

*Slide 117:* Module 11 Title Slide



MODULE 11

Practice Facilitation Sessions
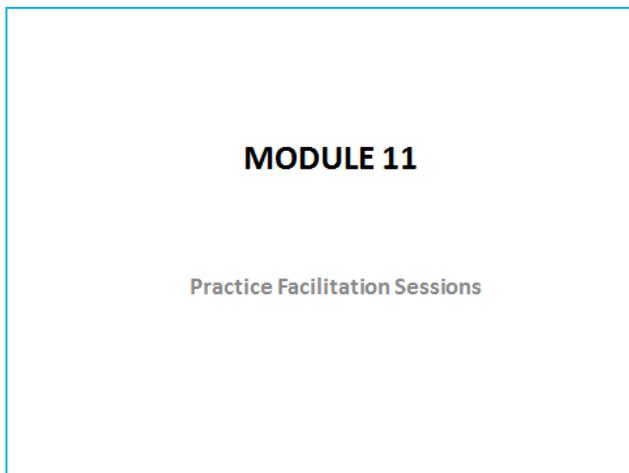
**Slide 118:** Objectives for Module 11

**Objectives for Module 11**

1. Practice and present a component of the training
2. Be prepared to provide training to colleagues at sites

Briefly review the objectives for this module.

It is important that participants have the opportunity to practice facilitating sessions during Day Two to help prepare them for sharing this information with their colleagues when they return to their site.

The purpose of this activity is to help participants become familiar with the materials and feel comfortable sharing the information with a group. The facilitator should circulate among the participants to respond to any questions and monitor their progress.

Allow participants approximately ⊕ *10 minutes* to review the materials they will present. Divide participants into two separate groups for small group presentations, allowing ⊕ *5 minutes* for each presentation.

**Slide 119:** Practice Facilitation Session

**Practice Facilitation Session**

• How was the experience?

• What will be important components to keep in mind when they carry out the training at their sites?

• What questions remain?

Following the presentations, bring the large group back together and review the experience.

Encourage participants who express hesitation to carry out additional individual practice with their partners before carrying out the training at their site.

Carry out a discussion surrounding any additional components or logistics that they will have to keep in mind as they move forward at the pilot sites. This may include:

- Scheduling the training so that all colleagues who will carry out the screening can attend
- Making sure that there is ample space for the training
- Making sure that participants have all the necessary materials for the pilot and training
- If possible, working with their Community Integration Leader so that he or she can also attend the training and assist.

✋ This concludes Module 11

**Session Objectives:**

By the end of the session participants will:

        1. Plan for the pilot activity

        2. Carry out data collection for the pilot activity

        3. Carry out referral documentation for an integrated community network

        3. Create a workplan.

**Time Needed:** ⏱ *Total session time is 60 minutes*

**Materials:**

☐   PowerPoint slides: Logistics (*Slides 120-133*)

☐   Handouts: **Mental Health and HIV Integration Workplan**, on page 117 of this manual

**Techniques:** Group Discussion, Large Group Brainstorm, and Lecturette

**Facilitator Notes:**

Take care to answer all the questions that arise during this session, as this session should provide very clear steps forward for the site staff training and pilot activity.

**Learning Activities:**

**1. Data Collection Responsibilities** (Lecturette) **-** ⏱ *20 minutes*

*Slide 120:* Module 12 Title Slide



Carefully considering logistics of how to integrate mental health services into routine HIV care is essential before implementation.

Participants should envision the first day of implementation and consider the various logistical arrangements that should take place for the pilot to be carried out in an organized manner.

**Slide 121:** Objectives of Module 12

**Objectives for Module 12**

1. Plan for implementation of the integrated program
2. Carry out data collection
3. Carry out referral documentation for an integrated community network
4. Create a work plan

Briefly review the objectives for this module.

**Slide 122:** The Importance of Data Collection

**The Importance of Data Collection**
- Data helps identify where the program is doing well
  - Number of referrals, Number of clients screened
- Data helps identify where the program can improve
  - Few clients referred despite positive screening results
  - Few providers carrying out screenings
- Data helps identify trends with clients
  - Can help to track one patient over time
  - Can help to track issues commonly arising in a patient population
- Data is also is used to identify gaps and improve the program

Data collection is beneficial to a program on a number of levels:

- Data can help a program identify where it is performing well.

- Data can help program planners identify where the program can improve.

- Data can help identify both individual trends in clients and programmatic trends.

Data should be routinely collected and analyzed so that it can be used for program planning to improve the quality of services for clients.

**Slide 123:** Data Collection at the Health Facility Level

**Data Collection at the Health Facility Level**

| | MRN | Gender (M or F) | Date of Assessment | SSQ Score | CAGE-AID Score | Referral (Y/N) | Organization where referred | Referral completed (Y/N) | Comments |
|---|---|---|---|---|---|---|---|---|---|

This sample Data Collection Sheet can be found in the *Standard Operating Procedure Manual.*

The information from each screen should be documented in the Data Collection Sheet. It is expected that this will take place at the end of each client encounter.

Each provider should receive his or her own Data Collection Sheet(s). Providers will use the sheet to document each client's medical record number and gender, the date of assessment, the results of the SSQ, the results of the CAGE-AID, whether a referral was carried out, whom the referral was made to, whether the referral was completed by the client, and any additional comments that they may have. Note that the job aid is available on the reverse side of each Data Collection Sheet to assist health providers throughout the pilot activity.

As Integration Leaders, you should keep a steady supply of Data Collection Sheets available, monitor all providers to make sure that they are routinely collecting data, and ensure that all data are provided to the Data Capturer.

*Slide 124:* Data Collection at the Community and Traditional Practitioner Levels



**Data Collection at the Community and Traditional Practitioner Levels**

Each CBO and traditional practitioner should also collect data that includes the client's identification number and gender, the date of assessment, the Abbreviated Community Screen score, whether a referral was made and to whom, and whether the referral was completed.

This sample Data Collection Sheet can be found in the *Standard Operating Procedure Manual.* The Integration Leader should routinely collect the Data Collection Sheets from participating CBOs and traditional practitioners. Note that the job aid is also available on the reverse side of each Data Collection Sheet at the community level to assist the CBO worker and traditional practitioner throughout the pilot activity.

**2. Integration Leader Responsibilities** (Lecturette and Activity) - ⏱ 20 minutes

*Slide 125:* Integration Leader Responsibilities

**Integration Leader Responsibilities**

- Will introduce the integration project to community leaders to provide visibility, advocacy and de-stigmatize mental health problems, substance use and HIV
- Train colleagues and other community sites as required
- Lead and monitor integration at their site and in the community
- Ensure protocols are followed
- Ensure linkages are in place within community
- Ensure continual availability of integration materials

Participants should envision the first day of the pilot activity and consider the various logistical arrangements that should take place for the pilot to be carried out in an organized manner.

Review each activity.

**Slide 126:** Inter-Organization Communication

> **Referrals and Linkages**
>
> The Integration Leader should:
> - Support and encourage colleagues to make referrals, and routinely monitor the Referral Register to ensure that referrals are recorded
> - Ensure that linkages remain strong for referrals within a facility and between facilities
> - Keep Mental Health/HIV Integration Referral Directory up to date
> - Routinely communicate with other Integration Leaders within the community to ensure a seamless referral system

The Integration Leader should also:

- Support and encourage colleagues to make referrals and supervise documentation to ensure that it is carried out per protocol
- Maintain and disseminate the Mental Health/HIV Integration Referral Directory
- Routinely communicate with other Integration Leaders in the community to improve the referral process.

Besides adequate supervision and guidance, additional needs include adequate infrastructure, materials, and a functioning communication system within the community network.

**Slide 127:** Mental Health Integration Logistics

> **Integration Requires: Infrastructure, Materials, and Communication**
>
> Adequate space for a private conversation
> - What if there is not space for privacy?
>
> Adequate materials (Referral Forms, Referral Register, Data Collection Sheets, Screening Tools)
> - What if the materials run out?
> - Where will the materials be located?
>
> Strong communication
> - Between colleagues and Integration Leader
> - Between the Community Integration Leader and Integration Leaders
> - Between AIDSTAR-One Consultants and Integration Leaders

Emphasize that Integration Leaders should also consider providing adequate space for privacy to carry out screening and counseling prior to beginning activities.

There should be an uninterrupted supply of materials. Identify who is responsible for ensuring that this supply is continuous. Communication at all levels is essential to ensure that strong linkages and referrals are in place and that when gaps in the system are noted, they can be addressed quickly.

**Slide 128:** Privacy and Confidentiality Issues

> **Privacy and Confidentiality Issues**
>
> Reinforce the importance of privacy and confidentiality in your setting.
> - Protect the client's privacy by making sure that doors are closed when carrying out a screen and counseling interventions
> - Do not discuss a client in a public area
> - Once a screen has been carried out, document the result on the Data Collection Form and place the screen in the medical record

Remind participants that confidentiality and the client's privacy must be respected at all times and that this should be reinforced routinely with all staff. This can be carried out by:

- Making sure that doors are shut and that screens are carried out in private
- Not discussing clients in public areas where other clients may overhear
- Documenting the results of the screen on the Data Collection Sheet and immediately placing the screen inside the client's medical record.

It is expected that participants will train their colleagues on integration of the screening tools and basic interventions once they return to their site. They should focus on the following points when they return and deliver the follow-on training.

### Slide 129: Training Colleagues

**Training Colleagues**

Ensure that all staff who provide direct client care can attend the training and:

• Understand the referral protocol

• Are comfortable utilizing screening tools and carrying out basic interventions

• Understand data collection responsibilities

All staff members who provide direct client care should attend the training. The Integration Leader should ensure that all colleagues understand the referral protocol related to the results of the screening tools and basic counseling interventions.

In addition, they should be comfortable with utilizing the screening tools in practice and should understand and agree to the data collection responsibilities.

**3. Creating an Emergency Action Plan and Workplan** (Activities) - ⏱ *30 minutes*

Participants should consider an appropriate protocol that staff at their site should follow in case of emergency, including procedures for acute suicidal ideation or acute alcohol withdrawal. Each site should create an action plan for the workplace.

Refer to the Emergency Action Plan in the *Standard Operating Procedure Manual* for a template to complete so that a protocol is in place should a client be identified as in acute alcohol withdrawal or an acute risk to him- or herself or to someone else. Guidelines for acute alcohol withdrawal and suicidal ideation from the Zimbabwe MOHCW are also available within the *Standard Operating Procedure Manual*. Participants have ⏱ *10 minutes* to complete this activity.

### Slide 130: Workplan

**WORKPLAN**

Mental Health and HIV Integration Work Plan

Tell participants that they will create a workplan so that they will quickly be able to move forward with integration activities once they return to their site. Hand out the **Mental Health and HIV Integration Workplan**, which can be found on page 117 of this manual.

Briefly explain that the workplan will help them define the required activities, the person responsible, and a timeline for carrying out the pilot activity. Some activities have already been placed in the workplan to assist them in getting started.

Participants should identify any additional activities that may be required at their site, determine which colleague is responsible for taking on the activity, and decide on the timing in which the activity will occur. Let participants know that you expect the training of colleagues at their site to happen within the next week, so that integration will occur within the next two to three weeks.

Let them know that they have approximately ☺ *15 minutes* to discuss and create their workplan. After ☺ *15 minutes* have passed, invite an individual to present his or her workplan to the larger group. Ask if there are any questions about moving forward and clarify as needed. Now that the participants have taken care of logistics, they will now take part in an activity where they have the opportunity to put all of the information that they have learned during the training together through some case studies.

## 4. Putting it All Together (Group Work) - ☺ *20 minutes*

*Slide 131:* Putting It All Together-Ivan

**Putting it All Together- Ivan**

Ivan visits the TMP for the first time and has not yet been screened.
- What screen should be used? What score(s) would be considered a positive screen?
- What should be done if the screen is negative?
- What should be done if the screen is positive?
- Where will you document the screening result?
- What type of documentation is required for a referral?
- When should you do a follow-up screen for a positive result?

- Ivan should have an Abbreviated Community Screen. A positive screen would be a 7 or greater to the sad or worry questions or a "yes" to the alcohol or substance use question.

- If the screen is negative and mental health problems are not suspected, he should be re-screened in one year.

- If the screen is positive for mental health or substance use problems, he should receive a basic counseling intervention, including a WRAP intervention or the Readiness to Change Rulers, and a referral for a full screen to the health facility.

- The screening result should be documented in the Data Collection Sheet.

- Ivan should be given a completed Referral Form with verbal instructions on how to complete the referral, and the referral should be recorded in the Register of Referrals – OUT log.

- He should be re-screened at the health facility during his next visit.

*Slide 132:* Putting It All Together-Joy

**Putting it All Together-Joy**

Joy visits the CBO today, she received an Abbreviated Community Screen one year ago which was negative, today she receives another screen and scores a 2 on the sad question, a 4 on the worry question and a 0 on the alcohol and substance use question, however, you still suspect that she is suffering from mental health problems.
- What should you do today?
- Where will you document results?
- What type of documentation is required for a referral?
- How will you know she completed the referral?

- Because Joy is suspected of having mental health problems despite a negative screen, she should still be considered to have a positive screen and referred to the health facility for a full screen.

- She should also continue to receive psychosocial services from the CBO.

- The screening results should be documented in the Data Collection Sheet.

- Joy should be given a completed Referral Form with instructions on how to complete the referral, and the referral should be documented in the Register of Referrals – IN log.

- You will know that she completed the referral when she follows up with the bottom half of the referral form completed by the health facility.

*Slide 133:* Putting It All Together-Derek

**Putting it All Together- Derek**

Derek attends the health facility today and has not ever received a screen.
- Which screen(s) should he receive today?
- What should be done if his screens are negative?
- What type of counseling intervention should be carried out if his SSQ is positive?
- What type of counseling intervention should be carried out if his CAGE-AID is positive?
- Where will the screening scores be documented?
- What documentation is required to make a referral?

Derek should receive an SSQ and CAGE-AID.

- If his screens are negative and mental health problems are not suspected, he should be re-screened in one year.

- If his SSQ is positive, he should receive a basic counseling intervention, including a WRAP, and be screened for higher-level assessment, counseling, and medication therapy as needed. He should also be referred to a CBO for psychosocial support.

- If his CAGE-AID is positive, he should receive motivational interviewing, including the Readiness to Change Rulers, and be referred for higher-level assessment and counseling (either internal or external).

- His screening scores should be documented in the Data Collection Sheet.

- Derek should be given completed Referral Forms with instructions on how to complete the referrals. The Register of Referrals – OUT should also be completed.

- Clarify any remaining questions on the protocol.

This concludes Module 12

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# Module 13:

# Closing Activities

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**Session Objectives:**

By the end of the session participants will:

      1. Play the review game to revisit the content from the training

      2. Have the opportunity to ask any remaining questions

      3. Take a post-test

      4. Provide a workshop evaluation.

**Time Needed:** ⏱ *Total session time is 90 minutes*

**Materials:**

    ☐ PowerPoint slides: Closing Activities (***Slides 134-137***)

    ☐ Handouts: **Mental Health/HIV Integration Review Game**, on page 119 of this manual
           **Mental Health/HIV Integration Review Game Answer Key**, on page 121 of this manual

**Techniques:** Group Discussion, Large Group Brainstorm, Lecturette, and Game

**Facilitator Notes:**

Prepare for this session by cutting out the **Mental Health/HIV Integration Review Game** pieces (on page 119 of this manual) and placing them in a hat or jar.

**Learning Activities:**

**1. Review of Next Steps-Group Discussion** (Group Discussion) - ⏱ *20 minutes*

***Slide 134:*** Module 13 Title Slide



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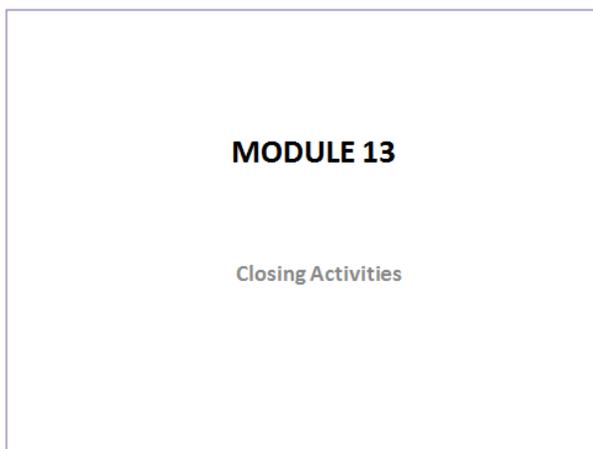
Briefly review the objectives for this module.

**Objectives for Module 13**

1. Play the review game to revisit the content from the training
2. Have the opportunity to ask any remaining questions
3. Take a Post-Test
4. Provide a workshop evaluation

*Slide 136:* Review of Next Steps

**Review of Next Steps**

- Organize and carry out a site training such that all employees who carry out direct client care will be trained on integration activities in the next week.

- Start Mental health/HIV Integration Pilot Activity within two-three weeks

- Provide on-going site support for the activity

Review the next steps, which include the site staff training within the next week and the commencement of integration activities within two to three weeks.

Participants should refer to their workplan for specific activities, responsibilities, and timelines that show when activities will be carried out.

Answer any remaining questions about the information that they have gained during this workshop or about their responsibilities as they move forward with the pilot activity.

**2. Mental Health and HIV Integration Review Game** (Game) - ⏱ *30 minutes*
*Slide 137:* The Mental Health and HIV Integration Review Game

The Mental Health and HIV Integration Review Game

Tell participants that they will now be playing a game to review the information that they have learned. Have participants join into groups and tell them that you have several questions that have been folded up inside your hat or jar. Each team will have the opportunity to select a question from the hat or jar and read it aloud to the group. Group members will have the opportunity answer the question. If they are unable to answer it, the other team(s) will have the opportunity to answer it. If no group is able to give the correct asnwer, provide it to them and move on to the next question. Each group should take turns answering questions.

Whoever answers the most questions correctly at the end will win a prize. See page 121 of this manual for the **Mental Health/HIV Integration Review Game Answer Key**. Provide the winning team with its prize at the conclusion of the game and thank all the participants for playing.

### 3. Post-Test and Workshop Evaluation and Closing - ⏱ *40 minutes*

Hand out post-tests and workshop evaluations and tell participants to answer the questions to the best of their ability and to raise their hands when they are finished so that the evaluations can be collected.

Ⓟ Answer and respond to any remaining questions in the Parking Lot.

Thank participants again for their attendance and for their attention during the activities for Day Two. Hand out certificates and let participants know that you look forward to supporting them as they move forward with the pilot activity.

✋ This concludes Module 13

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**ANNEX 1:**

# WORKSHOP FOR INTEGRATING MENTAL HEALTH INTO HIV SERVICES IN ZIMBABWE

## INTEGRATION LEADER'S TRAINING MANUAL

***This manual should be used by integration leaders to train their colleagues during site staff trainings.***

**The Training Manual**

This training manual is comprised of seven modules that include:

1. The mental health/HIV integration activity
2. Mental health basics
3. Alcohol and substance use basics
4. The screening tools
5. Therapeutic interventions
6. Linkages for an integrated community network
7. Data collection responsibilities and conclusion.

Share each module with your colleagues. Some modules have activities that should be carried out by training participants. Ensure that sufficient time is spent on each activity such that the information is shared, but also note that discussions should be monitored for time as the training may be lengthy if not carried out in an efficient manner.

At the end of each module is a list of questions that should be reviewed with participants. Be sure that all participants are able to answer these questions and understand the information prior to moving on to the next module. *Pay particular attention to ensure that your colleagues understand the correct protocols for screening and referrals.*

**Training Attendance**

This training uses a cascade approach; therefore, all colleagues who provide direct client care should attend the training. It is important to notify all staff ahead of time that they are expected to attend the training so that they can allow for time in their schedule to attend.

**Required Materials**

1. Ensure that there are adequate Data Collection Sheets for each cadre of health workers (health facility staff, CBO staff, and traditional practitioners).
2. Have sufficient copies of the Readiness to Change Rulers, the WRAP tools, the completed Directory of Community Services, and the Client Referral Form.
3. Ensure availability of job aids, including the Job Aid for the Health Facility, the Job Aid for the CBO and TMP, and the Mental Health and HIV Protocol.

**Required Time**

It is estimated that this training may take 8 to 10 hours to complete, although some sites may choose to spend additional time training. The trainers may opt to carry out all the modules in one day or they may choose to divide the training in half, such that Modules 1 to 4 are provided on Day One and Modules 5 to 7 are provided on Day Two; thus, allowing more time each day for client services.

# Module 1:

# The Mental Health/HIV Integration Pilot Activity

**1. Introduction and the Connection between Mental Health and HIV**

This training today will:
- A. Describe the pilot activity
- B. Review basic mental health problems
- C. Review harmful alcohol and substance use
- D. Introduce the screening tools and protocols for utilization
- E. Review therapeutic interventions based on the results of the screening tool
- F. Introduce protocols for referrals and linkages
- G. Explain data collection responsibilities.

Those suffering from mental health problems and harmful alcohol and substance use are more vulnerable to contracting HIV. Additionally, prevalence of mental health problems is much higher in people living with HIV (PLHIV) than in the general population. This is due to two factors: the vulnerability of those living with mental health problems and the great psychological burden that living with HIV places on the infected person. Substance use, which may be a coping mechanism to deal with the psychological burden of HIV, can negatively impact the progression of HIV, including non-adherence, care-seeking behaviors, and response to treatment.[1]

Persons suffering from mental health problems are more vulnerable to sexual exploitation, may have difficulties advocating for safe sex, and may be less likely to stay in long-term, monogamous relationships.[2] Those who use substances are less likely to take precautions with sexual activity and are also at an increased risk through the sharing of needles.

Self-care such as adherence to treatment, nutrition, sleep, exercise, and making and completing clinic appointments are also much more difficult in the presence of mental health problems.1

There are various points during the course of HIV that can cause the infected person to become more vulnerable to experiencing mental health problems.

The time surrounding diagnosis and disclosure can bring about increased stress resulting in depression and anxiety symptoms.
- Reactions to diagnosis may greatly vary among persons. It is important to speak with the person following a positive diagnosis to perceive his or her reaction, express compassion, and encourage him or her to find a support person or group on whom he or she may rely.
- Disclosure is also a very stressful period. The client may feel ashamed and fear losing a loved one if he or she discloses.

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[1] World Health Organization. 2008. *HIV/AIDS and Mental Health*. Report by the Secretariat. Available at http://apps.who.int/gb/ebwha/pdf_files/EB124/B124_6-en.pdf (accessed November 2013)

- Stigma, both internal (negative feelings and attitudes that the client places on him- or herself) and external (attitudes coming from society), is an enormous source of stress that can cause a client to reduce care-seeking behaviors in an effort to hide his or her HIV status. This may include missing clinic appointments and not taking medicine.2

For these reasons, routine mental health screens with HIV-positive clients may help improve rates of adherence and retention in care as well as their perceived quality of life.

**3. Review**

Explain why PLHIV are more likely to experience mental health problems.

Why might a person with HIV use alcohol or other substances?

List some particularly vulnerable periods for a PLHIV.

# Module 2:
# Mental Health Basics

**1. Basic Definitions**

According to the World Health Organization (WHO), health is "a state of complete physical, mental and social well-being and not merely the absence of disease."
- Mental health describes the psychological or mental state of an individual.
- A mental health problem is any disease or condition affecting the brain that significantly influences or disrupts a person's thinking, feelings, mood, ability to relate to others, and daily functioning.
- Mental disorder is when a problem or symptom disrupts daily functioning in the home, at school, and/or in the community.

*Review these mental health problems, definitions, and signs and symptoms with participants.*

| Mental Health Problem | Definition | Signs and Symptoms |
|---|---|---|
| Depression | Persistent feelings of sadness and loss of interest[3] | Low energy, sleep and appetite changes, persistent sad or anxious mood, low interest or pleasure in activities that used to be enjoyable, multiple physical complaints, difficulties carrying out usual work, school, or social activities[4] |
| Anxiety | Persistent worry about major or minor concerns[5] | Excessive fear or nervousness commonly occurs with depression, inability to fall asleep, racing thoughts, difficulty concentrating, hyper-vigilance and quick startle response, fear of leaving the house, avoidance of stress-inducing trigger/situations4 |

**2. Gender-Based Violence**

It is also important to consider the effect of gender-based violence and its contribution to anxiety and depression.
- Over half of women have been the victims of some form of violence in Zimbabwe, with one out of four being the victim of sexual violence.
- Violence can increase women's risk of experiencing anxiety.
- Trauma and sexual violence also increase their risk of contracting HIV. Women who have a history of sexual violence may report multiple somatic complaints, which often include genital pain.[6]

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[3] Mayo Clinic. 2013. *Depression*. Available at http://www.mayoclinic.com/health/depression/DS00175 (accessed November 2013)
[4] World Health Organization. 2010. *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings: Mental Health Gap Action Programme (mhGAP)*. Available at http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf (accessed November 2013)
5 Mayo Clinic. 2013. *Anxiety*. Available at http://www.mayoclinic.com/health/anxiety/DS01187 (accessed November 2013)
[6] Nyamayemombe, C., V. Mishra, S. Rusakaniko et al. 2010. *The Association between Violence against Women and HIV: Evidence of a National Population-Based Survey in Zimbabwe.* Zimbabwe Working Papers. Volume 4. Available at http://pdf.usaid.gov/pdf_docs/PNADR630.pdf (accessed November 2013)

If you suspect that the client is a victim of violence:
- Provide an opportunity to speak to the client alone so that the partner is not in the room (if the partner is, or is suspected of being, the perpetrator) and other clients and staff cannot overhear
- If the client is a woman, if possible make sure that the person doing the assessment is also a female to encourage sharing and help the client feel safe
- Listen to the client without judgment
- Offer additional appointments to return to the clinic for more help and check-ins
- Help the client to identify a trusted individual with whom he or she can speak
- Refer the client to psychosocial services in the area for additional support.

**3. Mental Health Emergencies**
Suicidal Ideation:
Certain points during the course of the illness may cause a severely depressed client to consider suicide. These points include the period of initial diagnosis, when the CD4 cell count first declines and medication begins, medical complications, periods of chronic pain, and rejection or death of a loved one.[2]

During the course of a screening a client may indicate that he or she is having thoughts of harming him- or herself or committing suicide. Anytime a client is suspected of having depression, he or she should be screened for suicide by asking some simple questions, including:

A. Are you thinking of hurting yourself?
B. Have you ever attempted suicide in the past?
C. Do you have a plan? If yes, what is it?

- If the suicidal thoughts can be attributed to worsening illness, provide treatment as appropriate. If the thoughts can be attributed to a loss or rejection, connect the client to mental health or counseling services as available. If these services are not available, ask the client who he or she can talk to about these feelings and explore ways to provide this social support for the client. Additionally, providing listening and some therapeutic counseling and support may help the client reframe his or her negative thought processes.[2]

- Make an agreement that the client will follow up or notify someone immediately if the suicidal thoughts return.

Immediate action should always be taken with suicidal clients. This includes bringing the client to the most qualified person on staff to carry out an immediate assessment and taking additional actions, including notifying the client's social network where available, providing close observation, and prescribing medication and referrals where appropriate.[9] **The Integration Leader has an emergency protocol available for acute suicidal ideation that will be posted at a central location.**

**4. Mental Health Case Study**
*Carry out the following case study with participants.*

Miriam, a 25-year-old married mother of three, was diagnosed with HIV six months ago. She has been relatively healthy; however, she has not been attending her appointments as scheduled. When she does attend, she appears withdrawn, impatient with her children who accompany her, and complains of generalized aches and headaches. What do you suspect and why?

– *Case Study Answer: The period surrounding initial diagnosis is a particularly vulnerable period for mental health problems. Miriam has not been routinely attending appointments; she appears withdrawn and irritable and has multiple somatic complaints, which should lead the assessor to suspect that she is suffering from depression.*

**5. Review**

 Define mental health.

 Define mental health problems.

 Describe the symptoms that are associated with depression.

 Describe the symptoms that are associated with anxiety.

 Describe the actions that should be taken if a client is suspected of gender-based violence.

 Describe the appropriate actions to take when a client is suspected of suicidal ideation.

## 1. Why Alcohol and Substance Use Is of Concern

- Although most women and just over 50 percent of men abstain from alcohol in Zimbabwe, there remains a significant issue among those who drink, with studies indicating that 39 percent of men and 20 percent of women who drink are heavy episodic drinkers.[7]
- In the setting of drug use, HIV may be transmitted through sharing needles or having sexual relations with an injection drug user. Risk-taking behaviors also increase with drug and alcohol use, resulting in unprotected sexual relations and non-monogamous relationships.
- A client may use a substance as a means to deal with the stress of living with HIV; however, substance use may interfere with adherence and care-seeking behaviors and may lower one's economic status.
- Substance use can negatively affect the progression of HIV, including non-adherence, care-seeking behaviors, and response to treatment.[4]

Stigma prohibits access to services: A study in South Africa found that negative social perceptions of substance use and the stigma surrounding substance use are major barriers in accessing treatment. To maintain social acceptance and avoid judgment by the community and by health care workers, substance users may deny that there is a problem, which prevents them from accessing much-needed treatment.[8]

- Although it may be difficult to understand why a client continues to use a substance when it is harmful to his or her health, it is important to understand the power of an addiction. Addiction causes physical and mental dependence to the point that the client is mentally fixated on the substance and may become physically ill when cutting down or stopping its use.

## 2. Harmful Alcohol and Substance Use Definitions

| Harmful Behavior | Definition | Signs and Symptoms |
|---|---|---|
| Harmful alcohol use | Drinking more than the accepted amount per week (21 units for men, 14 units for women)[9] | Appearing to be under the influence of alcohol (smell, appearance), presenting with an injury, somatic symptoms including insomnia, fatigue, anorexia, nausea, vomiting, indigestion, diarrhea, and headaches. Difficulties in carrying out usual work, school, and social activities.4 |

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[7] World Health Organization. 2010. *ATLAS of Substance Use Disorders: Resources for the Prevention and Treatment of Substance Use Disorders (SUD)*. Available at http://www.who.int/substance_abuse/publications/atlas_report/profiles/zimbabwe.pdf (accessed November 2013)
8 Myers, B., N. Fakier, and J. Louw. 2009. "Stigma, Treatment Beliefs, and Substance Use Treatment Use in Historically Disadvantaged Communities." *African Journal of Psychiatry* 22:8–222.

[9] Zimbabwe Ministry of Health and Child Welfare, World Health Organization. n.d. *Guidelines and Treatment for the Management of Common Mental Health Disorders in Primary Care*.

| Harmful substance use | Psychological dependence of a substance leading to a craving9 | Appearing drug affected (low energy, agitated, fidgeting, slurred speech). Signs of drug use (injection marks, skin infection, unkempt appearance). Requesting prescriptions for opioids and sleeping pills. Financial difficulties and crime-related legal issues. Difficulties in carrying out usual work, school, and social activities.4 |
| --- | --- | --- |

### 3. Acute Alcohol Withdrawal

When a client has been drinking large amounts of alcohol for a prolonged period of time, abruptly stopping from drinking can be dangerous because the alcohol is no longer present to suppress the nervous system. Without alcohol present, the client may experience a headache, hand and body tremors, sweating, nausea, vomiting, auditory or visual hallucinations, marked irritability and confusion, increased pulse and blood pressure, seizures, and in some cases death.

- Withdrawal symptoms typically begin 24 to 48 hours after the client's last alcoholic drink
- Fluids should be pushed and immediate emergency care or a referral provided to appropriately medicate the client
- Acute alcohol withdrawal is a life-threatening emergency and the client should be closely monitored.

If acute alcohol withdrawal is suspected, immediate action should be taken. It should be determined:
- When the client's last alcoholic beverage was
- If the client has a history of alcohol withdrawal seizures.

The client's responses to these questions, along with a symptom assessment, can assist to determine how rapidly the client will need emergency attention. Client's experiencing acute alcohol withdrawal should receive immediate medical attention based on the Ministry of Health and Child Welfare's guidelines for alcohol withdrawal. The client should be immediately referred to a qualified staff person who can provide the appropriate care. The Integration Leader has an emergency protocol available for acute alcohol withdrawal that will be posted at a central location.

### 4. Harmful Alcohol Use Case Study

*Carry out the following case study with participants.*

Joseph, a 54-year-old who is a recent widow, has been on antiretroviral therapy for five years with good adherence. He accesses services within the community for psychosocial support. When he presents to the community health worker this visit, he appears disheveled, has slurred speech, appears to have lost weight, and is markedly uninhibited. He shares that he does not remember the last time he filled his prescription for ART. What do you suspect and why?

- *Case Study Answer: Joseph is a recent widow. A red flag is that Joseph has been adherent with his medication for five years until recently. In addition, the weight loss, poor hygiene, slurred speech, and uninhibited behavior indicate alcohol use.*

## 5.  Discussion and Review

Do you think that assessing a client for alcohol and substance use is important? Why?

Sometimes it can be difficult to ask a patient about alcohol and substance use. Why do you think this is?

What are some ways to overcome this initial discomfort to ask about alcohol and substance use?

Describe the symptoms that are associated with harmful alcohol use.

Describe the symptoms that are associated with harmful substance use.

Describe the appropriate actions to take when a client is suspected of suicidal ideation.

Describe the symptoms of acute alcohol withdrawal.

Describe the appropriate action to take when a client is experiencing acute alcohol withdrawal.

**Training Notes:**

***Trainings at the health facility*** *should only train colleagues on use of the Shona Symptom Questionnaire (SSQ) and CAGE-AID.* _Only review the activities in this module that are specific to the health facility._ *However, you should note that the Abbreviated Community Screen exists and that community-based organizations (CBOs) and traditional medical practitioners (TMPs) will be making referrals to the health facility when a positive Abbreviated Screen occurs so that the client may receive the SSQ and CAGE-AID.*

***Trainings at the CBO and TMP*** *should only train their colleagues on use of the Abbreviated Community Screen.* _Only review the activities in this module that are specific to the CBO or TMP._ *However, you should note that the SSQ and CAGE-AID exist and are utilized at the health facility to carry out more in-depth screenings.*

**1. The Screening Tools and Protocol at the Health Facility**
There will be three different screening tools used during this pilot activity. The health facility will utilize the SSQ and the CAGE-AID. CBOs and TMPs will utilize the Abbreviated Community Screen, which is a simplified tool.

The Shona Symptom Questionnaire: *(Pass out tool to colleagues)*
The SSQ will be the screening tool that will be used to identify depression and anxiety symptoms. The SSQ was created in Africa by nurses and traditional practitioners to screen for emotional health symptoms. Although the SSQ may help identify hallucinations, it does not specifically screen for psychosis.[10]

*Review each question on the screen with participants.*

The screen is available here in English and Shona. There are a total of 14 questions on this screen. The client should be asked if he or she has experienced any of the symptoms during the past week.

At the completion of the screen, the total "Yes" responses should be totaled. A score of 8 or greater indicates that the client may be experiencing depression/anxiety symptoms and is in need of a referral.[10] However, if a client has a negative screen (7 or less) and is still suspected of mental health problems, he or she should be considered to have a positive screen.

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[10] Patel, V., G. Fungisai, E. Simunyu et al. 1995. *The Shona Symptom Questionnaire: An Indigenous Measure of Common Mental Disorder.* Department of Psychiatry, University of Zimbabwe Medical School, and Section of Epidemiology and General Practice, Institute of Psychiatry, London.

<u>The CAGE-AID:</u> *(Pass out tool to colleagues)*
The CAGE-AID is a tool that screens for harmful alcohol and substance use; it has been used throughout the world. This screen has been translated into Shona for the purposes of this pilot project.[11]

*Review each question on the CAGE-AID with participants.*

- Any "yes" responses should be totaled at the completion of administering the screening tool to arrive at the total score. Any "yes" response warrants further investigation and a referral; and a score of 3 to 4 indicates alcohol or substance use dependence unless proven otherwise. If a client has a score of 0, but is still suspected of harmful alcohol or substance use, he or she should be considered to have a positive screen.

<u>Protocol for a Positive SSQ or CAGE-AID</u>
A positive result should be viewed in terms of the stepped-care model, which is a model of care in which simple interventions are first utilized before advancing to more complicated, timely, and costly interventions. When a client has a positive screen, the following actions should occur:

      A. A basic counseling intervention

      B. A referral for further assessment to a health care provider (or a follow-up appointment if you would typically be the person to provide this level of care)

      C. A referral to supplementary services from a CBO.

- If the client does not improve, the health provider will likely link the client into more intensive counseling therapy and medication management.

- All adult clients should receive an SSQ and CAGE-AID screen at each visit.

- A referral to a psychiatric in-patient facility should occur only when the client can no longer be safely managed within the community, such as when he or she poses a threat to his or her own safety or that of someone else. Once a client is stabilized within a psychiatric facility, he or she should be directly referred back to the health care facility and the CBO for further ongoing support.

*Hand out the Job Aid for the Health Facility to Participants and review each point.*

*Request that all participants work in pairs to practice utilizing the screening tools relevant to their site.*

**2. The Screening Tool and Protocol at the CBO and TMP**
There will be three different screening tools used during this pilot activity. The health facility will utilize the SSQ and the CAGE-AID. CBOs and TMPs will utilize the Abbreviated Community Screen, which is a simplified tool.

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[11] Lanier, D., and S. Ko. 2008. *Screening in Primary Care Settings for Illicit Drug Use: Assessment of Screening Instruments—A Supplemental Evidence Update for the U.S. Preventive Services Task Force.* Evidence Synthesis No. 58, Part 2. AHRQ Publication No. 08-05108-EF-2. Rockville, MD: Agency for Healthcare Research and Quality.

The Abbreviated Community Screen: *(Pass out tool to colleagues)*
The Abbreviated Community Screen, which will be used by CBOs and TMPs, consists of three questions to screen for mental health issues and harmful alcohol and substance use.

*Review each question on the Abbreviated Community Screen with participants.*

- A rating of 7 or greater to the sad or worry questions or a positive response to the alcohol and substance use question warrants a direct referral to the health facility. If a client does not have a positive screen, but is still suspected of mental health problems and/or harmful alcohol and substance use, he or she should be considered to have a positive screen.

Protocol for the Abbreviated Community Screen
The protocol for a positive Abbreviated Community Screen will consist of the following steps:

> A. A simple counseling intervention that includes an assessment of suicidal ideation and acute alcohol withdrawal to determine the urgency of the referral

> B. A referral for further assessment to the health facility for additional screening

> C. Continuation of supplementary services from the CBO and referrals to any additional CBO programs that may benefit the client.

- All adult clients should be screened at each visit.

- A positive screen requires a strong system of communication, referrals, and linkages between CBOs and health facilities to ensure that the client has followed through on the referral and that the CBO is able to continually provide support to the client if a mental health problem is identified at the health facility level. Referrals will be discussed in depth later.

*Hand out the Job Aid for the CBO and TMP to participants and review each point.*

*Request that all participants work in pairs to practice utilizing the screening tools relevant to their site.*

## 3. Review for the Health Facility



What does the SSQ screen for?
– Mental health problems.



What does the CAGE-AID screen for?
– Harmful alcohol and substance use.

**What score is considered "positive" for the SSQ and CAGE-AID?**
- SSQ is 8 and above, the CAGE-AID is 1 and above. Remember that if a client is suspected of mental health problems or harmful alcohol and substance use and he or she has a negative screen, he or she should be considered to have a positive screen and treated accordingly.

**How often should the tools be utilized on a client?**
- At each visit.

**What are the three steps in the protocol for a positive SSQ or CAGE-AID?**
- Provide a brief counseling intervention, refer to higher-lever services, and refer to a CBO.

**When should a client be considered in need of hospitalization?**
- When he or she is at risk of harming him- or herself or someone else.

## 3. Review for the CBO or TMP

**What score is considered "positive" for the Abbreviated Community Screen?**
- A score of 7 or greater to the sad or worry questions or a "yes" to the alcohol and substance use question. If a client is still suspected of mental health or harmful alcohol and substance use and he or she has a negative screen, he or she should be considered to have a positive screen and treated accordingly.

**How often should the tools be utilized on a client?**
- At each visit.

**What are the three steps in the protocol for a positive Abbreviated Community Screen?**
- Provide a brief counseling intervention, refer to the health facility, and refer to a CBO that best meets the client's psychosocial needs.

**What should be assessed with each positive screen and when should an urgent referral be made to the health facility?**
- When a screen is positive the provider should screen for suicidal ideation and/or acute alcohol withdrawal. If the client exhibits either suicidal or withdrawal symptoms they should receive an urgent referral that day to a health facility for emergency services.

**Training Notes:**

*After reviewing Counseling Basics and Therapeutic Interventions, carry out a demonstration of therapeutic counseling for a positive mental health screen and a positive alcohol and substance use screen utilizing the scripts located in this manual.*

**1. Counseling Basics**

Practicing therapeutic communication is critical so that the client will feel that he or she can safely share personal information surrounding his or her emotional state. The client may also be more likely to take advice and information from a provider who expresses empathy and a nonjudgmental attitude. Good communication can also help build a strong connection with the client and his or her family so that they will be more likely to access care when difficulties arise and more easily share information.2

Methods to maximize the quality of a mental health screen are to ensure that the client feels comfortable during the screen. This can be assisted by:

- Routinely carrying out the screen as the last task during the visit so that the client has had sufficient time to become comfortable during the visit.

- Prior to carrying out the screen, explain that all patients receive this screen as a method to ensure that they are receiving the best care possible. This will help the client to not feel "singled-out" or self-conscious during the screen.

- After the screen is complete, thank the client for sharing the information with you and make sure to follow through on each referral wherever it is indicated. Additional counseling tips are provided on the back of the Data Collection Sheet.

Reassuring the client of confidentiality is important and can help build trust and maximize information sharing. Be aware that the client's privacy is maintained at all times by allowing a private space during the interview, guarding client information, and only sharing with colleagues and other organizations when absolutely necessary and with the client's permission.

**2. Therapeutic Interventions**
It is expected that each client who has a positive screen will receive a basic therapeutic intervention.

<u>A positive SSQ2 or a positive response to a mental health question with the Abbreviated Community Screen</u>
Providing the client with education regarding his or her illness can help offer perspective. Tell the client that:
- Depression is common, treatable, and temporary
- Coping can sometimes be more difficult if someone is experiencing depression, but this is only temporary
- It is normal to experience difficulties and feel depressed, but there are things that he or she can do to help him- or herself feel better.

Providing advice and simple talk therapy can help the client identify what his or her principal sources of stress are. Do this by:
- Helping the client to identify stressors in his or her life
- Encouraging a healthy diet, regular exercise, social activities, and a routine sleep schedule
- Discouraging alcohol and drug use
- Encouraging the client to follow through on referrals for community-based support and talk with trusted family and friends about his or her feelings.

**Tool:** *Pass out the WRAP handouts*
You may also carry out a Wellness Recovery Action Plan (WRAP), which allows the client to identify:
A. How he or she feels emotionally when he or she is feeling okay, and what actions he or she can take to maintain this state of well-being
B. How he or she feels emotionally when he or she is starting to feel unwell, and the actions he or she can take to improve his or her well-being
C. How he or she feels emotionally when he or she is in crisis, and what should be done when he or she is in a crisis state.

<u>A Positive CAGE-AID2 or a positive response to the last question on the Abbreviated Community Screen</u>
Access to treatment for alcohol and drug use is often limited. For this reason, provision of simple motivational interviewing techniques is essential to reduce these behaviors. Tell the client that:
- "It would be better if you cut down or abstained from using."
- "I understand the difficulty of cutting down or quitting, but I am optimistic that you will succeed."
- "I am willing to help you make plans."
- "I am willing to help you think about where this falls in relationship to your other goals and priorities."

*Provide participants with copies of the Readiness to Change Rulers and the Motivational Interviewing handouts.*

The four principal components of motivational interviewing include:

1. Expressing empathy; relating to the client that what he or she is experiencing must be difficult.

2. Developing discrepancy; helping the client determine a difference between what his or her behavior currently is and where he or she would like it to be.

3. Supporting self-efficacy; building the client's confidence that he or she will be able to reach his or her goal by identifying previous successes.

4. Rolling with resistance; refraining from arguing with the client if he or she is initially resistant to the behavior change.

The Motivational Interviewing Tip Sheet should be referred to for additional tips.

**Tool:** You may also carry out the Readiness to Change Rulers, which is a quick assessment that can be used to determine a client's readiness to change a specific behavior such as harmful alcohol or drug use. The Readiness to Change Rulers can assist you in assessing where the client is on a continuum between "not prepared to change" and "already changing." This can help you work with the client to identify and address barriers to healthy behavior changes. To utilize the Readiness to Change Rulers, the care provider should have the client point to where he or she is on the continuum in regards to preparedness to change the behavior. The provider can then lead a discussion based on the client's readiness with the guidance that is provided on the tip sheet.

**3. Observation of Basic Therapeutic Interventions**
*Utilize scripts in the back of this manual to demonstrate basic therapeutic interventions for a positive mental health screen and for a positive alcohol and substance use screen.*

**4. Review**

Describe the basic therapeutic communication techniques for a positive mental health screen.

Describe the basic therapeutic communication techniques for a positive alcohol and substance use screen.

What tool should be used for a positive mental health screen?

What tool should be used for a positive alcohol and substance use screen?

What are the four motivational interviewing questions that should be utilized for a client who is identified as having harmful alcohol or substance use patterns?

## 1. Creating Linkages

In order to create a community-wide system to support mental health integration, a strong system of referrals between facilities is a vital component of this program. Remember that health facilities, CBOs, and TMPs all have the potential to support mental health services within the community and should work closely together to form a network of services.

- Through building bi-directional linkages at the community level, the integrated network is able to provide continuity of care for clients, meaning that after they leave the health facility, they will continue to be offered services to provide further support.

- A network of linkages also offers the opportunity to receive healthy living messages at multiple services points in the community.

- Each organization most likely does not have the capacity to provide all the services clients might need; creating a network of linkages is a simple way to ensure that clients receive the services they need while not adding additional costs.

## 2. The Health and Community Services Directory

*Pass out copies of the Health and Community Services Directory. This will be theirs to keep throughout the pilot activity.*

The Health and Community Services Directory has been created for the purposes of this pilot. Included in this list are organizations to which a client may be referred when a positive screen occurs.

In the case of a positive screen, after a basic counseling intervention, two separate referrals should be made.

If the screen is done at the health facility, a referral should be made:
   a. To higher-level care for further counseling and/or medication management as appropriate
   b. To a CBO for psychosocial services.

If the screen is done at the CBO or TMP, a referral should be made:
   a. To the health facility
   b. To a CBO for psychosocial services.

Utilize the Health and Community Services Directory to identify the organization where you can make the referral.

## 3. The Client Referral Form

*Pass out the Referral Forms*

The Client Referral Form should be completed and given to the client each time a referral is made. The provider that is originating the referral should complete the top half of this form and give it to the client to bring to the appointment to which he or she is being referred. The organization receiving the client should cut along the dotted line, keep the top half of the referral form for their records, and complete the bottom half to give to the client, who can provide it during his or her next appointment to the original referring organization. This will provide proof that the client completed the referral and also will provide a mechanism for bi-directional communication and linkages in the community.

If a provider is in need of more Referral Forms, he or she should contact the Integration Leader.

## 4. The Register of Referrals
*Pass around the Referral Register*

In order to keep track of referrals, each organization has been given a Register of Referrals. There are two separate sections. The <u>first</u> section keeps track of referrals IN to the organization. Each time that a referral is received to take a client, it will be documented here.

Review the Register of Referrals – IN form.

The <u>second</u> section is to track referrals that are made OUT of the facility to other organizations. Each time a referral is made, it should be documented here.

Review the Register of Referrals – OUT form.

*Share where the Register of Referrals will be located.*

## 5. Referral Protocol
Each time a referral is made, the provider should:
   a. Explain the reason for the referral to the client
   b. Prepare the Referral Form
   c. Provide the client with
      – The contact information for the organization(s) where he or she is being referred
      – The completed Referral Form
      – Information on how to make the appointment (or make the appointment for him or her and provide a card with the appointment date and time)
   d. Remind the client to bring the Referral Form to the appointment
   e. Make a follow-up appointment with the client before he or she leaves

## 6. Review

What is the required documentation to make a referral?
   – Referral Form (top half), Register of Referrals – OUT

When a client referral is received, where should this be documented?
   – Referral Form (bottom half), Register of Referrals – IN

What information should be given to a client when a referral is made?

– Reason why the referral is made, oral and written instructions on how to arrive to the appointment, instructions on bringing the Referral Form to the appointment, and instructions for a follow-up appointment.

When should a referral be made and to where?
– From the CBO or TMP, a referral should be made to the health facility when the Abbreviated Community Screen is positive.
– At the health facility, a referral should be made for higher-level counseling and/or medication management (internal or external) when an SSQ or CAGE-AID is positive. A second referral should also be made to the CBO for psychosocial support.

**Training Notes:**

*Trainers from the health facility should only utilize the health facility section of this module. Likewise, trainers from the CBO and TMP should only utilize the CBO and TMP section of this module. All groups should utilize Section 3, Job Aids, in this module.*

## 1. Data Collection at the Health Facility
*Hand Data Collection Sheets at the Health Facility Level*

As a means to collect integrated data, all staff personnel who carry out screens should document each screen that they carry out. It is expected that this will take place at the end of each client encounter.

- Each provider will receive his or her own Data Collection Sheet(s) today. When he or she has completed the Data Collection Sheet, it should be turned into the Data Capturer on-site.
- Notify colleagues of where integration materials including Data Collection Sheets will be maintained.
- If Data Collection Sheets run out, notify the Integration Leader for additional sheets.

Providers will use the sheet to document each client's medical record number and gender, the date of assessment, the results of the SSQ, the results of the CAGE-AID, whether a referral was carried out, whether the client was given a Referral Form, and whether the referral(s) were documented in the Register of Referrals.

## 2. Data Collection at the CBO and TMP
As a means to collect integrated data, all staff who carry out screens should document each screen that they carry out. It is expected that this will take place at the end of each client encounter.

- Each provider will receive his or her own Data Collection Sheet(s) today. When he or she has completed the Data Collection Sheet, it should be turned into the Integration Leader promptly.

- Notify colleagues of where integration materials including Data Collection Sheets will be maintained.

- If Data Collection Sheets run out, notify the Integration Leader for additional sheets.

Providers will use the sheet to document each client's medical record number and gender, the date of assessment, the results of the Abbreviated Community Screen (note that each score should be placed under the respective question number), whether a referral was carried out, whether the client was given a Referral Form, and whether the referral(s) were documented in the Register of Referrals.

### 3. Job Aids

Job aids will be posted in areas where screening occurs. All providers should refer to these job aids as a reminder to use the correct protocol.

The WRAP tool and the Readiness to Change Rulers will also be posted in these areas to assist in providing therapeutic interventions.

*Remember that the Integration Leader has posted the Emergency Action Protocol in a central location in case of emergency.*

*Also remember that the Register of Referrals is also in a central location and should be routinely completed with any referral made.*

### 4. Review

Where should a client encounter be documented?
- In the Data Collection Sheet.

When should the client encounter be documented?
- Immediately following the encounter.

What should be done if you run out of Data Collection Sheets or Referral Forms?
- Request more from your Integration Leader.

What job aids will be posted and should be utilized during the pilot activity?
- Job Aid for the Health Facility, or CBO and TMP, WRAP, Readiness to Change Rulers.

Where is the Emergency Action Protocol posted?

Where is the Register of Referrals located?

# Annex 2: Training Materials

# Example Mental Health Counseling Role Play

On completing an SSQ of a client at the health facility, the client is found to have an SSQ of 9. The client is a 54-year-old HIV-positive woman who recently has been put on medication due to a declining CD4 cell count. She appears sad, but open to discussion today.

**Provider:** Thank you for responding to all of the questions. From your responses on this screen, it appears that you may be going through an emotionally difficult period. Can you share a little more about what is going on with you?

**Client:** It was very difficult for me to learn that I have HIV, but I was able to stay healthy for a couple of years without needing medication. I was hoping that I would never need to use it. My husband has also recently been getting sick and I am worried about not being able to take care of him if my health is also bad.

**Provider:** I am very sorry to hear that your husband is not doing well. It can be difficult when stressful events occur at the same time. Let's talk about how you typically feel, when you are feeling emotionally healthy. Please describe how you feel and what some actions are that you can take to maintain feeling well.

**Client:** Normally, I feel happy. I have energy, and I meet my friends, go to church, and volunteer. To stay that way, I should take my medicine and make sure that I am eating healthy and getting a little exercise every day.

**Provider:** Good for you. Now, let's talk about how you start to feel when things begin to feel like they are falling apart. What has been helpful to you in the past when you have experienced emotional difficulties?

**Client:** Well, when I was first diagnosed, I had a very difficult time. I noticed that I was easily angered and I stopped my social and volunteering activities. I wanted to sleep a lot and did not eat very much. During those times, I confided in my sister, and she made sure that I went to my appointments. I began to understand that I could still live a long life.

**Provider:** So now you have identified your symptoms when you are beginning to feel bad—easily angry, withdrawing from friends and activities, sleeping a lot and not eating enough. And you have also identified what helps you to feel better. How have you have felt when you were in a crisis, and what helped you to feel better?

**Client:** When my husband was once very ill and I did not think that he was going to survive, I panicked. I cried all of the time and did not do a good job taking care of myself. I didn't sleep or eat, and I did not want to talk to anyone. My neighbors and family saw that I was having a difficult time and they made sure that I was taken care of. They cooked for me, helped me take care of my husband, and listened to me when I was upset.

**Provider:** So, let me make sure that I understand. When you are experiencing a crisis, you cry and have a difficult time taking care of yourself, you have problems sleeping and eating, and you become antisocial. It is helpful for you when your neighbors and family come to take care of you in these instances. Is this correct?

**Client:** Yes, it is. Right now I am just having a tough time, but I am not having a crisis.

**Provider:** Okay, well in that case, do you feel like you can speak your sister and see if she can help you like she did previously? Because we also want to make sure that you continue to do well. I would like to make some referrals for you to make sure that you are getting the best care possible. I would like you to follow up for further assessment and counseling at this facility with Dr. Jacobs. She has experience speaking with clients who are experiencing emotional difficulties. I would also like to refer you to a CBO where you will also be sure to get psychosocial services in the community.

**(Hands the Referral Forms and documents in the Register of Referrals)**

# Example Alcohol Counseling Role Play

On completing a CAGE-AID today, the provider finds that Joseph has a score of 2. The provider has known Joseph for several years and did not previously note that he was drinking.

**Provider:** Thank you for doing the screen with me today. It is appreciated. From your responses to the screening test, I would like to ask what type of alcohol you typically drink?

**Client:** I usually like to drink beer, but sometimes when I feel like it, I drink liquor.

**Provider:** Why is it that you enjoy drinking—what are the good things about it?

**Client:** It helps me to forget about my problems, and lately at night I have had problems sleeping, so it helps me to relax and fall asleep.

**Provider:** How much do you drink on a typical day?

**Client:** It has been a bit more lately, between 12 to 16 beers a day. I have noticed that I start drinking earlier in the day now, too. Things have been stressful lately. I lost my job and I am worried about supporting my family. Drinking helps me to forget about that.

**Provider:** What are the not-so-good things about drinking?

**Client:** Well, my children and my wife have been getting upset with me. They don't like to be around me when I have been drinking. I have also noticed that I am not taking my medicine and eating as well as I used to. I have also not been looking for a job since my drinking increased, and I am just spending more money by drinking. So, I guess it is not really helping.

**Provider:** We use something called the Readiness to Change Rulers and this helps give an idea of where you might be on a scale of 1 to 10 in terms of changing your behavior to something that is healthier for you. Looking at the ruler, how important is it to you to change this behavior?

**Client:** Well, I really think that I need to find a job. And I would like to get along with my family better, so I would say it is an 8.

**Provider:** And on a scale of 1 to 10, how confident are you that you can change this behavior?

**Client:** I know it won't be easy, my friends will still want me to go out drinking with them, and I will have to say no. I would say a 6.

**Provider:** Well, I can tell you that it would be better for your health if you cut down or quit drinking. I understand that this may be difficult, but I am very confident that you will be able to do it. I am willing to help you make some plans to help you quit. What is a reasonable amount for you to cut down to and when will you do it by?

**Client:** I would like to cut down to 6 beers a day by next week. That will give me some time to think on it a bit more and maybe also make other plans than hanging out with my other friends who are drinking.

**Provider:** That is excellent. I would also like to refer you to another provider who is skilled in working with clients who are at risk of harmful alcohol use. I will also refer you to a CBO to make sure that you receive other services; they might be able to help you find a job.

***(Fills out the Referral Forms and writes in the Register of Referrals)***

# Interview Questionnaire

Choose a partner you do not know well. Each partner should interview the other partner for ☺ *5 minutes*. You may ask and report on whatever questions you like, but the histories should include at minimum the following questions. Please be sure to write down the answers to the questions.

1. Where do you come from?


2. What is your current job, and what are your duties and responsibilities?


3. Do you have any previous mental health experience?


4. What particular skills or expertise do you have that you think will be most helpful for this group?


5. What do you like to do in your free time?

# Values, Thoughts, and Perceptions Surrounding Mental Health

1. Mental health problems are…

2. Mental health services in this country are…

3. The connection between HIV and mental health is…

4. People with mental health problems are generally considered…

5. One can tell a client is suffering from mental health problems when…

6. Some of the traditional/cultural beliefs in this community around mental health problems are…

7. It is important to address mental health needs because…

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# Values, Thoughts, and Perceptions Surrounding Alcohol and Substance Use

1. Harmful alcohol and substance use is…

2. Alcohol and substance use services are…

3. The connection between harmful alcohol and substance use and HIV is…

4. People with harmful alcohol or substance use are generally considered…

5. Some of the traditional/cultural beliefs in this community around alcohol and substance use are…

6. It is important to address harmful alcohol and substance use because…

# Counseling Tip Sheet for Harmful Alcohol and Substance Use

Routinely ask about substance use with all clients in a nonjudgmental and empathetic manner. If it appears that a client may be dealing with alcohol or drug dependence issues, provide the following:

Counseling Tips:

- It would be better if you cut down or abstained from using.
- I understand the difficulty of doing it, but I am optimistic that you can succeed.
- I am willing to help you make plans and provide some ideas about how to do it.
- I am willing to help you think about where this falls in relationship to other goals and priorities.

Additional Tips:

- Be empathetic, but be clear about the risk that use of the substance may have for the client and for others.

- Tell the client very clearly that he or she should change this behavior due to the potential harmful consequences of continued use; emphasize that it is the right thing to do.

- Provide several options that the client may choose from to help change behaviors, including:
  - Helping identify the settings, situations, and people who place the client at high risk for participating in the behavior and make a plan to avoid them.
  - Helping the client set hard limits in terms of quantity of intake when participating in the behavior.
  - Helping the client identify a friend or family member who can provide him or her with support and encouragement as he or she cuts down or quits the behavior.

- Make a plan to help the client quit the behavior. This plan should include a list of everything the client will need to do, including throwing out any materials relating to the behavior, notifying family and friends of plans to quit, setting a date to quit, and planning for activities and support when temptation arises.

- Suggest other strategies for quitting, such as finding another distraction, attending a peer support group, or exercising.

# Motivational Interviewing

Motivational interviewing with a client-centered approach can bring about positive behavior change. In motivational interviewing, the client is considered to be the expert and is responsible for his or her own healthy decision making. Motivational interviewing can help strengthen the client's motivation to cut down or quit alcohol and drug use or make other difficult decisions. This collaborative process, which empowers the individual by emphasizing his or her independence, identifies the client's values and motivation for positive change.

**Tips for Motivational Interviewing (OARS)** (Miller 2011)
- ❖ **Open-ended questions:** Ask questions that compel the client to respond in a manner that requires a thoughtful response. Examples of open-ended questions include: "Tell me about your current relationship with your partner." "What are some ways that drinking alcohol affects your life?" and "What will your future be like if you quit school, and what will it be like if you stay in school?" Avoid questions that can be answered with a yes/no response.
- ❖ **Affirmations:** Provide genuine and positive feedback to the client that emphasizes his or her strengths so as to build the relationship and increase the client's confidence in his or her ability to make a positive change. Examples of affirmations include: "You are a very strong person," "That was a very smart decision," and "I am so glad that you came in today."
- ❖ **Reflections:** Actively listen to understand the client's perspective on an issue and repeat or paraphrase the statement back to the client to ensure that there is mutual understanding of what is being said and to let the client know that you are actively listening. Examples of reflection statements include: "It sounds like what you are saying is that…" and "Am I correct in understanding that…"
- ❖ **Summaries:** Utilize a summary statement at a transition point during the conversation or at the end of the appointment to emphasize specific items that were discussed. Summary statements help ensure a mutual understanding between the client and the health care provider and serve as a foundation for change. An example of a summary statement is: "To recap our conversation, you believe that you are prepared to take charge of your medications independently because you require minimal prompting from your caregiver to take them, and you have a greater understanding of their importance in maintaining your health. Did I miss anything?" Providing a summary may lead to making concrete plans for the anticipated change (Miller 2002).

**How Do I Incorporate Motivational Interviewing into Daily Practice?**
- ❖ Create a sharing environment by assuring the client that all discussions will be confidential.
- ❖ Ask open-ended questions that help the client understand the advantages and disadvantages of making decisions about personal health and safety.
- ❖ Explore the client's values and how his or her goals and value system align.
- ❖ Encourage the client to look forward in life. Elicit responses about how the client's situation will be if the current pattern of behavior continues and what the client envisions his or her life to be like in three years, five years, and so on.

❖ Strengthen confidence at every opportunity to increase the client's self-efficacy.

❖ Involve parents when appropriate and with the client's permission.

❖ Set goals and establish a plan together based on the client's readiness for change.

**What Should I Avoid?**

❖ Avoid arguing with and trying to persuade the client as a means to create a positive change.

❖ Do not assume the role that you are the expert; this is an interactive process.

❖ Do not criticize, make the client feel ashamed, or blame the client for any poor choices.

❖ Do not make the client feel rushed; he or she needs to know that you are actively listening and consider him or her important.

**Stages of Change**

Behavior change rarely happens overnight, but rather happens in a series of stages that the client will undergo to finally result in the desired behavior. Understanding these stages and how a client moves through them will help the provider understand where the client is on the change continuum and how to best support the client at that stage. Additionally, many clients can waver between the stages before moving up to the next stage (Zimmerman, Olsen, and Bosworth 2000).

❖ **Pre-contemplation stage:** The client is not aware that there is a problem and will not understand that any advice received about that particular behavior applies to him or her.

❖ **Contemplation stage:** The client is aware that there is a problem but resists making a change and will often make excuses about why the desired behavior change cannot occur.

❖ **Preparation stage:** The client prepares to go about making a behavior change, taking small steps to test what the next stage will be like.

❖ **Action stage:** The client makes a concerted effort to bring about the desired behavior change. Any efforts that are made should be fully encouraged and applauded by the provider.

❖ **Maintenance stage:** This consists of fully adopting the desired behavior into the client's lifestyle. The client may experience a relapse that may result in the re-experiencing the stages of change.

# Mental Health and HIV Integration Workplan

| | Activity/Task | Person Responsible | Weeks | | | | | | | | | | | | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | |
| 1 | Identify mental health referral pathway for site | | | | | | | | | | | | | | |
| 2 | Provide training to colleagues | | | | | | | | | | | | | | |
| 3 | Ensure that sufficient screening tools are available | | | | | | | | | | | | | | |
| 3 | Begin integration pilot activity | | | | | | | | | | | | | | |
| 4 | Check in with colleagues to determine if there are any questions/issues regarding pilot activity | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | |

1. Each activity or task is listed in the column "Activity/Task."'
2. Discuss and identify someone to take charge of each activity and put that person's name in the "Person Responsible'' column.
3. Discuss and decide when the task will be done by marking the appropriate weeks in the "Weeks" columns.
4. At the end of each week, mark each task that has been executed with an X for that week.
5. Add any additional comments in the "Comments" column.

# Mental Health/HIV Integration Review Game

1. Explain how HIV and mental health problems may be linked.

...........................................................................................................................................

2. How can mental health problems affect HIV-related outcomes?

...........................................................................................................................................

3. Define mental illness.

...........................................................................................................................................

4. Describe three signs/symptoms of depression.

...........................................................................................................................................

5. Describe three signs/symptoms of alcohol and substance use.

...........................................................................................................................................

6. Should the SSQ and CAGE-AID be carried out simultaneously? (Yes/No)

...........................................................................................................................................

7. Describe the Shona Symptom Questionnaire (SSQ).

...........................................................................................................................................

8. Describe the CAGE-AID Screen.

...........................................................................................................................................

9. Name three things that a provider should do who notes that a client scores a 9 on the SSQ.

...........................................................................................................................................

10. Describe the protocol for a positive Abbreviated Community Screen.

...........................................................................................................................................

11. Describe the referral protocol including what documentation should be completed.

...........................................................................................................................................

12. What should a provider do if a client expresses suicidal intentions?

...........................................................................................................................................

13. Describe three signs/symptoms of acute alcohol withdrawal.

...........................................................................................................................................

14. Name three therapeutic communication techniques.

...........................................................................................................................................

15. When is the Readiness to Change Rulers used?

# Mental Health/HIV Integration Review Game Answer Key

**1. Explain how HIV and mental health problems may be linked.**

- Persons suffering from mental health problems and harmful substance use are more likely to contract HIV
- Mental health problem prevalence in HIV-positive persons is much higher than in the general population
- An HIV-positive diagnosis poses a significant psychological burden
- Substance use can negatively affect the progression of HIV/AIDS and response to treatment.

**2. How can mental health problems affect HIV-related outcomes?**

- Treatment adherence
- Decreases HIV care and treatment-seeking behaviors
- Chronic depression has been associated with greater HIV-related mortality.

**3. Define mental illness.**

- Any disease or condition affecting the brain that significantly influences or disrupts a person's thinking, feelings, mood, ability to relate to others, and daily functioning.

**4. Describe three signs/symptoms of depression.**

- Low energy, fatigue, sleep, and appetite changes
- Persistent sad or anxious mood; irritability
- Low interest or pleasure in activities that used to be interesting or enjoyable
- Multiple symptoms with no clear physical cause (aches, pains, palpitations, numbness)
- Difficulties in carrying out usual work, school, domestic, or social activities.

**5. Describe three signs/symptoms of alcohol use.**

- Appearing to be under the influence of alcohol (smell, appearing intoxicated, hangover)
- Presenting with an injury
- Somatic symptoms associated with alcohol use (insomnia, fatigue, anorexia, nausea, vomiting, indigestion, diarrhea, headaches)
- Difficulties in carrying out usual work, school, domestic, or social activities
- Appearing drug-affected (low energy, agitated, fidgeting, slurred speech)
- Signs of drug use (injection marks, skin infection, unkempt appearance)
- Requesting prescriptions for sedative medication (sleeping pills, opioids)
- Financial difficulties or crime-related legal problems.

**6. Should the SSQ and CAGE-AID be carried out simultaneously? (Yes/No)**

Yes.

**7. Describe the Shona Symptom Questionnaire (SSQ).**

The SSQ consists of 14 questions that screen for mental health problems. It should be used within the health facility. ** Offer an extra point if the team can also provide the cut-off for a positive screen.

**8. Describe the CAGE-AID Screen.**

The CAGE-AID is a four-question screen for alcohol and substance use that may indicate potential issues in these areas. It should be used at the health facility. ** Offer an extra point if the team can also provide the cut-off for a positive screen.

**9. Name three things that a provider should do who notes that a client scores a 9 on the SSQ.**

- Assess for suicidal ideation (if the client is suicidal, ensure that he or she receives emergent attention)

- Provide a brief counseling intervention
- Refer the client to the most qualified provider for further assessment, counseling, and/or medication management
- Refer the client to a CBO for supplemental services

**10. Describe the protocol for a positive Abbreviated Community Screen.**

- Assess for suicidal ideation if the client scored positive on the sad or worry questions
- Assess for acute alcohol withdrawal if the client scored positive on the last question
- Provide a brief counseling intervention
- Refer to the health facility for full screening
- Provide a referral to the CBO for psychosocial services.

**11. Describe the referral protocol including what documentation should be completed.**

Receiving a client IN who has been referred

- Read the top half of the Referral Form
- Complete the bottom half of the Referral Form and instruct the client to bring it to his or her next appointment
- Document the referral received in the Register of Referrals – IN page.

Referring a client OUT for services

- Complete the top half of the Referral Form and give the client instructions to bring it to his or her next appointment
- Document the referral made in the Register of Referrals – OUT page.

**12. What should a provider do if a client expresses suicidal intentions?**

- Ask the client if he or she has a plan to hurt him- or herself or someone else
- Ask for more information as the client is willing to share
- Bring the client to a provider who can carry out the necessary mental health referral to receive additional services
- Involve the family and psychosocial services for additional support where appropriate and as the client agrees.

**13. Describe three signs/symptoms of acute alcohol withdrawal?**

- Headache
- Tremors
- Sweating
- Nausea, vomiting
- Auditory or visual hallucinations
- Marked irritability and confusion.

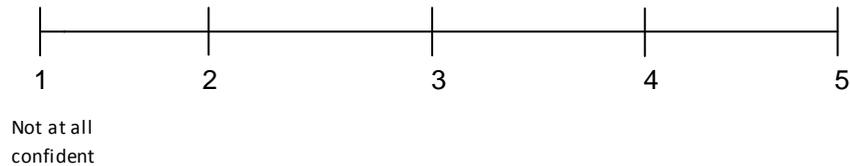**14. Name three therapeutic communication techniques.**

- Open-ended questions
- Reflective listening
- Empathetic comments.

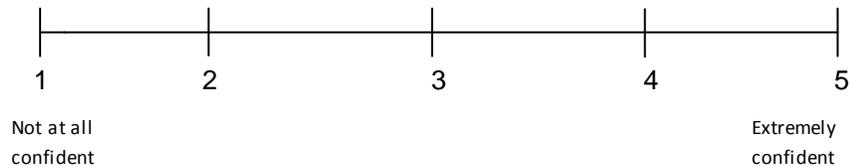**15. When is the Readiness to Change Rulers used?**
The Readiness to Change Rulers is used during a brief counseling intervention when an Abbreviated Community Screen or CAGE-AID score is 1 or greater.

# Pre-Test/Post-Test

On a scale from 1 to 5, how confident are you that you are able to integrate mental health screenings into the routine care that you provide, 1 being "Not at all confident" and 5 being "Extremely confident"?

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

Not at all
confident

On a scale from 1 to 5, how confident are you that you are able to make the appropriate referrals based on the results of a mental health screening, 1 being "Not at all confident" and 5 being "Extremely confident"?

| | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

Not at all                                    Extremely
confident                                     confident

1. The connection between HIV and mental illness is:

     a. Those with mental health problems and harmful substance use are more likely to contract HIV
     b. An HIV diagnosis poses a significant psychological burden
     c. Adherence to treatment is decreased in the presence of mental health problems
     d. All of the above.

2. Depression is best characterized as:

     a. Persistent sad or anxious mood, "thinking too much," and multiple vague physical symptoms
     b. Persistent auditory and visual hallucinations lasting over a period of 12 months
     c. Multiple physical symptoms with a clear biologic cause
     d. Screened for by use of the CAGE-AID.

3. A positive screen on the Shona Symptom Questionnaire:
     a. Indicates the presence of depression, anxiety, psychosis, and substance use
     b. Warrants a direct referral to an in-patient psychiatric facility
     c. Indicates that mental health problems may be present
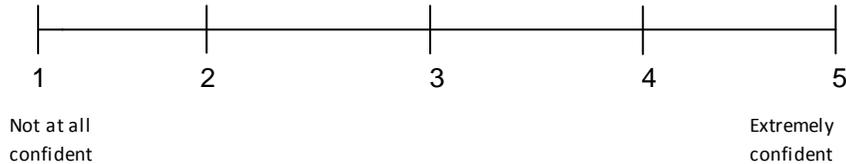     d. Is not something that warrants further investigation.

4. Acute alcohol withdrawal:

     a. May cause vomiting, hand tremors, hallucinations, seizures, and death
     b. Is not a cause for concern; clients should be sent home to rest
     c. Should be managed by providing foods high in sodium
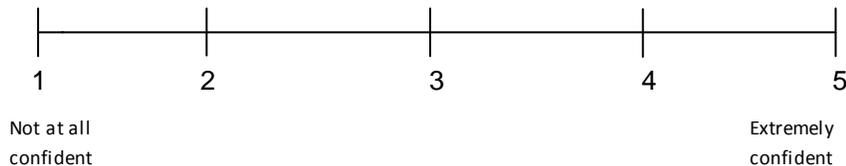     d. None of the above.

5. Effective Interviewing Techniques include:

    a. Use of closed-ended questions

    b. Limiting discussions surrounding difficult topics for the client

    c. Reflective listening and use of open-ended questions

    d. Only discussing the client's emotional status if he or she brings up the subject.

6. A client who screens "positive" in the Abbreviated Community Screen:

    a. Should only be monitored at the CBO

    b. Should be referred to a traditional healer for further screening

    c. Should be referred to the health facility for further screening

    d. Should be initiated on medication immediately.

7. In the integrated program, a referral should be made for further counseling and to a CBO when:

    a. A client has a positive Abbreviated Community screen

    b. A client has a positive SSQ or CAGE-AID screen

    c. Only if the client is acutely suicidal or experiencing acute alcohol withdrawal

    d. Answers B and C.

8. If a client screens "positive" on the Shona Symptom Questionnaire, he or she should:

    a. Receive an immediate referral to a psychiatric hospital

    b. Be referred to a provider who is qualified to provide counseling interventions and medicine; the client should also be referred to a CBO for psychosocial services

    c. Immediately be referred for an alcohol and drug detoxification program

    d. Receive another screen in one week to ensure improvement.

9. Suicide attempts are most common:

    a. During crisis such as initial diagnosis, declining CD4 cell count, rejection or loss of a loved one

    b. When a client has stopped using alcohol and other substances

    c. Once he or she has become accustomed to the diagnosis and is clinically stable

    d. Once he or she has built a strong support system within the community.

10. Integration Leader responsibilities include:

    a. Training colleagues and CBO representatives within one week

    b. Providing leadership throughout the pilot activity

    c. Gathering Data Collection Sheets from colleagues

    d. All of the above.

# Pre-Test/Post-Test Answer Key

On a scale from 1 to 5, how confident are you that you are able to integrate mental health screenings into the routine care that you provide, 1 being "Not at all confident" and 4 being "Extremely confident"?

```
|--------+--------+--------+--------|
1        2        3        4        5
Not at all                  Extremely
confident                   confident
```

On a scale from 1 to 5, how confident are you that you are able to make the appropriate referrals based on the results of a mental health screening, 1 being "Not at all confident" and 5 being "Extremely confident"?

```
|--------+--------+--------+--------|
1        2        3        4        5
Not at all                  Extremely
confident                   confident
```

1. The connection between HIV and mental illness is:

   a. Those with mental health problems and harmful substance use are more likely to contract HIV
   b. An HIV diagnosis poses a significant psychological burden
   c. Adherence to treatment is decreased in the presence of mental health problems
   **d.** All of the above.

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   b. Warrants a direct referral to an in-patient psychiatric facility
   **c.** Indicates that mental health problems may be present
   d. Is not something that warrants further investigation.

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10. Integration Leader responsibilities include:

a. Training colleagues and CBO representatives within one week

b. Providing leadership throughout the pilot activity

c. Gathering Data Collection Sheets from colleagues

d. All of the above.

# Mental Health/HIV Integration Post-Training Workshop Evaluation

The purpose of this brief survey is to learn more about the effectiveness of the Mental Health/HIV Integration Training. The information you provide will help us adjust and improve the training.

**All surveys are confidential; however, for coding purposes, we are asking for your birth year and month to match the pre- and post-training evaluations.**
Your birth year: _____
Your birth month (1-12): _____

**Training Objectives**

Please describe the extent to which this training fulfilled its objectives (mark an "x").

| The training increased my knowledge about how to: | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| Use effective therapeutic communication techniques | | | | |
| Implement the SSQ and CAGE-AID or Abbreviated Community Screen | | | | |
| Create strong community linkages utilizing referral protocols | | | | |
| Train program staff about the integration pilot | | | | |
| Handle emergency situations including alcohol withdrawal and suicidal ideation | | | | |

| The training increased my understanding of: | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| Integration Leader responsibilities | | | | |
| Mental illness | | | | |
| Alcohol and substance use | | | | |
| The intervention and referral protocol for various screening results | | | | |

As a result of the training, I will be able to perform Integration Leader responsibilities and support pilot activities at my site.

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|
|  |  |  |  |

As a result of the training, I will be able to screen clients for mental illness and implement the appropriate intervention and referral activities.

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|
|  |  |  |  |

As a result of the training, I will be able to screen clients for substance use and implement the appropriate intervention and referral activities.

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|
|  |  |  |  |

Please evaluate the training with respect to the following aspects.

The trainer(s) demonstrated appropriate knowledge in the subject matter of this training.

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|
|  |  |  |  |

The trainer(s) demonstrated an ability to impart knowledge to participants in a clear and consistent manner.

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|
|  |  |  |  |

Rate your satisfaction level with this training from 0 to 5. (5=extremely satisfied, 0=not at all satisfied).

| 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|
| Extremely satisfied | Very good | Good | Fair | Not at all satisfied |

How likely would you be to recommend this training to a colleague? (5=extremely likely, 0=not at all likely).

| 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|
| Extremely likely | Somewhat likely | Likely | Unlikely | Not at all likely |

What lectures and activities did you find most useful and why?

Which were least useful and why?

Please comment on any challenges that you foresee in implementing what you have learned at the training.

The setting for the training facilitated learning.

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|
|  |  |  |  |

Please give any other comments and suggestions that you might have about this training in the following space.

For more information, please visit aidstar-one.com.