Mental Health and HIV Integration

A CQUIN Webinar: May 7, 2024

Part of the CQUIN Integration Focus Series

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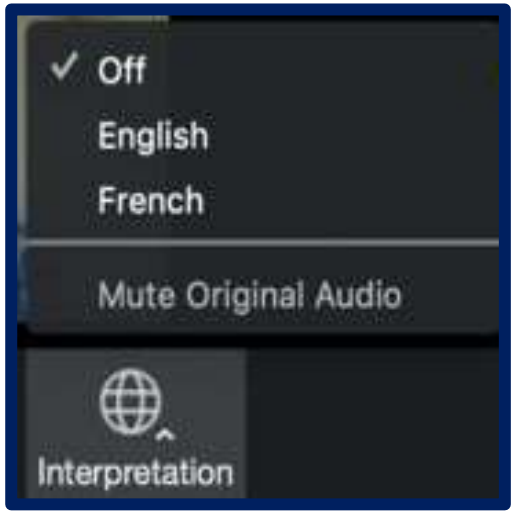
Welcome/ Bienvenue

Peter Preko
CQUIN Project Director
ICAP at Columbia University

- Be sure you have selected the language of your choice using the “Interpretation” menu on the bottom of your screen.
- Assurez-vous d’avoir sélectionné la langue de votre choix à l’aide du menu <<Interprétation>> en bas de votre écran Zoom.



Housekeeping

- 90-minute webinar with framing presentations followed by a panel discussion with Q&A
- Slides and recording will be available on the CQUIN website (www.cquin.icap.columbia.edu)
- Please type questions in the Q&A box located on the toolbar at the bottom of your screen
- If you would prefer to speak, please use the "raise hand" function on the toolbar and we will unmute you so that you have control of your microphone
- If you are a French or English speaker, please ask your question in your language of choice and the interpreters will translate as needed

Framing Remarks

Gillian Dougherty
Deputy Director, HRH Unit
CQUIN Quality Improvement Lead
ICAP Columbia University

Webinar Objectives

Provide diverse perspectives from a panel of experts on the current state and future directions of mental health and HIV integration in global settings.

Explore strategies and best practices for capacity building in the context of mental health and HIV integration, as well as, understanding challenges, opportunities, and innovative solutions.

Agenda

Case Study Presentations:

1. Milton Wainberg, Columbia University
2. Zerihun Hika Itana, Ethiopia Ministry of Health

Moderated Panel Discussion:

Ayibatari Burutoli, Global Health Security and Diplomacy / PEPFAR

1. Tafadzwa Dzinamarira- ICAP Zambia
2. Belay Reta Derbew-NEP+
3. Erin Ferenchick- United for Global Mental Health

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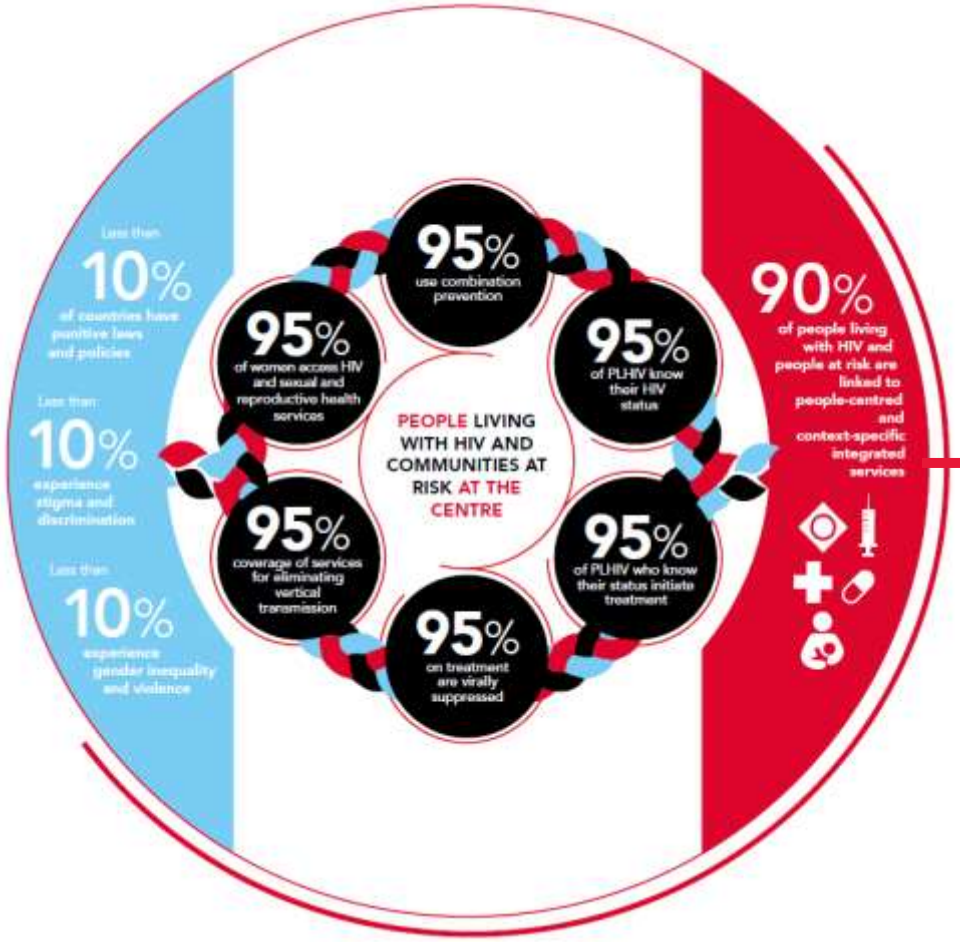
The HIV and Mental Health Syndemics

- The relationship between HIV and mental health is complex and bidirectional with each condition influencing the other in a myriad of intersectional links.
- Studies from Africa (8) have shown;
  - 19.2% HIV prevalence in people with severe metal illness
  - The prevalence of mental health conditions in PLHIV range from 19% to about 50%
- The prevalence of depression in PLHIV is estimated to be 24%, compared with less than 3% for the general population.
- Evidences demonstrates that mental health conditions lead to poor outcomes along the HIV care continuum
- Depression has been identified as one of the strongest predictors of poor ART adherence
- A 2022 study conducted in 4 African countries showed cumulative exposure to depressive symptoms was substantially associated with the risk of mortality
- The treatment gap for mental health disorders in the general population is estimated to be between 50–90%, with low-income countries experiencing the highest gap at 90%

Key messages from WHO guidance

Global HIV and mental health integration targets



*90% of PLHIV and individuals at ↑ risk of HIV linked to and access NCDs, **mental health** and other services for their overall health and wellbeing*

Population-specific:

- 90% PLHIV have access to HIV treatment and CVD, Cx Cr, **mental health**, diabetes services, health education, smoking cessation, PA
- 90% of gay men and other MSM, sex workers, transgender people have access to HIV services integrated with/linked to **mental health and PSS**
- 90% of PWID have access to comprehensive harm reduction, including **mental health,** services
- 90% of AGYW have access to SRHR services, including HPV/cervical cancer screening and treatment, that integrate HIV services

World Health Organization

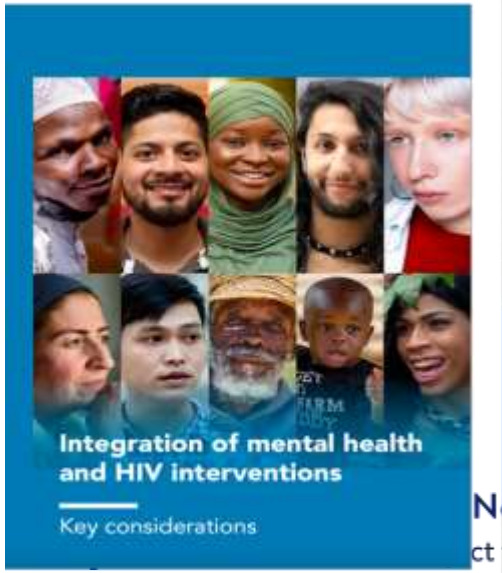
CONSOLIDATED GUIDELINES ON PERSON-CENTRED HIV STRATEGIC INFORMATION
STRENGTHENING ROUTINE DATA FOR IMPACT

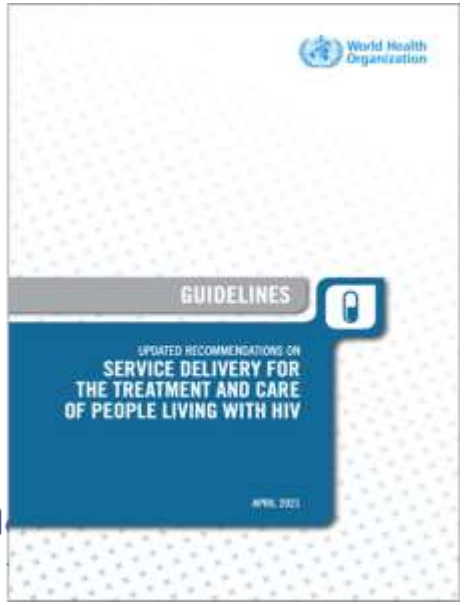
Slide courtesy of Wole Ameyan, WHO

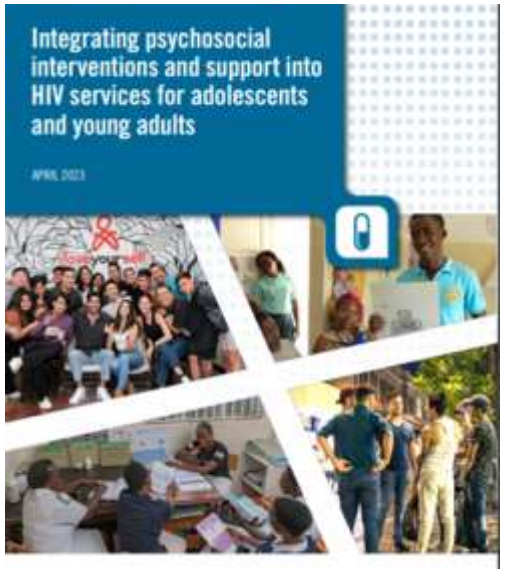
UNAIDS

Closing the Mental Health Treatment Gap for Recipients of Care

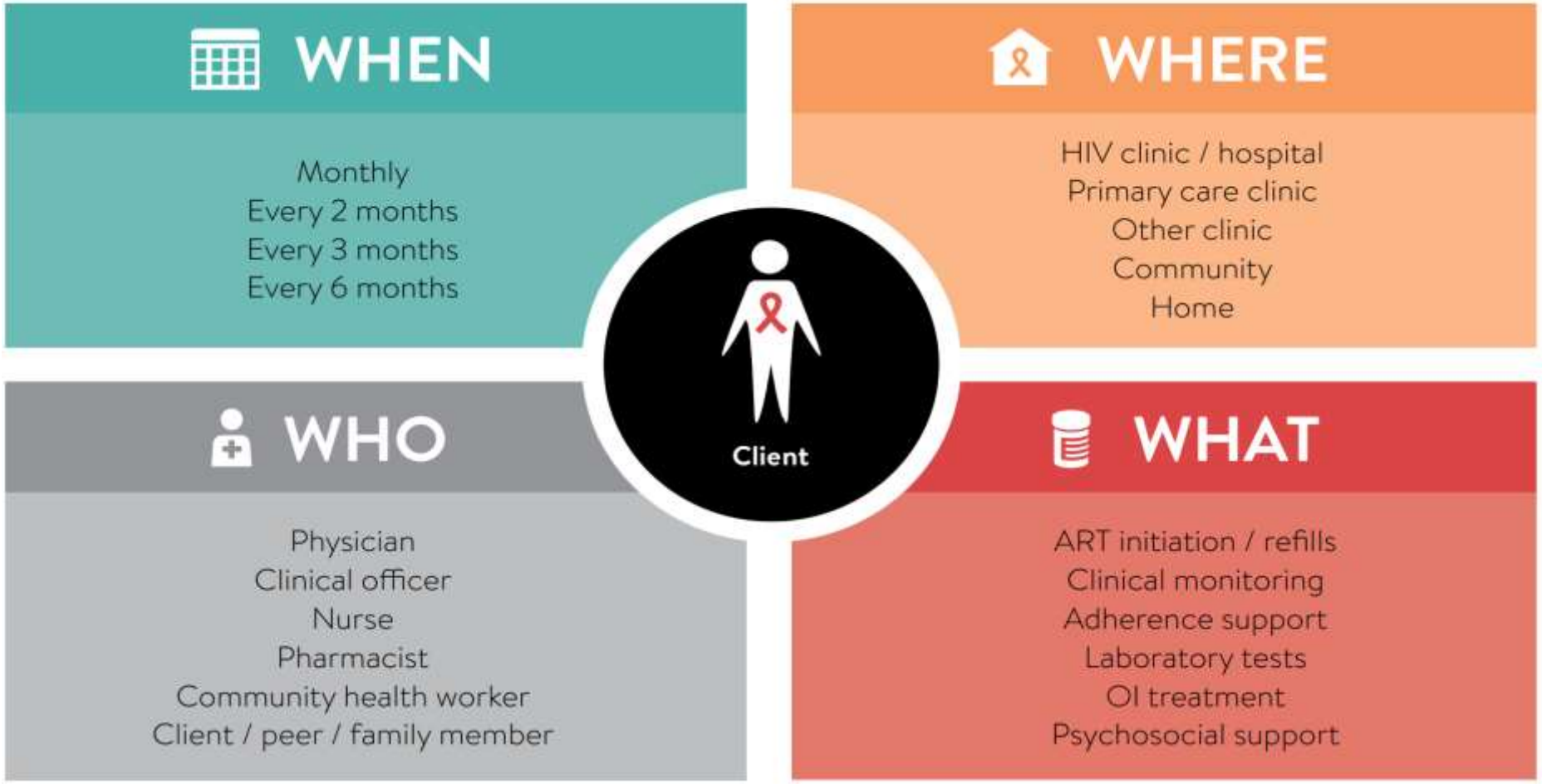
- A growing body of evidence shows that mental health conditions can be effectively managed in a diverse range of low resourced settings.
- In environments with shortages of mental health specialists, adopting a task-sharing approach with peers, lay health workers, treatment adherence counsellors, or other community-based resources has been shown to be an important strategy for providing evidence-based psychosocial support in communities affected by HIV.
- Studies have shown that directing investments toward the expansion of mental health treatment programs for conditions like depression and anxiety disorders is not only economically sound but also has the potential to yield a substantial return on investment





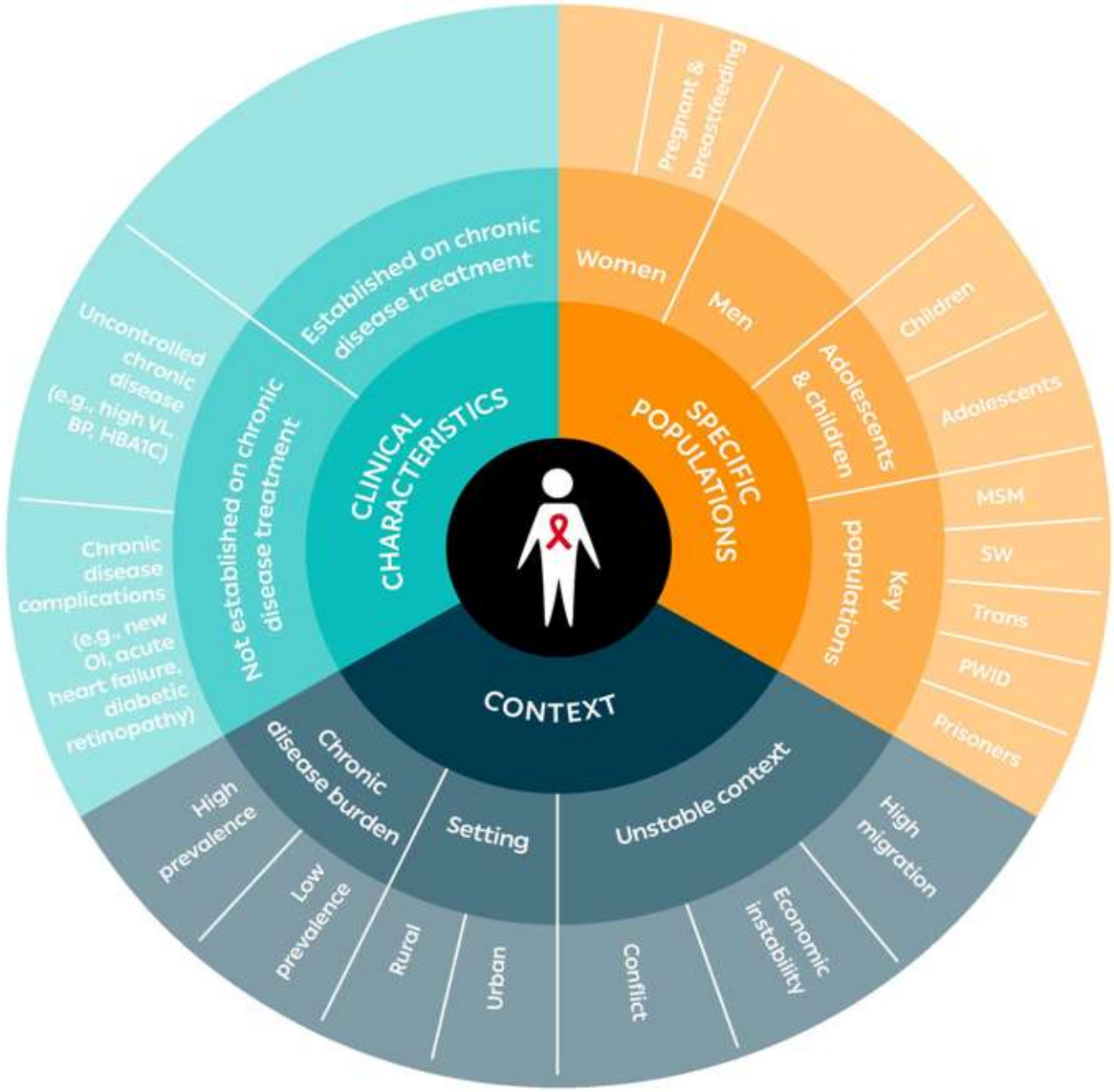


Building Blocks of Differentiated Service Delivery and Considerations for Integration

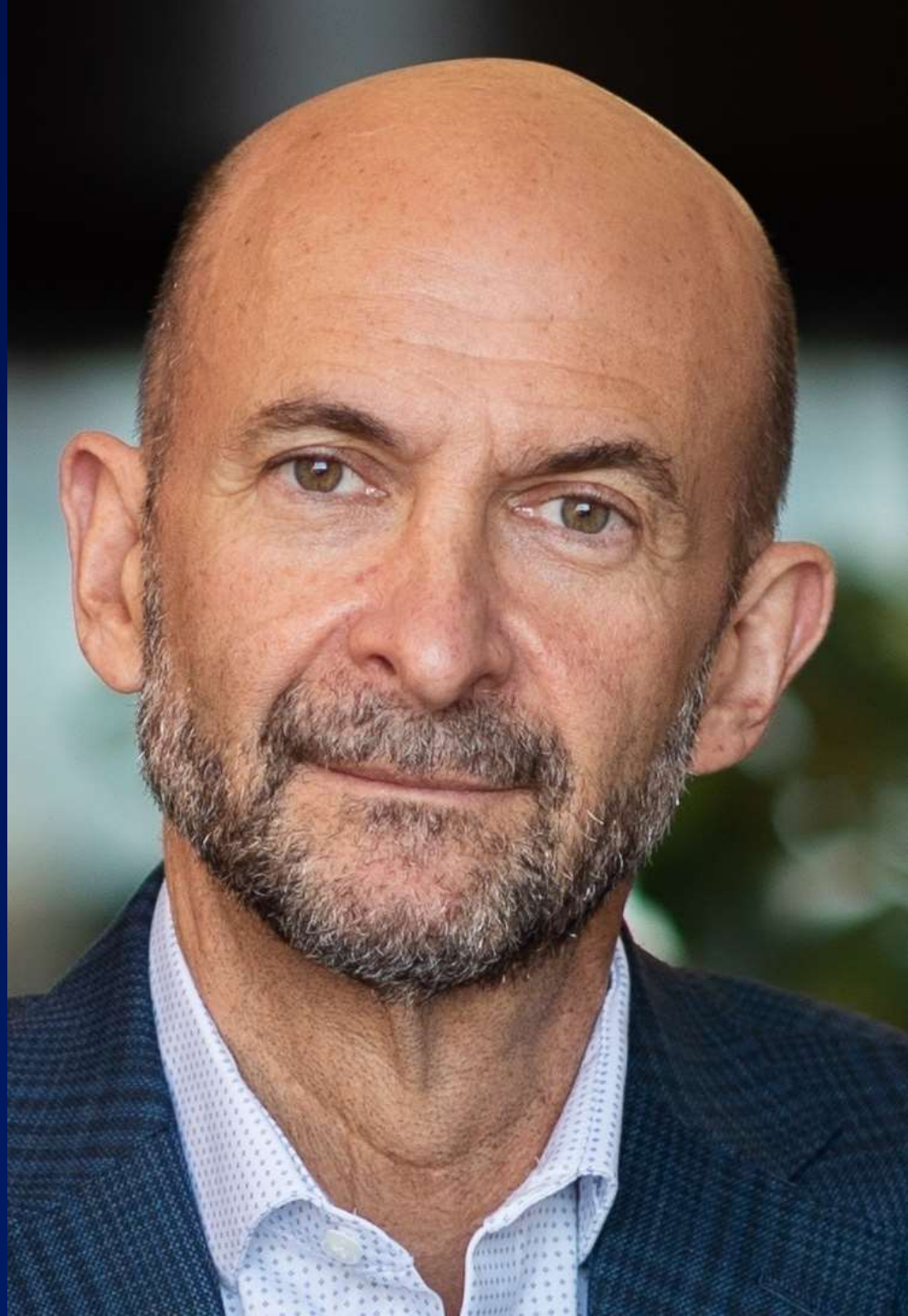


Source: International AIDS Society

Person Centered Elements to consider in Differentiated Services and Integration



Milton Wainberg, M.D.
Professor of Clinical Psychiatry
Columbia University
New York State Psychiatric Institute



The Mental Wellness Digital Platform:

Stepped-Care for ALL Mental and Substance Disorders Integrated in Community, Primary or Mental Health Care

Each provider can assess 4,300 people in the community and treat 1,400 individuals per year

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Clinician-HIV Psychiatry (intersectionality/disparities)

R01 AA11745, Morgenstern (US HIV/Alcohol)
R01 DA015971, Morgenstern (US HIV/Drugs)
P30 MH043520, Erhardt (US Global HIV/MH)
R01 AA023163, Hasin (US HIV/Alcohol)
R01 MH065163, Wainberg (Br, HIV/MH)
R34 MH090843, Rabkin/Wainberg (US HIV/MH)
R01 DA026775, Wainberg (US HIV/Alcohol/Drugs)
T32 MH096724, Wainberg (US/Global MH Imp Science)
D43 TW009675, Wainberg/Oquendo (Moz GMH IS)
R01 MH112139, Stanley (US MH/Suicide IS)
U19 MH113203, Wainberg/Oquendo (Moz+sSA GMH IS)
U19 MH113203-S, Wainberg (US COVID19-MH/task-shifting)
R01 AA025947, Wainberg (Moz, Alcohol/Drugs IS)
P30 MH043520, Remien (US/Global HIV/MH-IS/Equity)
D43 TW011302, Sohn/Wainberg (Asia-Pacific HIV/MH IS)
UG1 DA050071, Elkington/Nunes/Wainberg (US Opioids IS)
H79 FG000751, Wainberg (US MHIS task-shifting)

COLUMBIA | PSYCHIATRY

CU/NYSPI: M Wainberg, M Weissman, C Duarte, M Wall, B Stanley, R Shelton, M Arbuckle, F Cournos, K McKinnon, JM Bradford, R Shelton, C Mellins, B Remien, K Elkington, J Rabkin, Y. Neria, L Dixon, D Hassin, A Sweetland, S Tross, K Lovero, E Susser, M Mello, P Scorza, A Giusto, C Basaraba, A Norcini, J Mootz, MC Green, T Nicholson, M Stockton, B Waller, E Ferenchick, C Borges, A Fiks, B Kann, B Camara, M Tepper, A Pantz, O Jimenez-Salomon, S Chao, V Pereira, A Su, I Gutierrez, L Capri, Y Padilla, S Patel, M Rahman, A Velazquez, S Roberts, J Dierkens, A Friedman, T Smith, L Rosenberg.

UPenn: MA Oquendo, D Mandell, G Brown, R Beidas, R Schnoll, Z Cidav, R Gur

Mozambique Ministry of Health, U Eduardo Mondlane & MIHER: Q Fernandes, L Gouveia, W Fumo, AO Mocumbi, M Sidat, R. Thompson, E Noormahomed, P Santos, A Sulemam, P Feliciano, D Mabunda, F Mandlate, S Khan, L Massinga, V Cumbe, A Xavier, A Novela, R Mulumba, A Anube, R Muthemba, D Ferrão, E Fernandes, J Matuele, A Simone, S Noormahomed.

S Africa: G Wolvaardt, A Medina-Marino, M Freeman, C Bezuidenhout, P Ngwepe, E Manzinho

Asia-Pacific: A Sohn, J Ross, R Rajasuriar, RA Ditangco, MI Echanis Melgar, N Phanuphak, WN Songtaweesin, R Janamnuaysook, PL Wong, ML Chong, M Dungca, N Bora, T Dizon, MS Chhay, B Ngauv, O Vichea, K Hasmukkharay, A Kukreja, A Alonto, K Pakingan, L Aurpibul, A Hiransuthilkul, P Yimsaard.

Brazil: P Mattos, M Tavares Calvacanti, D Pinto, CG Mann, SB Oliveira, M Melo, M Guimarães, J Mari, C Matsuzaka

Champions & collaborators: H Swiller, J Morgenstern, S Vermund, D Indyk, S Golub, CM Audet, C Carlson, T Irwin, C Barbosa, K Clougherty, L Palinkas, L Saldana, M O'Grady, HOMIYAH team, Maccabi-Klalit MH team, ITC, VIVID.me, J Parsons, P Collins, Shual Foundation, A Brunstein-klomek, L Helpman, D Roe, J Blanch.

Family, friends and other mentors

Thank you!

Mental and Substance Use (MSU) Problems Matter! (Summary Points!)

- MSU problems are elevated among people at-risk for HIV and PLWHA
- MSU problems contribute to HIV acquisition and poor outcomes along the HIV treatment continuum
- We have the necessary assessment (screening) tools and efficacious treatments.
- In the HIV context, promising advances have been made integrating mental health care into primary care (via task-shifting, and stepped-care interventions)
- Integrating MSU assessment and treatment into HIV care should be routine and is essential to achieving our “95-95-95” and “Ending the Epidemic (EtE)” goals
- PROBLEMS TO ADDRESS:
  - Funding (finally there is some after decades of almost no funding)
  - Human resources
  - Go beyond one disorder at a time
  - Rigor – ONLY use efficacious treatments (Evidence Based Intervention)
  - Sustainability

The Global Public Mental Health (MH) Reality

- 1 in every 4 people experience mental illness in their lifetime
- 1 in every 8 people experience mental illness currently
- 1 in every 5 people experience mental illness in humanitarian settings
- 1 in every 2-5 PLWHIV experience mental illness currently
- Pervasive Individual & Structural Stigma/Intersectionality at multiple levels

➢ **BURDEN: HEALTH, EDUCATION, WORK, PRODUCTIVITY, FAMILY, AND THE ECONOMY**

- Lack of resources: MH care budgets are low (<5%) - Lack of MH providers
- No community-level care with profound MH disparities

➢ **GLOBALLY: THE MH WORKFORCE CAN NOT MEET THE DEMANDS: 50-85% OF THOSE IN NEED DON'T RECEIVE CARE**

Wainberg et al, CurrPsychRep 2017; Patel V, et al., Lancet. 2016; Lovero et al, LancetPsych 2020; Rahman et al, LancetPsych 2020; Wainberg, et al, LancetPsych, 2018; Hanherson et al, 2022

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Current training and delivery of service model

Focused on treating diseases, not people (it is not patient-centered)

1:1 treatment model – the best treatment for each diagnosis:

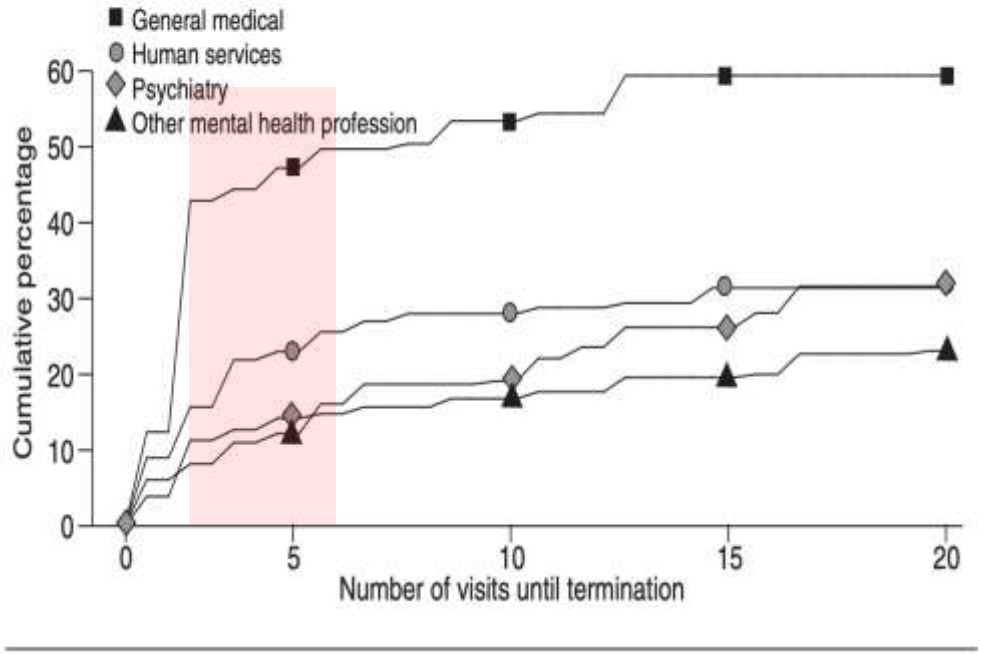
- ***For severe cases:*** **Emergency room, hospitalization, chronic outpatient care – according to resources, severity, and risk to self and others.**
- ***All others – mostly one option:*** **Weekly (not time-limited) chronic outpatient care. Range of therapies (supportive, psychodynamic, family, etc.)**

➢ ***Lack of a public mental health lens!***

Even IF care is available

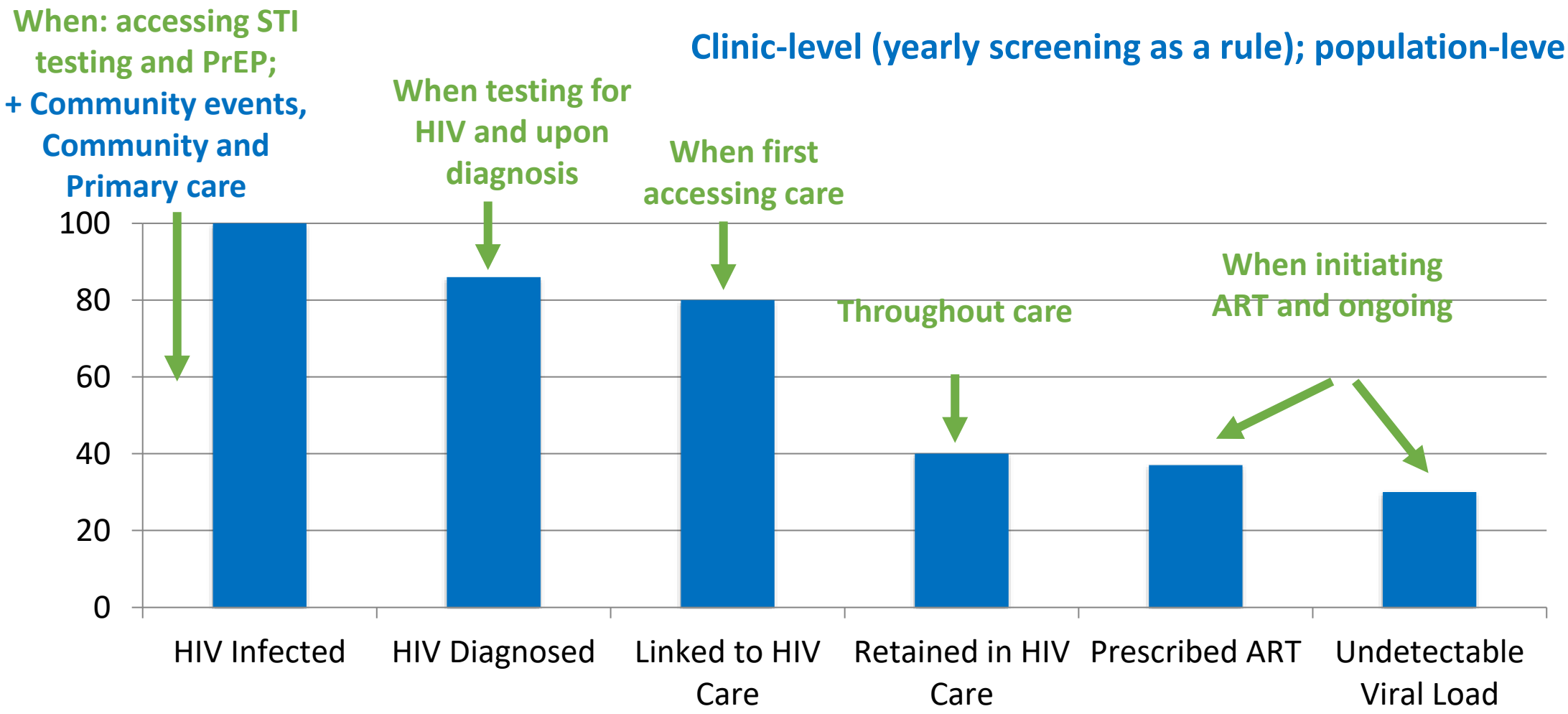
- Access to care barriers are common
- Waitlists are long (no early intervention)
- Treatment option: long-term treatment – systems of care seldom use short-term psychological interventions
- Treatments don't match preferences/needs:
  - US: 60% drop out between sessions 3-5
  - Globally: Median number of sessions = 1
- Task-shifting approaches are uncommon

Cumulative probability of dropout over the course of treatment among National Comorbidity Survey Replication respondents who had received mental health treatment in the past 12 months, by sector

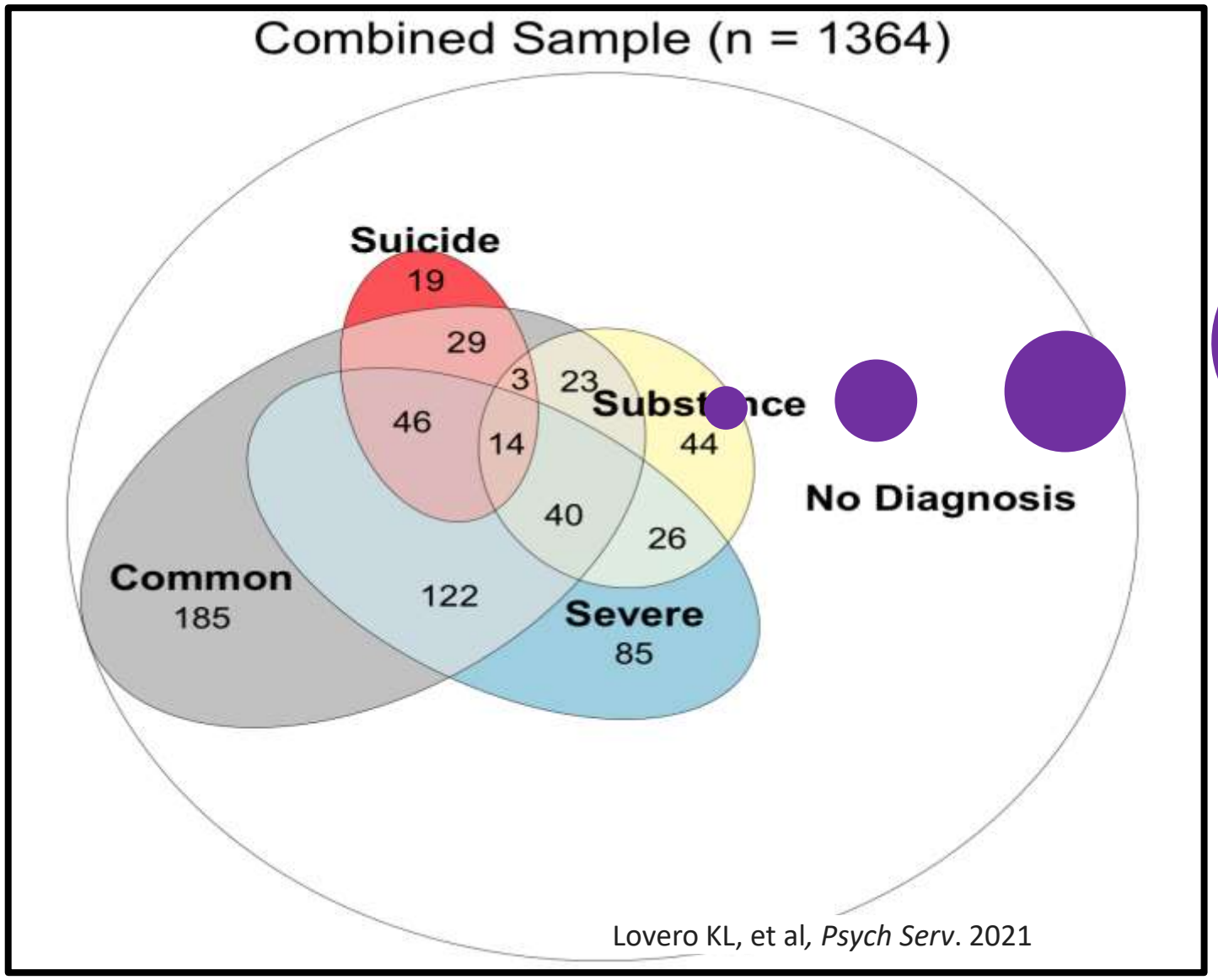


Olfson M, et al. Dropout from outpatient mental health care in the United States. Psychiatric Services. 2009

Individual-level opportunities for intervention: Mental health screening and intervening



PHYSICAL AND MENTAL HEALTH COMORBIDITIES ARE COMMON



Lovero KL, et al, *Psych Serv*. 2021

We need to SCREEN, IDENTIFY *(IN MULTIPLE SETTINGS)* and TRIAGE *(ALL DISORDERS)* TO THE APPROPRIATE LEVEL OF CARE

(How many items? "3-5")

75% were identified in PRIMARY CARE SETTINGS

30% PLWHIV

COLUMBIA

BRIEF, EFFICIENT AND VALID COMMUNITY- AND INDIVIDUAL-LEVEL SCREENING

The Mental Wellness Tool

Brief Screening Tool for Stepped-Care Management of Mental and Substance Use Disorders

Kathryn L. Lovero, Ph.D., Cale Basaraba, M.P.H., Saida Khan, M.A., Antonio Suleman, M.D., Dirceu Mabunda, M.D., Paulino Feliciano, B.S., Palmira dos Santos, Ph.D., Wilza Fumo, M.D., Flavio Mandlate, M.D., M. Claire Greene, Ph.D., Andre Fiks Salem, B.S., Jennifer J. Mootz, Ph.D., Ana Olga Mocumbi, M.D., Cristiane S. Duarte, Ph.D., M.P.H., Lidia Gouveia, M.D., Maria A. Oquendo, M.D., Ph.D., Melanie M. Wall, Ph.D., Milton L. Wainberg, M.D.

RESEARCH ARTICLE

Medical Research Archives

An Ultra-Brief Proxy Measure for Early Mental and Substance Use Disorders and Suicide Risk Case Detection at the Community and Household Level: An Efficient and Feasible Clinical and Population-level Service Needs Screening Tool

Melissa A Stockton[1*], Ernesha Webb Mazinyo[2, 3], Lungelwa Mlanjeni[4], Kwanda Nogemane[5], Nondumiso Ngcelwane[5], Annika C. Sweetland[6, 7], Cale Basaraba[8, 9], Charl Bezuidenhout[10], Griffin Sansbury[11], Kathryn L. Lovero[12], Maria Lídia Gouveia[13], Palmira Fortunato dos Santos[13], Paulino Feliciano[13], Wilza Fumo[13], Antonio Suleman[13], Maria A. Oquendo[14], Christoffel Grobler[15], Melanie M Wall[6, 9], Phumza Nobatyi[5], Andrew Medina-Marino[4, 14], Milton L. Wainberg[6, 7]

AIDS and Behavior
https://doi.org/10.1007/s10461-022-03852-w

ORIGINAL PAPER

Does It Matter What Screener We Use? A Comparison of Ultra-brief PHQ-4 and E-mwTool-3 Screeners for Anxiety and Depression Among People With and Without HIV

Cale N. Basaraba[1] · Melissa A. Stockton[2] · Annika Sweetland[3] · Andrew Medina-Marino[4,5,6] · Kathryn L. Lovero[7] · Maria A. Oquendo[4] · M. Claire Greene[8] · Ana Olga Mocumbi[9] · Lidia Gouveia[9,10] · Milena Mello[2] · Palmira dos Santos[9,10] · Antonio Suleman[9] · Dirceu Mabunda[9] · Flávio Mandlate[9] · Amalio Xavier[10] · Wilza Fumo[9,10] · Luciana Massinga[9] · Saida Khan[10] · Paulino Feliciano[9] · Bianca Kann[2] · Andre Fiks Salem[2] · Charl Bezuidenhout[11] · Jennifer J. Mootz[2] · Cristiane S. Duarte[2] · Francine Cournos[12] · Melanie M. Wall[1,2,13] · Milton L. Wainberg[2]

Lovero et al. BMC Psychiatry (2022) 22:549
https://doi.org/10.1186/s12888-022-04189-3

BMC Psychiatry

RESEARCH Open Access

Validation of brief screening instruments for internalizing and externalizing disorders in Mozambican adolescents

Kathryn L. Lovero[1*], Salma Ebrahim Adam[2], Carolina Ezequias Bila[2], Elda D. Canda[2], Maria Eduarda Fernandes[2], Teresa I. Baltazar Rodrigues[2], Mariel C. Tai Sander[3], Claude A. Mellins[3,4], Cristiane S. Duarte[3], Palmira Fortunato dos Santos[2] and Milton L. Wainberg[3]

COLUMBIA
COLUMBIA UNIVERSITY
IRVING MEDICAL CENTER

Performance of the Mental Wellness Tool (mwTool) for index case and proxy (community) respondents in the validation sample (n=463)

INDEX CASE*	No.	%	Sensitivity	95% CI	Specificity	95% CI
Any Disorder (First 3 items)	*178*	*39*	***0.94***	*0.89-0.97*	*0.34*	*0.28-0.40*
Severe Mental Disorder	82	18	0.82	0.72-0.89	**0.63**	0.58-0.68
Common Mental Disorder	134	30	0.93	0.87-0.96	**0.72**	0.67-0.77
Substance Use Disorder	29	6	0.86	0.68-0.96	**0.82**	0.78-0.86
Suicide Risk	35	8	0.77	0.60-0.90	**0.93**	0.90-0.96
PROXY (FAMILY)	**No.**	**%**	**Sensitivity**	**95% CI**	**Specificity**	**95% CI**
Any Disorder	48	48	**0.73**	0.58-0.85	0.31	0.19-0.45

*Female/Male and PLWHIV

Validated in the US, Spain and South Africa.
Being validated in 4 Asia-Pacific countries

Lovero K…Wall M…Basaraba C…Wainberg ML.. Psych Services 2021; Wainberg et al, 2021

The COMMUNITY- AND INDIVIDUAL-LEVEL SCREENING The Mental Wellness Tool

Validated in Mozambique, Spain, South Africa & the US

(Portuguese, English & Spanish)

Being validated in the Asia-Pacific region and the Middle East

(Hebrew and Arabic)

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The Electronic Mental Wellness Tool (EmwT):
Screening (3-items; Self and Proxy) + Categorization (9-items + 1-item for drug abuse)

	QUESTIONS	NEGATIVE	POSITIVE		
PHQ2	1. In the last 2 weeks, how often have you been feeling down, depressed, or hopeless?	Not at all	Several days	More than half the days	Nearly every day
GAD1	2. In the last 2 weeks, how often have you been feeling nervous, anxious, or on edge?	Not at all	Several days	More than half the days	Nearly every day
GAD5	3. In the last 2 weeks, how often have you been so restless that it's hard to sit still?	Not at all	Several days	More than half the days	Nearly every day

If POSITIVE to questions 1 or 2 or 3, CONTINUE SCREENING. If NEGATIVE for all three, STOP.

AUDIT1	4. In the past year, how often do you have a drink containing alcohol?	Never	Monthly or less	Between 2 and 4 times a month	Between 2 and 3 times a week	4 or more times per week
	If "never", SKIP to question 6					
AUDIT2	5. In the past year, how many drinks containing alcohol do you have on a typical day when you are drinking? EXPLAIN "STANDARD DRINK"	1 or 2	3 or 4 (Women)	5 or 6 (Men)	7 to 9	10 or more

6. In the past year, how many times you used a recreational or illegal drug, or used a prescription medication for non-medical reasons?	Never	Once or twice	Monthly	Weekly	Daily or almost daily

PSQ2A	7. In the past year, have you ever felt that your thoughts were being directly interfered with or controlled by some outside force or person in a way that many people would find hard to believe (for instance, through telepathy)?	No	Not Sure	Yes
PSQ3B	8. In the past year, have there been times when you felt that a group of people was plotting to cause you serious harm or injury?	No	Not Sure	Yes
PSQ4A	9. In the past year, have there been times when you felt that something so strange was going on that other people would find it very hard to believe?	No	Not Sure	Yes
PSQ5A	10. In the past year, did you at any time hear voices saying quite a few words or sentences when there was no one around that might account for it?	No	Not Sure	Yes

CSSRS1	11. In the past month, have you wished you were dead or wished you could go to sleep and not wake up?	No	Yes
CSSRS2	12. In the past month, have you had any actual thoughts of killing yourself?	No	Yes
CSSRS6A	13. In the past 3 months, have you ever done anything, started to do anything, or prepared to do anything to end your life**?**	No	Yes

Partnerships in Research to Implement and Disseminate Sustainable and Scalable Evidence-Based Practices (PRIDE) in Mozambique

Milton L. Wainberg, M.D., Kathryn L. Lovero, Ph.D., Cristiane S. Duarte, Ph.D., Andre Fiks Salem, Milena Mello, Charl Bezuidenhout, Jennifer Mootz, Ph.D., Paulino Feliciano, Antonio Suleman, M.D., Palmira Fortunato dos Santos, Ph.D., Myrna M. Weissman, Ph.D., Francine Cournos, M.D., Andrea Horvath Marques, M.D., Ph.D., Wilza Fumo, M.D., Dirceu Mabunda, M.D., Jean-Marie E. Alves-Bradford, M.D., Marcelo Mello, M.D., Ph.D., Jair J. Mari, M.D., Ph.D., Phuti Ngwepe, Zuleyha Cidav, Ph.D., Ana Olga Mocumbi, M.D., Ph.D., Andrew Medina-Marino, Ph.D., Melanie Wall, Ph.D., Lidia Gouveia, M.D., Maria A. Oquendo, M.D., Ph.D.

Digital mental health

ORIGINAL RESEARCH

Technology and implementation science to forge the future of evidence-based psychotherapies: the PRIDE scale-up study

Milton L Wainberg,[1,2] Maria L
Paulino Feliciano,[4] Antonio Su
Andre Fiks Salem,[1,2] M. Claire
Kathryn L Lovero,[1] Palmira Fo
David S. Mandell,[8] Rogerio M
Flavio Mandlate,[3] Francine C
Terriann Nicholson,[1,2] Bianca
Jair de Jesus Mari,[12] Marcelo
Myrna M Weissman[1,2]

treat), CHWs screen and refer patients to PC
and pharmacological EBIs in community cli

Leveraging a Digitized Mental Wellness (DIGImw) Program to Provide Mental Health Care for Internally Displaced People

Jennifer J. Mootz, Ph.D., Catherine Chantre, M.Sc., Kathleen Sikkema, Ph.D., M. Claire Greene, Ph.D., Kathryn L. Lovero, Ph.D., Lidia Gouveia, M.D., Ph.D., Palmira Santos, Ph.D., Antonio Suleman, M.D., Andrea Simone Comé, B.S., Paulino Feliciano, B.A., José Miguel Uribe-Restrepo, M.D., Annika C. Sweetland, Dr.P.H., Rachel C. Shelton, Dr.P.H., Jeremy Kane, Ph.D., Milena Mello, M.A., Wilza Fumo, M.D., Yazmin Cadena-Camargo, M.D., Ph.D., Myrna Weissman, Ph.D., Milton L. Wainberg, M.D.

Scale-Up Study Protocol of the Implementation of a Mobile Health SBIRT Approach for Alcohol Use Reduction in Mozambique

António Suleman, M.D., Jennifer J. Mootz, Ph.D., Paulino Feliciano, B.S., Terriann Nicholson, M.D., Megan A. O'Grady, Ph.
Ana

ELSEVIER

Journal of Substance Abuse Treatment

Volume 134, March 2022, 108549

JSAT

Mobile technology and task shifting to improve access to alcohol treatment services in Mozambique

Jennifer Mootz [b], Antonio Suleman [c], Annika Sweetland [b],
nube [c], Paulino Feliciano [c], Charl Bezuidenhout [e],
os [d], Wilza Fumo [d], Lidia Gouveia [d], Ilana Pinsky [b],
[b], Milton L. Wainberg [b]

nobile application–
BIRT–Conventional
ill be delivered by
The Consolidated
will guide the au-
out the study.

tool kit to guide SBIRT scale-up of community services addressing hazardous drinking in other low- and middle-income countries and low-resource settings in high-income countries.

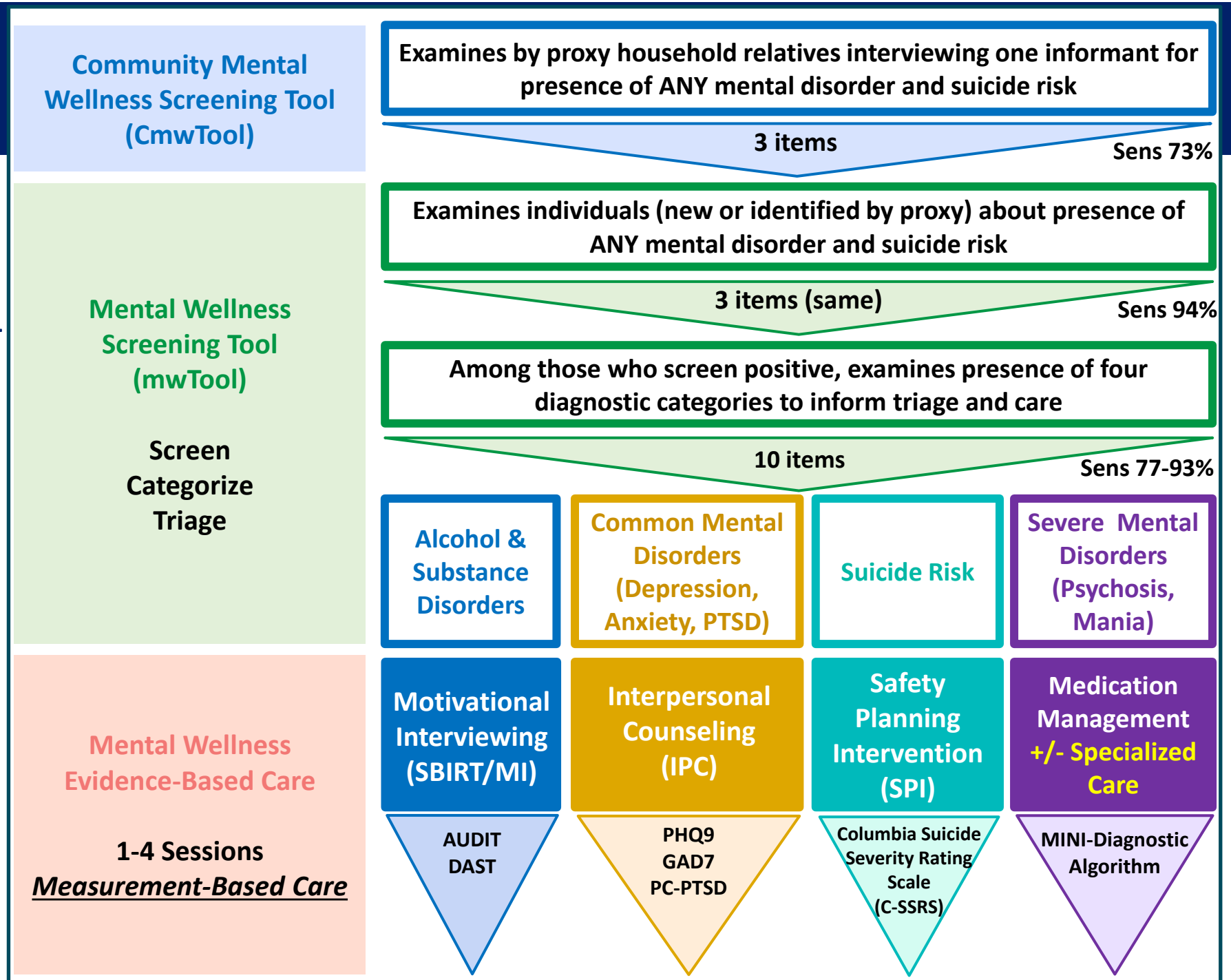
Psychiatric Services 2021; 72:1199–1208; doi: 10.1176/appi.ps.202000086

Mental Wellness Digital Platform (NIMH)

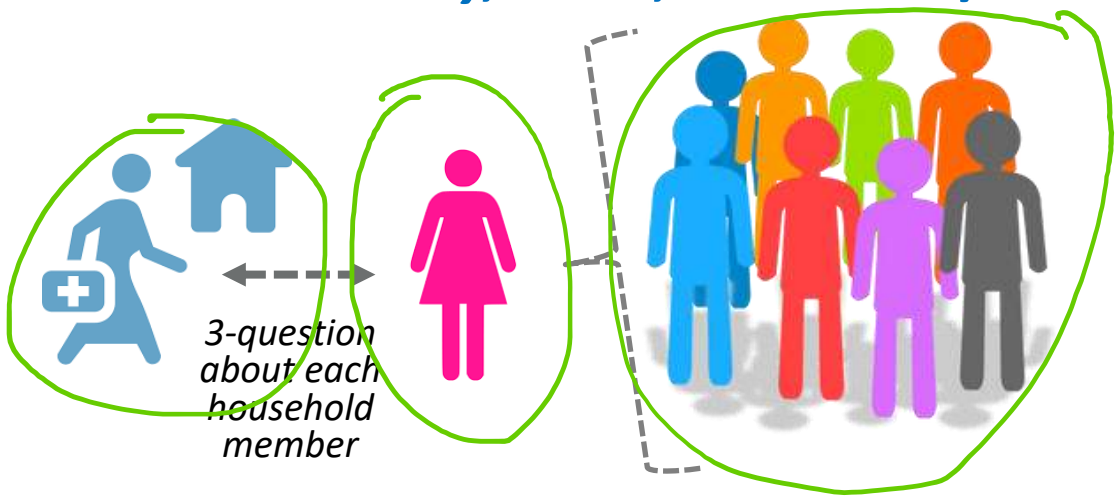
ALL Mental/Substance Use Disorders & Suicide Risk for Adults (Youth, almost ready)

Task-shifting, stepped-, stratified- and measurement-based care

- Integrated in the system of care with existing personnel
- Patient, services, and implementation outcomes
- Each provider can assess 4,300 community cases and treat 1,400 per year – allows for Prevention/Promotion
- Mozambique (NIH): 45 trainers, 23 MH specialists, 600 CHWs, 277 primary care providers; **no funding for scale-up**
- USA (NYS Office of MH) and other HICs: **requires changing policies**



ACCESS: Community, Clinic, Telehealth/Phone & Self-Assessment



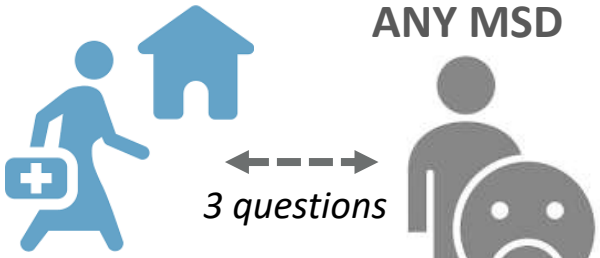
73% Sensitivity for ANY MSD

Identification by proxy

Mental Wellness Tool (*mwTool*)

TESTED *DIGITIZED* ASSESSMENTS

94% Sensitivity for ANY MSD



10 questions

No Disorder

DIAGNOSTIC CATEGORIES

TESTED *DIGITIZED* TREATMENTS

Severe Disorder (Psychosis, Mania)	Diagnostic Medication Assessment (PCPs) +/- Long-Term Therapy (MH Specialists)
Suicide Risk	Safety Planning Intervention: 1-4 sessions
Alcohol / Substance Abuse	Motivational Interviewing: 1-4 sessions
Depression Anxiety PTSD	Interpersonal Counseling: 4 sessions

Each CHW can assess 4,300 and treat 1,400/year

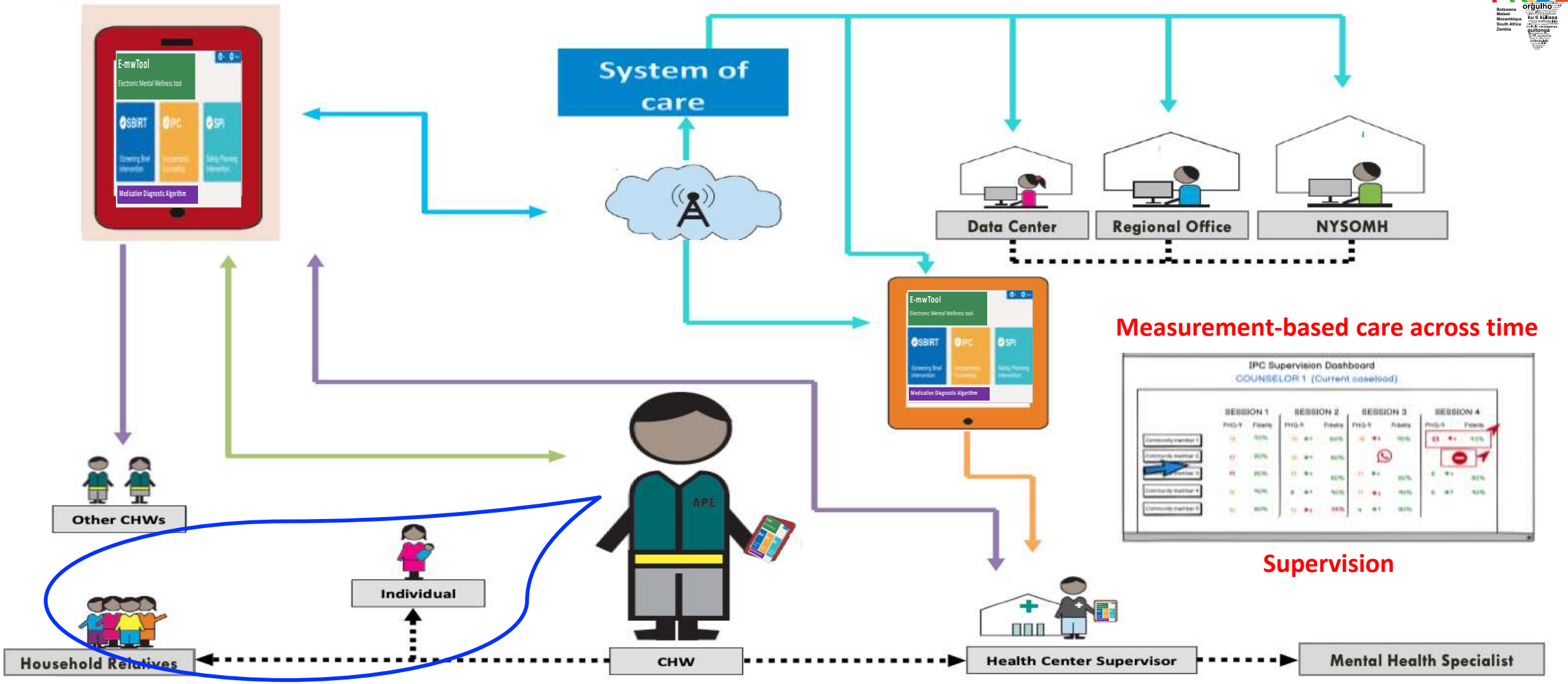
Task shifting personnel

MSD: Mental and substance use disorders;

CHWs: Community health worker; PCPs: Primary care providers

Lovero K…Wall M…Basaraba C…Wainberg ML.. Psych Services 2021

TECHNOLOGY ALLOWS FOR QUALITY COMMUNITY CARE WITH IMMEDIATE INTERCONNECTIVITY FOR DATA COLLECTION (EHR) AND SUPERVISION ACROSS TIME



The Mental Wellness Digital Platform *automatically and directly* collects multi-level outcomes during patient care

Without extra work!

PATIENT

Clinical Effectiveness (measurement-based care)

Early Detection

Social Determinants of Health

SERVICES

Safety

Equity

Efficiency

Timeliness

IMPLEMENTATION

ACCESS to care

Evidence Fidelity and Uptake

Sustainability

Costs

COMMUNITY & POPULATION

Prevalence*

Incidence*

*GPS catchment area mapping Prevention & Promotion

Adapted from Proctor et al, 2009; Wainberg et al, 2020

COLUMBIA

2014 – **CAPACITY BUILDING:** Masters (3); PhDs (9); PhDs pending (8); Trainers & Supervisors (58); 65 publications

2015 – Mental Wellness Tool (Fica Bem!) (Patients 1,364) Maputo and Nampula

2017 – PRIDE-SCALE-UP (All … chs. (33); P… 559)

2018 – I-STAR (Pro… Psychiatric…

2019 – PRIDE-A… on; Lovero…

2019 – Mental … ts (Lovero)

2019 – Mental … **BEM HIV**: MH providers trained (170)

2019 – PRIDE-… olence; M… (1)

2020 – Men… 9; FICA BE… gists (15)

2021 – FI… -19 provi…

2021 – PI… E: Primary… 00)

2022 … e in all … ders)

20… oing

2023 – FICA BEM Training of Psychology Students and Psych Technicians ongoing

+ More FICA BE to come (early intervention for psychosis, etc.)

PARTNERSHIP:

- Mozambique, Brazil and US researchers;
- Ministry of Health (WHO? HIV, MH, etc.);
- Communities;
- Providers,
- Patients and their relatives.

10 Master Trainers
25 Trainers and Supervisors
(trainer of trainers)

19 Co-Trainers and Supervisors

300
Primary Care Providers
600
Community Health Workers
(Competency: 3-4 days training + 3 successful cases under supervision)

949 New task shifting MH Providers so far!

Our training is now part of the regular training of MH specialists (Ministry of Health and one University so far)

Similar work has received funding to be implemented in South Africa, New York State (USA) , and the Asia-Pacific and the Middle-East Regions

COLUMBIA

SUSTAINABILITY, SUSTAINABILITY & SUSTAINABILITY

Zerihun Hika Itana, M.D. MPH
Senior HIV Program Advisor
Federal Ministry of Health, Ethiopia

Mental Health and HIV Program Integration in Ethiopia

Outline

- Background
- Program strategy
- Integration methods- Phased approach
- Initial phase Results
- Mental Health Integration Tools

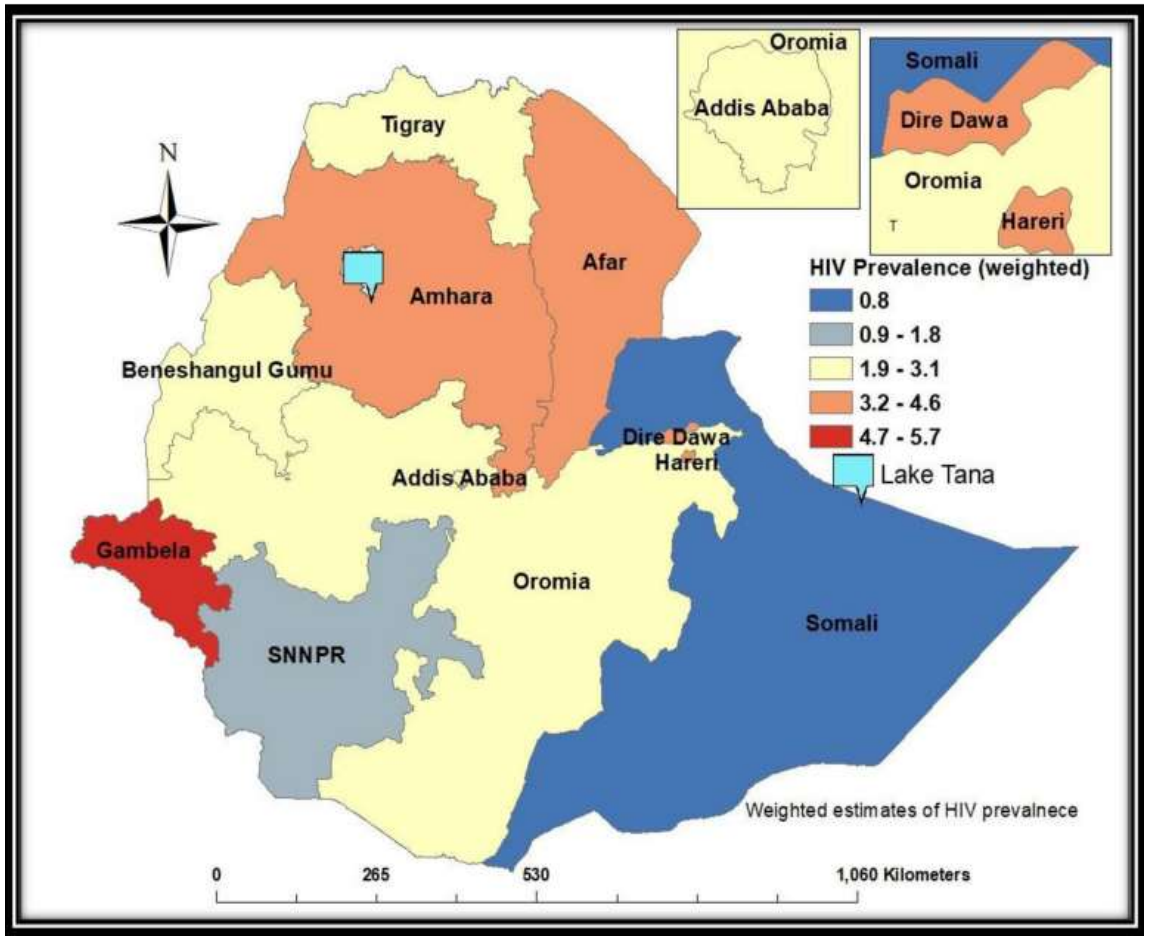
Background: Current HIV Epidemic Status

Ethiopia is close to attaining HIV epidemic control

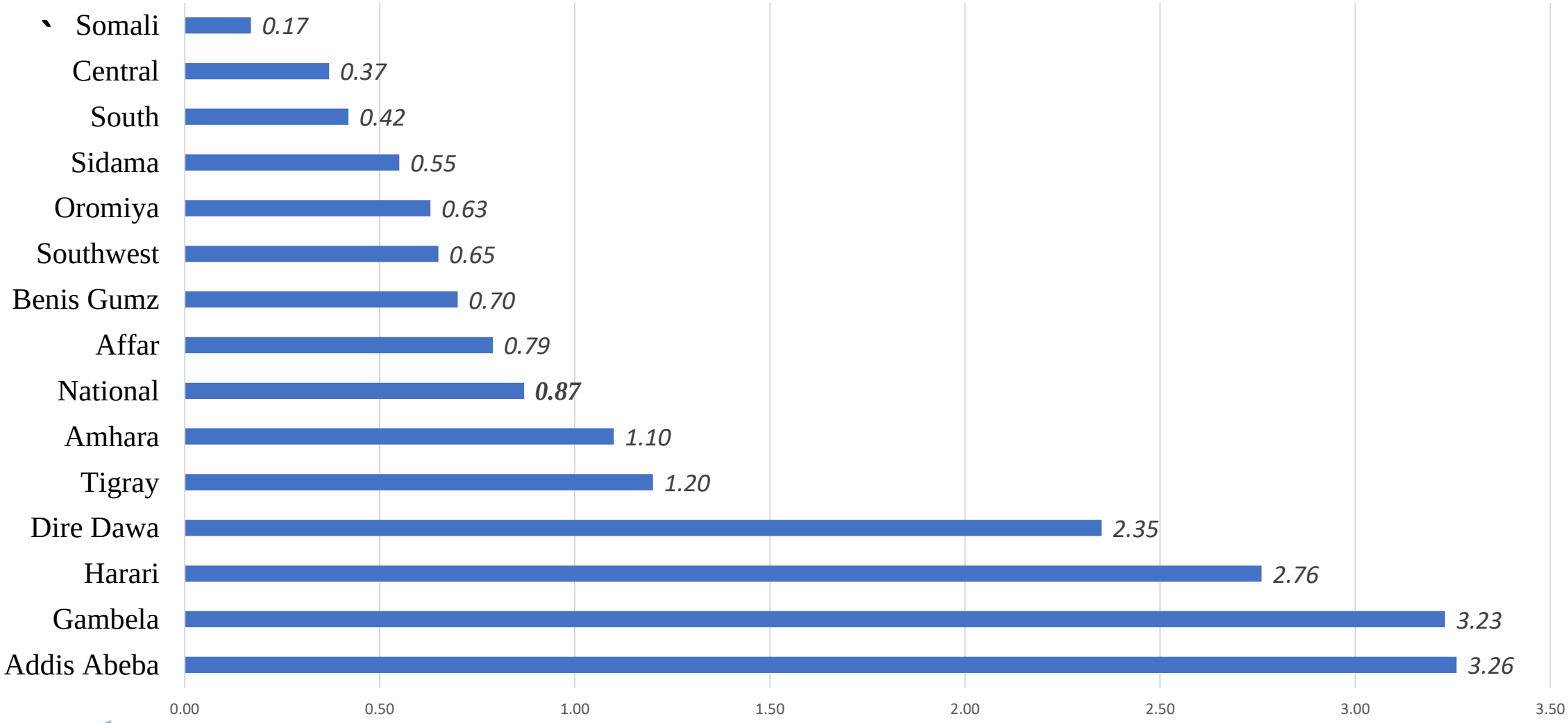
- **HIV prevalence is 0.9%**
- **There are an estimated 605,523 PLHIV in 2023**
- **90%** Percent of people living with HIV who know their status (**EPHI**, 2023)
- **85% coverage of adults and children are receiving ART (UNAIDS, 2023)**
- **82%** people living with HIV who have suppressed viral loads (**EPHI, 2023**)

Urban areas have 7 x's higher prevalence vs rural settings (2.9% vs 0.4%) (EDHS 2016)

The number of new HIV infections has reduced from 16,442 in 2016 to *7,293* in 2023 (>50% reduction in 5 years). (EPHI, 2023 spectrum estimates)



Ethiopia Regional States: Variation of Adult (15+) HIV prevalence, 2023



Background

Worldwide, mental health problems are more common among PLHIV

Similarly, a study conducted in Ethiopia found that nearly half of PLHIV were depressed or anxious, and the proportion increased to two-thirds among people co-infected with HIV and tuberculosis

Moreover, the mental health illness and substance use disorders are likely to be exacerbated by humanitarian emergencies

Background

The negative health consequences of common mental health conditions and substance use disorders coupled with stigma toward mental health problems, have made access to mental health services a challenge in Ethiopia.

The Ethiopia MOH has made a commitment to reduce the mental health and HIV related challenges through an integration approach (MH into HIV) in collaboration with ICAP and CDC through PEPFAR support and has implemented training the healthcare providers and case managers.

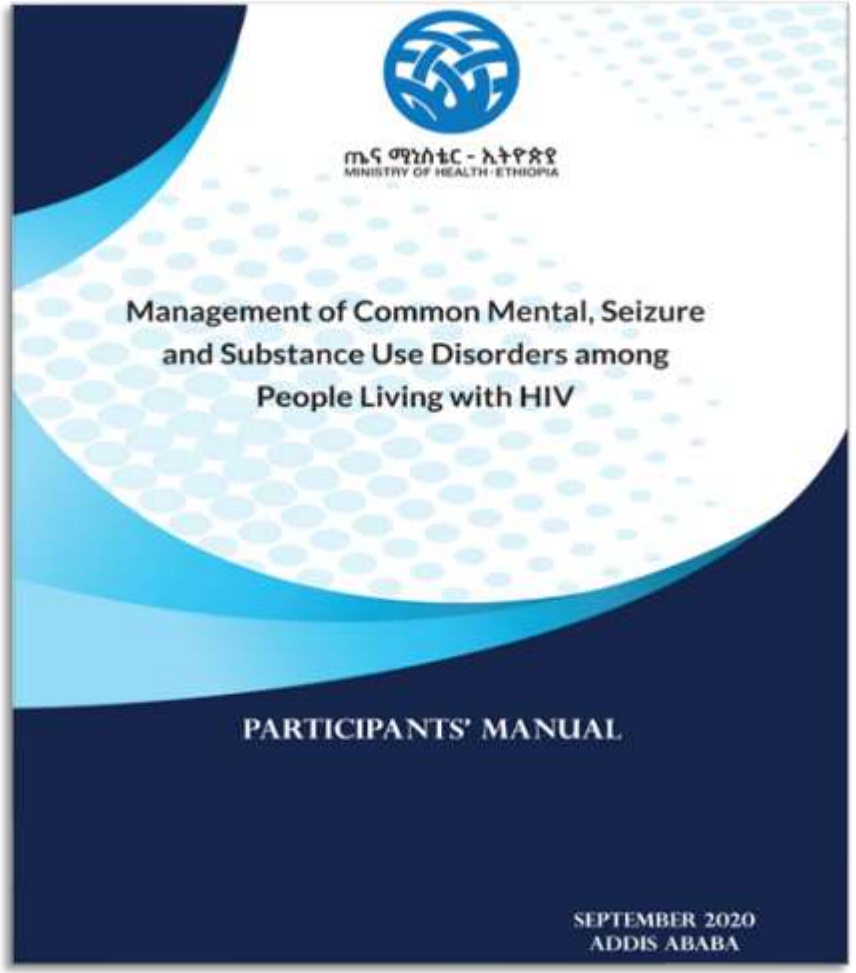
Integration Approach

Need assessment was conducted in 4 regions to inform mental health integration (MHI) approach into HIV care

Based on the needs assessment findings, necessary materials were developed:

- MHI training curriculum
- Screening checklist and referral form
- Client education materials in local language
- Provider support tools and standard operation procedures for MH services
- Case managers logbook and monthly reporting form.

Integrating Mental Health Screening for Recipients of Care



I. MHI priority clients – RoC on ART

1. Newly initiated on ART
2. Unsuppressed viral load
3. Re-starting ART
4. Adherence challenges
5. Challenges with disclosure
6. Suspected to have a MH condition

II. MHI priority clients – RoC not on ART

1. Declined ART with out identifiable reasons
2. Adherence preparation > 2 weeks
3. Advanced disease management
4. Suspected to have a MHI condition

icap Global Health

HIV Learning Network

The CQUIN Project for Differentiated Service Delivery

Mental Health Integration Approach- Processes

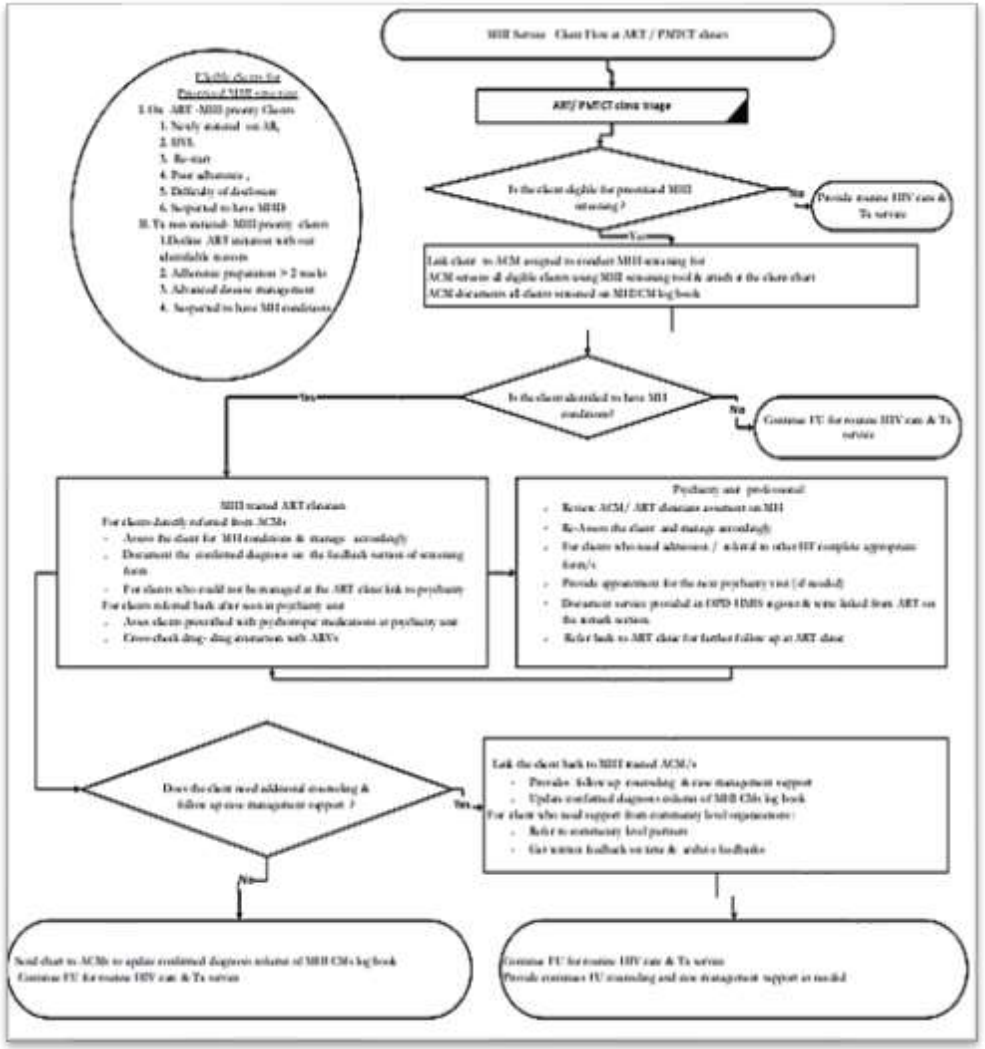
Adherence Case Mangers (ACM) or Adherence Supporters provide health education on MH in client waiting areas.

Eligible clients identified and linked to ACM, who screen them using the MHI screening tool and attach it to the client chart.

ACM escort clients who screen positive to the ART clinic/psychiatric clinic at the HF and serve as an ongoing link between the psychiatric and ART clinics, facilitating communication, documentation and follow-up.

Clinicians at ART/ psychiatric clinic will review ACM assessment, re-assess the client and manage accordingly.

Clinicians will complete a feedback form and revert back to ACMs for documentation and record keeping.



Regional Health Bureau Sample Assessment Data FY23

	AA		SNNP		Oromia		Amhara	
	#	%	#	%	#	%	#	%
# Screened by ACMs for MHD	6580		539		6476		5925	
# Identified for MHD by ACMs	2452	37%	499	93%	450	7%	2646	**45%**
# Referred to ART clinician/ provider	1881	77%	468	94%	428	95%	2245	**85%**
# Feedback received from ART clinicians	1268	67%	362	77%			1974	**88%**
# Confirmed diagnosis for MHD by ART clinician/ provider	290	12%	90	18%	222	49%	705	**27%**
# Referred to psychiatry unit by ART clinician/ provider	222	12%	68	15%	83	19%	575	**26%**

Tools: MH Client Education and Screening Materials

Mental Health DSD Framework

Who:

- Peer support/ACM
- ART providers
- Psychiatrist by referral

What:

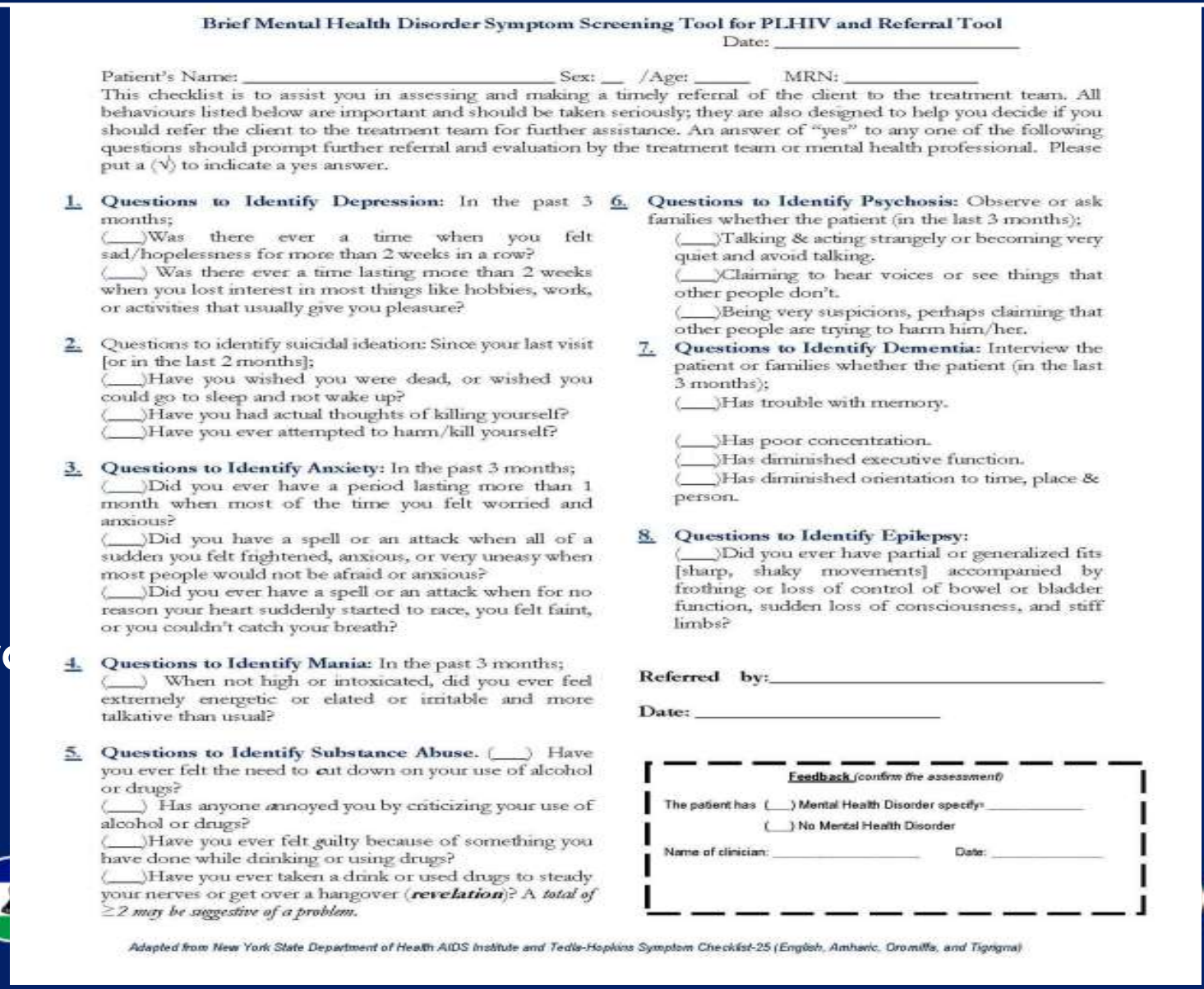
- Screening for common mental illness
- Link to psychiatrist

Where:

- ART clinic, PMTCT clinic, KP clinic, Community service delivery points, DIC

When:

- At each client visits as per NGL, (1M, 3M,6M), including unscheduled visits



Brief Mental Health Disorder Symptom Screening Tool for PLHIV and Referral Tool

Date: _____

Patient's Name: _____ Sex: __ /Age: _____ MRN: _____

This checklist is to assist you in assessing and making a timely referral of the client to the treatment team. All behaviours listed below are important and should be taken seriously; they are also designed to help you decide if you should refer the client to the treatment team for further assistance. An answer of "yes" to any one of the following questions should prompt further referral and evaluation by the treatment team or mental health professional. Please put a (√) to indicate a yes answer.

1. **Questions to Identify Depression:** In the past 3 months;
(____)Was there ever a time when you felt sad/hopelessness for more than 2 weeks in a row?
(____) Was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?

2. Questions to identify suicidal ideation: Since your last visit [or in the last 2 months];
(____)Have you wished you were dead, or wished you could go to sleep and not wake up?
(____)Have you had actual thoughts of killing yourself?
(____)Have you ever attempted to harm/kill yourself?

3. **Questions to Identify Anxiety:** In the past 3 months;
(____)Did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?
(____)Did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?
(____)Did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath?

4. **Questions to Identify Mania:** In the past 3 months;
(____) When not high or intoxicated, did you ever feel extremely energetic or elated or irritable and more talkative than usual?

5. **Questions to Identify Substance Abuse.** (____) Have you ever felt the need to cut down on your use of alcohol or drugs?
(____) Has anyone annoyed you by criticizing your use of alcohol or drugs?
(____)Have you ever felt guilty because of something you have done while drinking or using drugs?
(____)Have you ever taken a drink or used drugs to steady your nerves or get over a hangover (***revelation***)? *A total of ≥2 may be suggestive of a problem.*

6. **Questions to Identify Psychosis:** Observe or ask families whether the patient (in the last 3 months);
(____)Talking & acting strangely or becoming very quiet and avoid talking.
(____)Claiming to hear voices or see things that other people don't.
(____)Being very suspicions, perhaps claiming that other people are trying to harm him/her.

7. **Questions to Identify Dementia:** Interview the patient or families whether the patient (in the last 3 months);
(____)Has trouble with memory.
(____)Has poor concentration.
(____)Has diminished executive function.
(____)Has diminished orientation to time, place & person.

8. **Questions to Identify Epilepsy:**
(____)Did you ever have partial or generalized fits [sharp, shaky movements] accompanied by frothing or loss of control of bowel or bladder function, sudden loss of consciousness, and stiff limbs?

Referred by:_____

Date: _____

Feedback *(confirm the assessment)*

The patient has (___) Mental Health Disorder specify: _____
(___) No Mental Health Disorder

Name of clinician: _____ Date: _____

Adapted from New York State Department of Health AIDS Institute and Tedla-Hopkins Symptom Checklist-25 (English, Amharic, Oromiffa, and Tigrigna)

Tools: Mental Health Recording and Reporting

Mental Health Data Flow

ACM monthly to ART clinic monthly to HF management monthly then to RHB to MoH quarterly

Mental Health Key Indicators:

-Screened by ACM for MHD
-Identified MHD by ACM
-Linked to MHI trained provider
-Feedback received from ART clinicians
-Confirmed diagnosis for MH conditions from ART clinic
-Referred to psychiatry unit from ART clinic

Mental Health Case Management Service Recording Register

S/N	Visit Date (--/--/--)	MRN (Medical record UAN	Clinet Name Father Name	Sex	Age	Client ART Status: On Anti Retroviral Treatment (ART) (1-5)	Client ART Status: Not on Anti Retroviral Treatment (ART) (1-4)	Mental Health disorder symptoms identified on Screening (1-10)	Only for Clinets with Mental health problesm identified during the assessment/ screening: Referred to (1-3)	HCPs Assesment result(1-10)	Treatment and medical advise provided ? (Yes/No)	Remark
1	2	3	4	5	6	7	8	9	10	11	12	13

Name of HF Reporting period ____/_____/_____to ____/_____/_____

MHI Cascade reporting format for MHI priority clients

MHI Cascade Indicator	On ART client		Treatment non initiated HIV positive clients		Total	
	M	F	M	F	M	F
Screened by ACMs for MH conditions						
Identified for MH conditions by ACMs						
Referred / Linked to MHI trained provider						
Feedback received from ART clinicians						
Confirmed diagnosis for MH conditions from ART clinic						
Referred to psychiatry unit from ART clinic						

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Thank you

Panel Discussion

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Slides & recordings from this session are available on the CQUIN Website https://cquin.icap.columbia.edu

The next webinar will be held on June 4:

Family Planning and HIV Integration

HIV **Coverage, Quality, and Impact Network**

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