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MINISTRY OF HEALTH - ETHIOPIA
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Management of Common Mental, Seizure and Substance Use Disorders among People Living with HIV

Participants' Manual

September 2020

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Acknowledgement

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1. Dr Teketel Tegegn (Eka Kotebe General Hospital)
2. Dr Kibrom Haile (St Amanuel Mental Specialized Hospital)
3. Dr Dereje Assefa (Ministry of Health-Ethiopia)
4. Mrs Hiwot Solomon (Ministry of Health-Ethiopia)
5. Mr Abebaw Ayele (Ministry of Health-Ethiopia)
6. Mr Ismael Ahmed (CDC Ethiopia)
7. Dr Daniel Atnafu (ICAP Ethiopia)
8. Dr Miftah Kemal (ICAP Ethiopia)
9. Dr Kunuz Abdella (Ministry of Health-Ethiopia)
10. Mr Zegeye Yohannes (St Amanuel Mental Specialized Hospital)
11. Mr Belete Melesegn (Kotebe Metropolitan College)
12. Sr Alemnesh Beyene (St Amanuel Mental Specialized Hospital)
13. Mr Jemal Teshome (Ministry of Health-Ethiopia)
14. Mr Muluken Alemayehu (Ministry of Health-Ethiopia)
15. Mrs Sofia Seid (Ministry of Health-Ethiopia)
16. Mrs Agitu Tadesse (Ministry of Health-Ethiopia)
17. Mr Andargachew Abebe (Ministry of Health-Ethiopia)
18. Mr Kassahun Tadesse (ICAP Ethiopia)
19. Dr Alemu Asgedom (Federal Prisons Referral Hospital-Ethiopia)
20. Mr Dinku Worku (NEP+)
21. Mrs Haregewoin Amare (NEP+)
22. Mr Yohannes Guade (NEP+)
23. Mr Tegene Arega (Ministry of Health-Ethiopia)

Reviewers

1. Dr. Teketel Tegegn (Neuropsychiatrist, Eka Kotebe General Hospital)
2. Dr. Kibrom Haile (Expert psychiatrist, St Amanuel Mental Specialized Hospital)
3. Mr. Ismael Ahmed (MPH, CDC Ethiopia)
4. Dr. Daniel Alemayehu (MD, ICAP Ethiopia)
5. Mr Abebaw Ayele (MA, Psychologist, Ministry of Health-Ethiopia)
6. Mrs Sofia Seid (MSc, Ministry of Health-Ethiopia)
7. Mr Tegene Arega (MPH, Ministry of Health-Ethiopia)

8. Dr. Dereje Assefa (Expert psychiatrist, Ministry of Health-Ethiopia)
9. Mrs Hiwot Solomon (MPH, Ministry of Health-Ethiopia)

Abbreviations

ACM ----------Adherence case manager
ADHD ----------Attention-deficit hyperactivity disorder
AIDS ----------Acquired immune deficiency syndrome
ART ----------Anti-retroviral treatment
ARV ----------Anti-retroviral
AS ----------Adherence supporter
CM ----------Case management
CTS ----------Clinical training skills
DDI ----------Drug-drug interactions
DSM-5 ----------Diagnostic and statistical manual-5th edition
GAD ----------Generalized anxiety disorder
HAND ----------HIV associated neuro-cognitive disorder
HCP ----------Health care provider
HCW ----------Health care worker
HE ----------Health education
HF ----------Health facility
HIV ----------Human immune-deficiency virus
IPD ----------In-patient department
IST ----------In-service training
JSS ----------Joint supportive supervision
MDT ----------Multi-disciplinary team
MH ----------Mental health
MHD ----------Mental health disorder
MHI ----------Mental health and HIV care integration
MoH-E ----------Ministry of Health-Ethiopia
MSS-D ----------Mental, seizure and substance use disorders
OCD ----------Obsessive-compulsive disorder
OI ----------Opportunistic infection
OPD ---------- Outpatient department
PIP ----------Performance improvement plan
PLHIV ----------People living with HIV
PMT ----------Performance monitoring team
PRM ----------Performance review meeting
PST ----------Provider support tool
PTSD ----------Post-traumatic stress disorder
RHB ----------Regional health bureau
SDP ----------Service delivery point
SOP ----------Standard operating procedure
TOT ----------Training of trainers
TWG ----------Technical working group

Way forward

As Ministry, we consider that lack of standard training manual has been a major problem to effective delivery of Mental and HIV Care Integration (MHI) trainings for ART clinicians to ensure the achievement of the desired outcome across the country. Trainings were not previously provided in the standard format, and the training manuals were not accredited by the appropriate governmental body. These shortcomings have affected the achievement of the intended outcomes from the trainings provided so far.

Considering the shortcomings mentioned thus far, the Ministry of Health of Ethiopia (MoH-E) organized a national technical working group to prepare and update the training manual in order to make it up to the standard for accreditation. This manual is the result of the work of the technical working group. All institutions which will provide the MHI training to ART clinicians are expected to use this manual which is up to the national standard, and also accredited for that purpose.

It is my belief that this manual will help to improve the management of mental, neurological as well as substance use related problems in PLHIV.

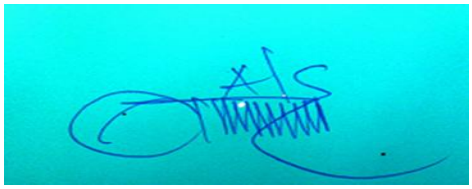
I would like also to take this opportunity to thank all contributors who were involved in the development of the training material, as well as CDC Ethiopia and ICAP Ethiopia for the technical and financial support they provided in the development of this manual.

Mrs Hiwot Solomon (MPH)
Disease Prevention and Control Directorate, Director
Ministry of Health, Ethiopia

Approval statement of the ministry

The Ministry of health of Ethiopia has been working towards standardization and institutionalization of In-Service Trainings (IST) at national level. As part of this initiative, the Ministry developed a National In-service Training Directive and Implementation Guide to implement trainings in standardized manner. The directive requires all in-service training materials fulfill the standards set in the Implementation Guide to ensure the quality of in-service training materials. Accordingly, the Ministry reviews and approves existing training materials based on the IST standardization checklist annexed on the IST Implementation Guide.

As per the national IST quality control process, this training package titled '***Management of Common Mental, Seizure and Substance Use Disorders among People Living with HIV'*** has been reviewed using the Standard Review Checklist and approved by the Ministry in September, 2020.



Mr Asegid Samuel (MSc)
Human Resource Development Directorate
Director
Federal Ministry of Health, Ethiopia

Introduction to the manual

Mental, seizure and substance use disorders (MSS-D) are important in HIV care because of issues related to adherence, risk of HIV transmission, and overall outcome of HIV care. Mental disorders are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (U.S surgeon general, 1999). The neurological disorder included in this manual is seizure disorder. Even if seizure disorder is not a mental disorder, it could manifest with thinking, mood and/or behavioral symptoms and signs. Seizure disorder is common in primary health care setting, and even more common among people living with HIV (PLHIV). Substance use disorders are characterized by pathological pattern of behaviors related to use of the substances. Substance use disorders are defined by the cluster of cognitive, behavioral, and physiological symptoms indicating, and or necessitating that the individual continues using the substance despite significant substance-related problems (DSM-5). Mental, neurological and substance use disorders are risk factors for acquisition of HIV; likewise, HIV-related biological, psychological and social factors can cause mental, neurological and substance use disorders. Because of this, the prevalence of mental, neurological and substance use disorders is found to be higher among PLHIV than the general population.

The occurrence of MSS-D among PLHIV is worth giving due consideration due to several reasons. The presence of MSS-D among PLHIV makes management of either condition more difficult and complicated. Managing the MSS-D can be more difficult among PLHIV because the biological, psychological and social consequences of the HIV infection make treatment of the MSS-D more difficult and complicated. Without addressing the HIV/AIDS problem, the MSS-D cannot be managed effectively. On the other hand, the outcome of treating HIV/AIDS becomes poor in the presence of MSS-D. PLHIV who also have MSS-D are less likely to have good adherence to HIV care and treatment. In addition to that, PLHIV who have MSS-D are likely to have behavioral consequences of the MSS-D which makes self-care very difficult in them. The result could be poor outcome of ART in those PLHIV who also have MSS-D. The other issue worth mentioning with regard to comorbid HIV and MSS-D problems is drug-drug interactions (DDIs) between the ARV drugs and the psychotropic drugs. DDIs are important to consider in the co-treatment of the two health conditions because they make either group of drugs less effective or toxic.

The problems mentioned so far in the context of comorbid condition between HIV and MSS-D are very important for the clinician working with PLHIV. This is because of the fact that it becomes impossible to treat HIV/AIDS without managing the MNS problems. The best way to deal with the comorbid condition is the provision of integrated HIV and MSS-D care. Integrated MSS-D and HIV care (MHI) is the most preferred to other options due to the presence of stigma attached to both conditions. MHI makes treatment of both conditions more accessible, acceptable and comfortable to the patients. Therefore, this training is

intended to provide clinicians working in HIV care with the knowledge, skill and attitude necessary to treat manage MSS-D in their patients.

In this manual, MSS-D problems are addressed in clusters of their manifestations; that means, common symptom clusters of MSS-D are grouped together in modules, rather than specific diagnostic entities. This makes it more convenient to understand, recognize and manage the problems to the participants. However, some of the most relevant diagnostic entities are briefly discussed to further inform the participants.

Rationale of the course

The available literature shows that the prevalence of MSS-D is higher among PLHIV than among the general population. This makes the likelihood of finding a client with MSS-D in HIV care units high. The presence of MNS among PLHIV is fundamental to HIV care because of two important reasons. One is the issue of adherence to the HIV care itself; PLHIV with MSS-D comorbidity are less likely to comply with the HIV care. This makes the outcome of ART poor in those patients. The other reason is the issue of risky behavior among the PLHIV who have comorbid MSS-D; those patients are likely to be involved in risky behavior which makes HIV dissemination a problem in that group of patients. In addition to the above-mentioned facts, parallel treatment of HIV and MSS-D by different group of professionals is less effective. This is due to the stigma related to both conditions, which makes them reluctant to adhere with treatment in the two separate units. Therefore, integrated HIV and MSS-D care is the choice, and any cases which need specialist care can be managed with referrals and linking for that particular event necessitating advanced management. This training intends to address this issue with the most favorable outcome.

Core competency of the course in which the trainees need to be aware about

This training package has the following core competencies:

- Diagnose PLHIV for mental, neurological and substance use problems
- Identify risk issues related to mental, neurological and substance use problems
- Identify and manage when another medical condition is causing the mental, neurological and substance use problems
- Provide psychosocial intervention measures
- Prescribe medications to treat mental, neurological and substance use disorders
- Identify and manage drug-drug interactions between ARV drugs and psychotropic drugs.

This manual has nine modules and one practical session. The modules are listed below.

Module 1: Introduction to mental health issues in HIV care; and approach to communication skills and assessment
Module 2: Psychosis and neuro-cognitive disorders (delirium and dementia)
Module 3: Depression
Module 4: Anxiety disorders, obsessive-compulsive disorder (OCD) and post-traumatic stress

disorder (PTSD)
Module 5: Substance use disorder
Module 6: Seizure disorder
Module 7: Behavior and developmental issues in children and adolescents
Module 8: Mental health aspects of living with HIV
Module 9: Monitoring and evaluation
Clinical practice

COURSE SYLLABUS

Course title: ***Management of common mental, seizure and substance use disorders among PLHIV***

Course description: This 6-day course is designed to equip participants with the knowledge, the skills and attitude required to provide prevention and treatment of mental, neurological and substance use disorders with PLHIV.

Course goal: To provide the participant with the necessary knowledge, skill and attitude to identify, diagnose and treat mental disorders in PLHIV.

Participant learning objectives

After completing the course, participants will be able to:

1. List the signs and symptoms of MSS-D;
2. Provide appropriate treatment to clients who have mental health problems in PLHIV;
3. Identify risk behaviors related to mental health problems in PLHIV;
4. Manage risk behaviors related to mental health problems in PLHIV;
5. Identify appropriate treatment when an OI is associated with causation of mental health problems;
6. Provide appropriate treatment when an OI is associated with causation of mental health problems;
7. Provide appropriate psychosocial support to PLHIV and their families;
8. Prescribe appropriately the necessary psychotropic medications to treat mental health problems in PLHIV;
9. Identify adverse effects of medications and DDIs;
10. Manage adverse effects of medications and DDIs;
11. Make appropriate referrals to specialists.
12. Demonstrate the necessary attitude towards people with mental health problems

Training methods

- Interactive presentations
- Group discussions and presentations
- Case studies
- Role plays

- Exercises using worksheet
- Illustrative videos
- Think-pair-share

Training materials

- Printed materials
  - Participant manual
  - Facilitator guide
- Non-projected materials
  - Flip chart
  - marker
- Projected materials
  - LCD
  - Laptop computer
  - Powerpoint slides
- Audio-visual materials
  - Video tapes
  - Speakers

Participant selection criteria

I. Basic training

- Healthcare providers (doctors, health officers and nurses) that work in or intend to work in healthcare settings that provides care and treatment for HIV/AIDS.
- Currently working at ART clinic
- Trained on Comprehensive ART training
- After taking this training who have a commitment and willing to work ART clinic.
- MH professionals

II. TOT training

- Have basic training
- HCPS who have experience in MHI
- Interest in providing trainings

Trainer selection criteria

- Has TOT on MHI and have good facilitation skills
- Has a good knowledge or experience in HIV care and MHI
- Has a reputation for good work discipline

Methods of course evaluation

Participant

- Pretest

- Post test
- Checklist-guided observations during discussions, case studies, role plays and practice
- Participant attendance

Course

- Daily course evaluation
- End of course evaluation

Certification Criteria: Participants will be certified when they achieve 100% attendance rate, and when they score more than 75% for basic training and more than 85% for TOT in the summative assessment (both checklist-guided observation, and post-test).

Course duration: 6 days

Suggested class size: 20 to 25 participants, 4 trainers and 3 preceptors

Training venue: Training will be delivered in accredited IST centers.

Course schedule

Day	Time	Activity	Presenter/facilitator
Day 1	8:30 AM-10:00 AM	Registration	
		Opening remark, participant introduction & expectations	
		Group norms	
		Goal, objectives & schedule	
		Pre-course test	
	10:00 AM-10:20 AM	Tea break	
	10:20 AM-12:30 PM	Module 1: Introduction to mental health issues in HIV care; and approach to communication skills and assessment	
	12:30 PM-2:00 PM	Lunch break	
	2:00 PM-3:30 PM	Module 2: Psychosis and neuro-cognitive disorders (delirium and dementia)	
	3:30 PM-3:50 PM	Tea break	
	3:50 PM - 5:30 pm	Module 2: Psychosis and neuro-cognitive disorders cont'd	
Day 2	8:30 AM-10:00 AM	Recap 10 min	
		Module 2: Cont'd (for 60 min)	
		Module 3: Depression	
	10:00 AM-10:20 AM	Tea break	
	10:20 AM-12:30 PM	Module 3: Cont'd	
	12:30 PM-2:00 PM	Lunch break	
	2:00 PM-3:30 PM	Module 3 cont'd (50 minutes)	
	3:30 PM-3:50 PM	Tea break	
	3:50 PM - 5:30 pm	Module 4. Anxiety, obsessive-compulsive and	

		trauma-related disorders	
Day 3	8:30 AM-10:00 AM	Recap 10 min	
		Module 4 cont'd (10 minutes)	
		Module 5: Substance use disorders	
	10:00 AM-10:20 AM	Tea break	
	10:20 AM-12:30 PM	Module 5: cont'd (20 minutes)	
	12:30 PM-2:00 PM	Lunch break	
	2:00 PM-3:30 PM	Module 6: Seizure disorder	
	3:30 PM-3:50 PM	Tea break	
	3:50 PM - 5:30 pm	Module 6: Cont'd	
Day 4	8:30 AM-10:00 AM	Recap 10 min	
		Module 7: Behavior and developmental issues in children and adolescents	
	10:00 AM-10:20 AM	Tea break	
	10:20 AM-12:30 PM	Module 7: Cont'd (20 minutes)	
	12:30 PM-2:00 PM	Lunch break	
	2:00 PM-3:30 PM	Module 8: Mental health aspects of living with HIV	
	3:30 PM-3:50 PM	Tea break	
	3:50 PM - 5:30 pm	Module 8: Cont'd (20 minutes)	
		Provision of directions to the clinical practice next day	
Day 5	8:30 AM-5:30 pm	Clinical practice in health facilities	
Day 6	8:30 AM-10:00 AM	Recap 10 min	
		Discussions based on cases and other relevant clinical encounters from the clinical practice	
	10:00 AM-10:20 AM	Tea break	
	10:20 AM -12:30 PM	Module 9: MHI Implementation process, documentation and reporting	
	12:30 PM-2:00 PM	Lunch break	
	2:00PM – 3:30 PM	Module 9: Cont'd	
	3:30 PM-3:50 PM	Tea break	
	3:50 PM - 5:30 pm	Posttest, training evaluation and close up	

Module 1: Introduction to mental health issues in HIV care; and approach to communication skills and assessment

Duration: 105 minutes

Module description: This module deals with and is intended to provide introduction to mental health issues, causes of mental illness and the impact of mental health problems in HIV care; as well as provide skills in effective communication skills, making standard assessment, and using appropriate protocol to address the problems. The module is supposed to address important participant gaps in the spectrum of awareness, attitude and skill parameters that make consideration of mental health issues in HIV care possible.

Primary objective: At the end of this module participants will be able to apply assessment methods, first line interventions, ways of helping PLHIV with mental health problems, and apply 'stepped' care approaches to treatment of mental health problems in PLHIV.

Enabling objectives: at the end of this module participants will be able to:

- Define 'mental health' and 'mental disorder';
- Explain causes of mental illness;
- Explain the importance of mental health care in HIV care;
- Apply a flow chart to make decisions about how to deal with mental health problems in PLHIV;
- Apply effective communication skills to build a therapeutic connection with families;
- Apply effective communication skills to help families disclose concerns in actionable and efficient ways;
- Apply effective communication skills to provide advice that is likely to be accepted;
- Apply a few screening questions that can be asked to every patient at intake and periodically during follow-up to open discussion of mental health issues;
- Apply a focused "mental status" interview that helps decide which assessment/ treatment module to use first when it is not obvious.

Outline

1.0. Introduction
1.1. What do we mean by "mental health problems?"
1.2. What are the causes of mental illness and myths?
1.3. Why is mental health important to caring for PLHIV?
1.4. What is mental health treatment?
1.5.Introduction to communication skills
1.6.Communication skills
1.7.Routine questions
1.8. How to conduct mental health assessment

1.9. Introduction to the client flow in HFs where HIV care is provided
1.10: Module summary

1. Introduction

Module 1 Activity 1*: Individual reflection*

Purpose: to assess level of participant and stimulate learning
What is mental health?
What causes mental disorders?
Time: 5 minutes

This module will introduce the participant to the subject of mental health, and its application and relevance to HIV care. The module persuades the participant to address mental health problems appropriately in PLHIV so that, the HIV care would have a better outcome. The module will address basic attitudinal issues that may be involved in relation to mental health problems. The module provides basic understanding and practical skills for using effective communication skills, and establishing a working therapeutic alliance with the client. The module provides general approach to conducting assessment protocol for better outcome. The concepts and skills provided by this module will be applicable in subsequent modules, and the participants will become more and more proficient along the course.

1.1.What do we mean by "mental health problems?"

"Mental health problems" may mean many different things to many people. It is not always easy to say someone has a mental health problem since there are no tests that confirm the diagnosis. One way to look at it is to say that when people have good "mental health" they feel a certain way about life: they feel good about themselves, they get along well with others, and they feel capable of meeting the challenges that face them. Many people go through brief periods in their lives where they do not feel this way. During those times, they can still go about most of their business as usual, and with some support they soon return to feeling good.

However, there are other sorts of mental health problems that can last longer, that get in the way of day-to-day life, and that often do not get better without help. One group of these problems goes by the name of "common mental disorders" – because they are so common – 10% or more of people will experience one of them in the course of their life. It includes problems with low mood, excessive worry, or difficult behaviors that do get in the way of daily function. These problems can go on for months or years, and even though people with them can usually still work, or live with their families, the problems can cause a lot of misery

and disability.

The second group are often referred to as “severe mental disorders.” They are much less common, but much more serious. They include problems with thinking that severely limit function and may make the person a danger to themselves or others. People with these problems may behave very strangely. They may see and hear things that others do not perceive and develop strange beliefs about themselves and others. They can seem frightening when they are ill, though most of the time they are dangerous only to themselves. Without treatment, people with these problems cannot work or live at home.

In this manual, we will also include seizure disorders (epilepsy). In Ethiopia, seizures are usually treated by psychiatrists and/or or other mental health professionals. Often times, seizures are perceived as a form of mental illness, which they are not; however, they can be very disabling and there is a high rate of co-occurrence of seizures and depression.

1.2. Causes of mental illness and myths

There are three basic modern explanations for causes of mental illness. The model which uses those three explanations is called the bio-psychosocial model.

1. The biological system emphasizes the anatomical, structural, and molecular substrate of disease and its effects on the patient's biological functioning.
2. The psychological system emphasizes the effects of psychodynamic factors, motivation, and personality on the experience of illness and the reaction to it
3. The social system emphasizes cultural, environmental, and familial influences on the expression and the experience of illness.

Biological, psychological and social factors are all interlinked and important with regard to promoting health or causing disease. The mind and the body are not independent and separate things but rather are connected and interdependent things. What affects the body will often affect the mind, and vice versa; what affects the mind will often end up affecting the body. However, the traditional causative explanatory models attribute the causes of mental illness to **spiritual** (such as possession by spirits, punishment by God, curse, etc), and **moral** (the attribution of mental illness to the lack of moral values in someone). Figure 1 illustrated the specific factors within each category.

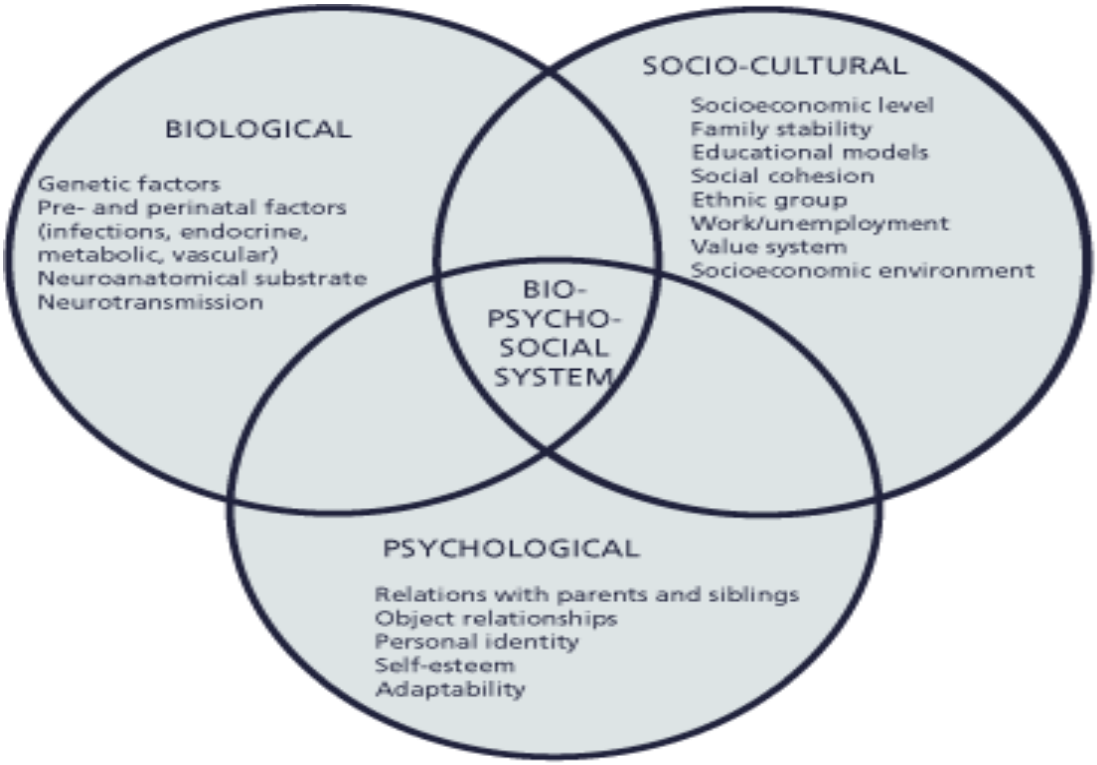


Figure 1.1: Bio-psychosocial model of causes of mental illness

1.3. Why is mental health important to caring for PLHIV?

Globally, Mental Health Disorders (MHD) are more common among People Living with HIV (PLHIV) than among the general population. Depression, anxiety, PTSD, and cognitive impairment are common types of MHD in patients following HIV diagnosis or during its progression to AIDS (Remien R. et al. 2019).

Magnitude of common MHD among PLHIV in Ethiopia has been studied and the following results show that the prevalence is significantly high. A meta-analysis has shown that prevalence of depression among PLHIV in Ethiopia was 36.65% (Tadele Amare et al 2018), and the prevalence for common mental disorders among PLHIV in Ethiopian population have been found to be 33% in Hawasa (Duko B. et al., 2019) and 24% in Debre Markos (Zewdu S. and Abebe N. et al., 2015).

Reading:
HIV infects the brain, and it can directly cause some mental health problems. When HIV infection results in compromised immunity it can lead to brain infections (toxoplasmosis, Cryptococcosis, cytomegalovirus, and others) and tumors. The stresses of living with HIV/AIDS can also cause mental health problems, as can problems with poor nutrition, sleep, and chronic pain that are caused by, or made worse by, the illness. In addition to the trauma of learning about their diagnosis, people living with HIV face ongoing stigma, the burdens of ongoing medical treatment, and worry about their own health and that of friends and family members. In addition, some of the medicines used to treat HIV and the infections that come

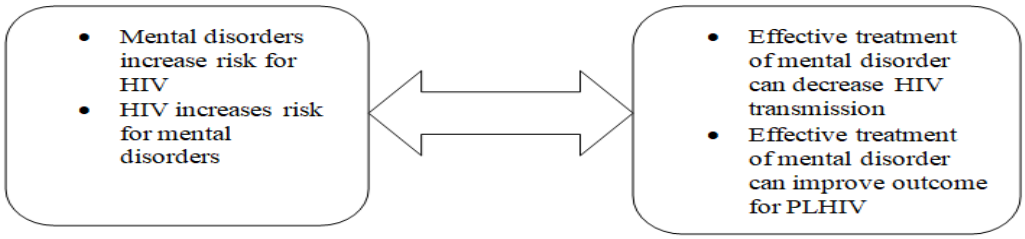
with it have mental health side effects.

Another reason why mental health problems are more common among people with HIV/AIDS is that having a mental health problem is one of the risk factors for becoming infected with HIV. People with mental health problems are more likely to be exploited by others and less able to negotiate safe sexual relationships with partners. They may be less likely to stay in the kind of steady, long-term relationships in which partners can protect each other from getting HIV. Some kinds of mental health problems (in particular substance abuse) make it less likely that people will take precautions (using condoms, avoiding impulsive sexual activity) to avoid getting infected.

Mental health problems also impact HIV treatment in many ways:

- Mental health problems are a major reason for decisions to decline or stop taking ART, and they are a major reason for poor adherence among those who don't completely stop.
- Side effects and drug-drug interactions (DDIs) limit the medication choices available
- Changes in mental health can be early signs of poorly controlled HIV infection or its medical complications.
- Patients with poor mental health are a cause of frustration and burn-out among HIV treatment personnel.

In summary, treatment of co-morbid psychiatric conditions may improve adherence to HAART regimens, underlining the importance of recognition and treatment of psychiatric conditions. The figure below summarizes the bidirectional relationship of HIV and mental illness.



1.4. What is mental health treatment?

For many people, mental health treatment means medicines or visits to a psychiatrist. But there are many other ways people with mental health problems can be helped, and most people with mental health problems need a combination of treatments. We will talk about all of these forms of treatment in the modules that follow.

Reading:

- Routine interactions in clinic help people feel cared for, understood, and respected. A study conducted in Addis Ababa (Biadgilin, 2009) found that having a steady health care provider, and feeling that the clinic was a friendly place for adults and children, was

related to greater HIV medication adherence.

- Help given with practical issues including support to get adequate food, housing, education and employment can reduce stress, improve mood, and reduce worry. The same study in Addis Ababa found that lack of stable housing and food supply were the biggest barriers to taking medication consistently.
- Helping people with their social relationships can reduce stress and improve mood, in addition to helping people get other forms of treatment and support that they need. This can happen through counseling the person himself, or through counseling and educating family members and even friends.
- Giving brief advice about how to deal with specific problems, teaching people about mental health problems and what to expect from them, and treating an underlying medical problem that is causing the person to feel different or that may be causing changes to their brain are all forms of treatment for PLHIV who develop mental health problems.

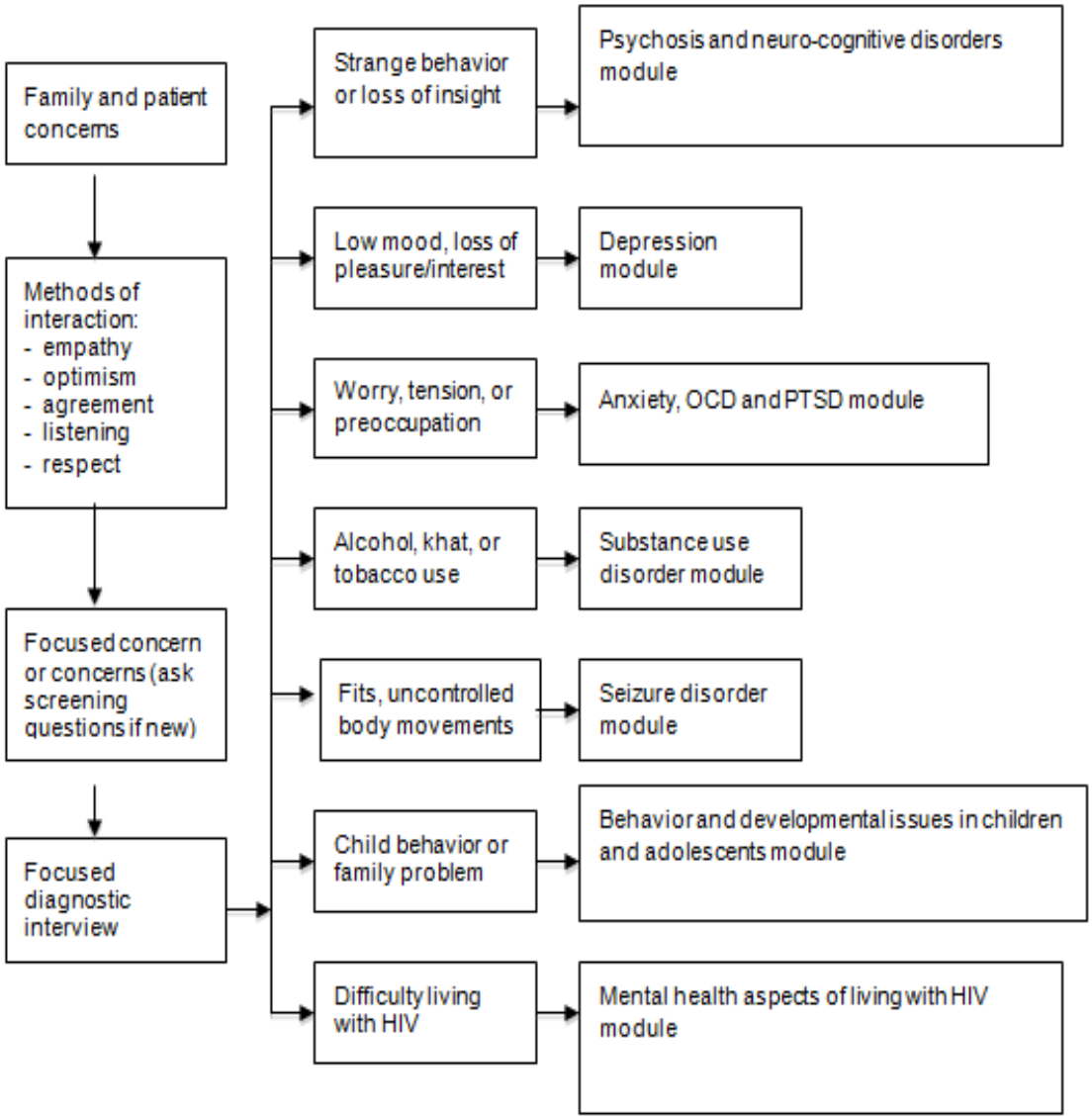
Many of the treatments do not have to be given by a mental health specialist, though having one around for help with diagnosis and deciding on treatment is always helpful! In fact, general medical facilities can be good places to care for mental health problems because they are a lot like other chronic conditions – they come and go, and often treatment needs to be adjusted or boosted. And you may have noticed that treatment likely requires a team – no one person can usually supply all that might be needed. Treatment of mental health problems requires an "attitude" as well as skills and knowledge. Your caring and willingness to listen is an essential part of treatment.

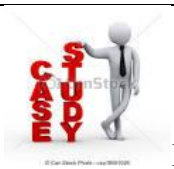
Module 1 Activity 2: *Group discussion*

Purpose: to practice the generic classification plan.

Instruction: In your groups read and discuss about figure 1.2 for 10 minutes and select one participant from the group to give 5-minute presentation to the class.

Figure 1.2: Generic classification plan





Module 1 Activity 3: Case study

Purpose: practice the relationship between mental illness and HIV
Instruction: In your groups, read the following cases for 2 minutes each, and answer questions given below.
Total time: 10 minutes

Case 1
W/t Tsehay is a 25-year-old woman, a secretary, who has a 5-year history of recurrent

psychotic illness - schizophrenia. She periodically stopped taking her psychotropic medication, but it was effective while she was taking it. When she relapses after stopping medication, she stops going to work and disappears from home for days. About a year ago, she started experiencing body aches and she was easily fatigued and had low energy with occasional fever. Evaluation by the General Practitioner at the health center, which included various lab tests, showed no abnormality. A detailed personal history revealed that Tsehay had, during her relapses, frequent unprotected sex with strangers. HIV serology subsequently revealed that she was HIV positive.

- What are the similarities and differences between HIV and schizophrenia treatment?
- Why do people with serious mental illness have a greater than average risk of being exposed to HIV?

Case 2

Ato Tollosa is a 34-year-old divorced businessman from Ambo. He found out two years ago that he was HIV positive, but kept it a secret. Just one month ago, his CD4 count became very low and viral load high; his doctor recommended that he start ART. Since then his behavior has changed. He says that he cannot concentrate on his business. He has isolated himself from any social interaction, and felt so sad that he has contemplated killing himself.

- What do you think Tollosa is experiencing and why do you think it is happening now?
- Are there other periods where individuals with HIV may develop psychiatric signs and symptoms?

1.5. Introduction to communication skills

The quality of patient and health care worker relationship is crucial to the practice of HIV and mental health care. To screen, diagnose, manage, follow up and support a person the health care professional must learn to listen. They need to apply their skills of effective communication that can help them achieve effective relationship. An effective relationship is characterized by good rapport which is the spontaneous, conscious feeling of harmonious responsiveness that promotes the development of a constructive therapeutic alliance. It implies an understanding and trust between the doctor and the patient. Frequently, the doctor is the only person to whom the patients can talk about things that they cannot tell anyone else. Most patients trust their doctors to keep secrets, and this confidence must not be betrayed. Patients who feel that someone knows them, understands them, and accepts them feel they have a source of strength (Synopsis of Psychiatry 10^{th} edition).

1.6. Communication skills

1.6.1 Basic interviewing technique

There are some basic skills that could be helpful:

Use 'open-ended' questions

- An open-ended question is one that can't be answered with simply "yes" or "no" or a single fact.
- Open-ended questions encourage people to tell you more about what they are thinking and feeling.
- Examples:
  - An open-ended question about medicine: "Tell me what it has been like to take that medicine?"
  - A closed-ended question: "Do you like taking that medicine?"

Apply reflective listening

Sometimes all you need to do is show that you are paying close attention and act as if you are expecting to hear more. There are various ways to do that:

- You can just use facilitator words like "Ok," "ish," "kazass."
- You can repeat a little of what the patient said: "So, it's been a hard couple of weeks."
- You can name the emotion the patient has been expressing: "You look really anxious when you say that."

Use empathic approach

Showing empathy refers to saying or showing through body language something to show that you understand how the person feels. Showing empathy can help build trust and encourage the individual to tell you more sensitive things. Examples of empathic comments:

- "I can imagine how anxious that makes you feel."
- "I'm sorry that you had to go through that."
- "I know that can be very difficult."

Module 1 Activity 4: *Role play*

Purpose: to practice interviewing and communication skills
Instruction: In your groups read and discuss the following case for 5 minutes. Then take turns being the patient, clinician, and an accompanying family member and do the role play for 10 minutes.

Case
A mother is concerned that tension between her and her husband is having an impact on her child's mood and behavior. She initially tells the health care worker about the child's behavior (clingy, won't play alone as much, waking up a lot at night and wanting comfort from the parents) without telling what she believes is the underlying reason. The health care worker's job is to use good communication skills to elicit this underlying concern, which she is reluctant to disclose because she is ashamed and not sure that this is the place to talk about it.

- Use active listening
- Use open-ended questions
- Ask if there is “anything else” that might be of concern

Effective communication core skills

Create an environment that facilitates open communication

- Meet the person in a private space
- Be welcoming and conduct introductions in a culturally appropriate manner
- Make eye contact and use body language and facial expressions that facilitate trust
- Explain that information discussed during the visit will be kept confidential
- If careers are present, suggest to
- Speak with the person alone, if possible, and obtain consent to share clinical information

Involve the person

- Include the person (and with their consent, their careers and family) in all aspects of assessment and management as much as possible.
- This includes children, adolescents and older adults.

Listening

- Actively listen
- Be empathic (not sympathy) and sensitive
- Don’t interrupt while the person talks
- If the history is unclear, be patient and ask for clarification
- For children, use language that they can understand. For example, ask about their interests (toys, friends, school, etc.).
- For adolescents, convey that you understand their feelings and situation.

Be friendly, respectful and non-judgmental at all times

- Always be respectful.
- Don’t judge people by their behaviors and appearance
- Stay calm and patient

Use good verbal communication skills

- Use simple language.
- Be clear and concise.
- Use open-ended questions,
- Make clarifications.
- Summarize and repeat key points.
- Allow the person to ask questions.

Respond with sensitivity when people disclose difficult experiences

- Show extra sensitivity with difficult topics.
- Remind the person that what they tell you will remain confidential.
- Acknowledge that it may have been difficult for the person to disclose the information.

1.6.2 Starting off a visit

Efficiently getting all the concerns

Many patients don't give their full list of concerns when first asked. This is especially true for sensitive or embarrassing subjects. Sometimes patients don't get a chance because the clinician interrupts and takes over the discussion before the main concern isdivulged. Sometimes patients give lead-ins or hints, but clinicians ignore them and move on to other topics. But a lot of the time patients are simply afraid of what the clinician will say. For example, some people don't tell doctors they are depressed because they are afraid they will be pressured into taking a medication or told that they are crazy.

It's possible to overcome these barriers, even when you are busy. You can show your interest and attention through good eye contact, not fussing with papers, sitting down, and closing the door. Try through your manner to show that you have the time to listen. Here's a sequence of things to try:

- Start the visit with an open-ended greeting -- "How have things been since the last time?"
- Then, try not to interrupt the patient's initial answer by asking specific questions or giving information. Show your interest in having them continue: either nonverbally, verbally by briefly summarizing what they have said so far, or by asking if they can tell you more about what they have noticed about the problem. Often all that is needed is a pause of a few seconds and people will begin to elaborate on what they have been saying.
- Try not to ignore "hints." Consider this exchange:
  - Health professional: "How have you been since last time?"
  - Patient: "Well, I guess ok."
  - Health professional: "You don't sound too enthusiastic. What has been happening?"
- Ask if there is "anything else?" until there are no additions to the list. Important concerns often comes at the end.

Setting the agenda

Sometimes it seems obvious that all of someone's concerns are really about a single issue. You can speculate on this, check for the patient's agreement, and ask them if it's something they'd like to talk about.

- "You've said a lot of different things about how hard it is for you to take all of the medicines and how you still don't have that much energy. I'm wondering if you are

having some trouble keeping up hope? If that's right, is it something you'd like to talk more about?"

If there are several concerns and their relationship is not clear, play back the list and your impression of what seems to be the most important:

- "You've mentioned several things but it seems that your worry about your health is what concerns you the most, is that right? Maybe that is what we should focus on today."
- Or, "You've mentioned several concerns -- which ones did you want to make sure we talked about today?"

Scenarios to consider during setting the agenda

What if people go on and on?

Gently interrupt, paraphrase, and ask for additional concerns: "I'm sorry to interrupt, but, so that we don't run out of time, let me see if I understand your concern.... [Paraphrase, get confirmation]. OK, good, now was there anything else that concerned you?" Or, gently interrupt, paraphrase, and refocus: "I think I understand what you are talking about. You started by talking about [some original issue]. So we don't run out of time, do you want to get back to that, or do you want to talk about [the new/tangential issue] now?"

What if a child, spouse, or relative is there, too?

Make a connection with each person present: a specific greeting for each, a handshake if appropriate; while talking, shift eye contact and body position to address everyone; get everyone's name if you are not sure; use their name when you address them.

If that is appropriate, invite each to add to the list or validate the priorities. "Is that what is most important to you, too?" "Do you have anything else that you want to bring up?"

If there is disagreement, reassure that ultimately you can make opportunities for discussion of everyone's concerns. "We might only be able to get at one of those things today, but I want to make sure that I write down what you are saying so that we can be sure to talk about it the next time we meet."

When people seem to be asking for advice

Even when people seem to be clearly stating a concern or even directly asking for advice, it is not always the case that they are likely to accept suggestions made in response.So when people ask you for advice, or when you are ready to give it, consider asking:

- What sorts of ideas had the patient had about what to do?
- What kinds of things would get in the way of them doing it?
- Is there anything about the plan that they don't understand?

If people seem reluctant to take your advice**,** the most important thing to remember is not to insist or just try to persuade. Sometimes a three-step approach works well:

- You look worried. I know these can be hard choices. Can you tell me more about what worries you about this plan?
- Is it ok if I tell you some more about the plan?
- So what do you think? Was I able to answer your concerns?

 **Module 1 Activity 5: *Role play***

Purpose: to practice addressing client's underlying concerns

Instruction: In your groups read and discuss the following case for 5 minutes. Then take turns being the patient, clinician, and an accompanying family member and do role play for 10 minutes.

Case

The patient is a factory worker who has been abusing alcohol for the last many years and who was diagnosed with HIV three weeks ago. He was divorced 3 years ago; his heavy drinking was a factor. His sleep is poor. Now he is not able to work as much as before because of frequent, uncontrollable worry. He is nervous, cannot concentrate, and easily becomes irritable. He often gets into quarrels with his boss as well as his co-workers. He is afraid of being dismissed from work. He asks you if maybe he should just sell his few possessions and move back to the village where he grew up so that he can start his life over again.

- The health care worker's job is to use good communication skills to elicit his underlying concerns.

Think about how you would respond to his request for advice.

1.7. Routine questions

Reading:

In many forms of health care we are familiar with the idea of screening – giving some kind of a test (sometimes a laboratory test, sometimes a questionnaire) to every patient to detect an important condition. When we do this we have two main goals: to make sure that no patient misses the opportunity to have the condition detected and treated, and to try to find the condition as early as possible, when it is easier to treat.

We do not have any good screening tests that cover the whole range of mental health problems that can occur. The screening questions listed below can be used:

For adults and adolescents, ask the patient and partner, if they are accompanied by one and the patient gives permission:
Have you (or has the patient) been having problems sleeping at night?
Have you (or has the patient) been feeling unhappy or more irritable?
Have you (or has the patient) lost interest in things or not felt like being with other people?
Have you (or has the patient) been feeling worried, nervous, or frightened?
Have you (or has the patient) been having trouble remembering things or doing things you (or he/she) used to do?
Do you (or has the patient) worry or have you been told that you smoke too much, use too much alcohol, or any other drug?

For children, ask the child and the parent/guardian:
Have you (or has the patient) been having problems sleeping at night?
Have you (or has the patient) been feeling unhappy or more irritable?
Have you (or has the patient) lost interest in things or not felt like being with other people?
Have you (or has the patient) been feeling worried, nervous, or frightened?
Have you (or has the patient) been having trouble remembering things or doing things you (or he/she) used to do?
Have you (or has the patient) been having problems at school with behavior or learning?

1.8. How to conduct an assessment

There are times when a patient's problems will seem to obviously fit into one of the clinical modules, and you can go directly from the patient's concerns to the further evaluation and treatment described in the module. But there may be other time, especially early in your work with mental health problems, when you will want to go briefly through this assessment to help you decide which module might best apply. You will see that some of the sections include questions you can ask; in others you will just be recalling things that the patient or family may already have told you.

The assessment outline provided below is included here to help you in those situations.

1.8.1. History and mental status examination format

Unique aspects of assessment for mental disorders

Because there are few or no diagnostic tests for many mental health problems, we look to a patient's past to see if there's an increased chance he or she may have one. Though it's not known why (there are many possibilities), having relatives with a mental health problem increases the chances you will have one. So we try to ask about *family history*, knowing that people may be reluctant to tell you, or that it may have been a secret and they don't know.

We also want to know about *current stresses and recent losses*. It's well known that these sorts of things can trigger mental health problems or make existing ones worse; knowing

what they are may lead to specific kinds of help that either relieve the stress or help cope with the loss.

Ask about drinking (alcohol) or the use of other drugs or medications, now or in the past.

It is always important to ask *if anything like this has ever happened before*, and, if so, if anything helped at that time.

Finally, it is good to get an account of the patient's problems from family or other people who know the patient; it is particularly difficult for people to describe their own mental health problems.

Components of the assessment

***How does the patient look*?**

- Is someone dressed very oddly, or does it seem that they have been neglecting to care for themselves? These could be signs of low mood or of thought problems.
- Does the person look sad, frightened, threatening, or agitated?

How is the patient interacting with you?

It's normal for people to be somewhat anxious or even shy when they see you, and sometimes they are angry for having to wait or because they feel other staff were rude. But is all of this more or less within the range of normal for your patients, or is it different? Odd behavior is often a sign of a thought problem or intoxication.

- Are they moving around more or less than usual? Can they sit still, or are they too still?
- What is their talking like? Can you hear and understand the words they are saying? Do they talk to themselves or mumble? Do they talk very quickly or hardly at all?
- Do they seem to be following the usual patterns of social interaction – as if they know who you are – and the usual sort of exchange between a patient and clinician?

How do they describe their mood?

Do they say that they are sad, anxious, worried, indifferent, irritable, or something else?

What is their thinking like?

Sometimes you can understand, at first, what someone is saying, but the more you listen the more you feel that the person is not making sense. Perhaps they are convinced that unknown people are trying to harm them; perhaps they are so focused on one event in their life, or one thing that they must see happen, that they can't talk about anything else. Mental health experts recognize some particular patterns of talking that suggest people are having trouble thinking:

- *Circumstantial speech*: people seem very long-winded and only get to their point after

many remarks that are only a little related and don't seem to be needed; sometimes they don't get to their point at all.
- *Flight of ideas and loose associations:* people change subjects suddenly and to subjects that don't seem to be related at all.
- *Perseveration:* people keep repeating the same thought or answer over and over, even when you ask a completely different question. Sometimes they will just echo back what you are saying.
- *Thought blocking*: people just suddenly stop talking in the middle of a sentence.

Sometimes what someone is saying is very clear, but it seems very unlikely to be true. *Delusions* strongly held but false beliefs are another sign of serious thought problems. The most common delusions are about conspiracies to harm the person, that there are hidden messages for the person on the radio or elsewhere, or that there is something foreign inside someone's body. Men or women can also have delusions that their partner is not faithful – but of course it is not always possible to know immediately if these are delusions or not.

How is the patient's judgment? Sometimes this is obvious – they say they can walk somewhere that it is impossible to go on foot, or they clearly over-estimate their ability in other ways. Poor judgment can be a sign of intoxication or thought or memory problems.

Can someone do harder kinds of thinking – such as telling you the meaning of something subtle, such as a proverb? (This is called "abstract thinking.") Or can they tell you what is alike and different about a banana and an orange?

Perceptions

A fairly common symptom of serious mental illness is seeing or hearing things that other people don't see or hear. Does the patient report any of this? Do they seem to be experiencing it now?
- *Auditory (hearing) and visual hallucinations* are the most common in serious mental health problems. Particularly worrisome are voices that seem to be talking directly to or about the person, or that are telling them what to do.
- *Tactile hallucinations* are more common in medical illnesses that affect the brain and in alcohol withdrawal

Alertness and awareness

Does the patient seem fully awake and alert? Are they aware of where they are and do they know who you are? There are many questions to ask (see the thought problem module). If you have doubts, for starters you can ask:
- Can you tell me the day and date?
- Can you tell me the name of the place we are now and what we do here?
- Can you count the days of the week backwards?

The neurologic exam

In addition, when thinking about mental health problems in the context of HIV, one usually wants to know something about the patient's neurologic examination (gait, vision, abnormal body movement, motor and sensory function). Is it basically normal? Abnormalities make one think immediately of serious brain infections, tumors, or strokes.

Functioning

Though it's not part of the classic mental status exam, how well a person functions (or if their function has changed) is often the most important sign that there is a problem, or that treatment is working or failing. Some of these changes could be just because of mood, but others could be caused by damage to the brain from HIV or other infections or conditions. It is hard to come up with ways of measuring changes in function that cut across all cultures, but some categories include (Antinori 2007):

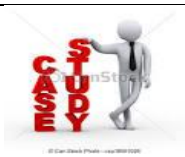
- Does the person need any more help than usual with things like taking medicine, using money, shopping, chores around the house, cooking, getting to places, or taking care of their children?
- Do they have trouble doing a job that they used to be able to do?
- Did they have to quit, cut back on responsibilities, or do they just work more slowly or make more mistakes?

The following chart summarizes the components of the psychiatric assessment and report-writing format:

Psychiatric Assessment Format

Identification	Name, age, sex, educational status, occupation, marital status, address, number of visits, brought by whom (source of referral)
Chief compliant	The most important complaint which necessitated the current visit and its duration
History of present illness	Pertinent signs and symptoms, onset of illness, duration of illness, sequence of developing symptoms, precipitating factors, aggravating factors, risk issues such as suicide, homicide, violence, any treatment history, and systematic review
Past psychiatric history	History of mental illness, substance abuse and suicide in the past
Medical history	Past or current medical illness such as HIV, TB, DM, Cancer, etc and surgical history Medications taken in the past and present.
Family history	Family history of mental illness, suicide, substance abuse, seizure
Personal history	Historical description of relevant biography of the patient
Premorbid personality	The usual personality description of the person before becoming ill, including pattern of behavior, relationships, coping, etc
	General appearance – Dressing style; self-care; grooming; eye contact; attitude towards examiner includes cooperative, defensive, guarded, playful, hostile
	Psychomotor activity: restless, fidgety, agitation or retardation

Mental Status Examination/MSE/	**Speech** -Volume, tone, rate, content, pressured speech
	Mood-Depressed, elated, irritable
	Affect-Depressed, elated, irritable, constricted, blunt, flat
	Thought form disturbances –Examples: Circumstantial, tangential, flight of ideas, perseveration, thought block, etc.
	Thought content disturbance-Examples: presence of **Delusions, suicidal thoughts**, **plan**
	Perceptual disturbances : Hallucinations such as auditory and visual hallucinations, etc.
	Cognition • **Alertness/ consciousness –** Awareness of the environment, stupor, coma, confusion • **Orientation** to time, place and person • **Memory** – remote, recent and immediate memory impairment • **Attention and concentration impairment** • **Insight :** Poor insight, Partial insight, full insight
Physical and gross neurologic examinations	Vital signs, findings on physical examinations, gait abnormality, sensory and motor impairment
Diagnosis and differential diagnosis	
Immediate and follow up management plan	Medications, psycho-education, psychosocial support



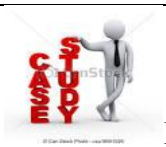
Module 1 Activity 6: ***Case study***

Purpose: to practice identifying mental illness symptoms

Instruction: In your groups, read and answer the questions listed in this activity. Take 2 minutes to read and understand each of the cases provided and provide answer to each of them. Then select one person from your group to give a 5-minute presentation to the class based on the group work.

1. A 45-year-old female with a chronic psychiatric disorder claims that wherever she goes people stare at her, make some indirect remarks about her and laugh at her. She even believes that the radio announcer said something about her, indirectly.
2. The health officer at the OPD finds it hard to follow a patient's train of thought because he gives very long, complicated explanations and many unnecessary details before finally answering the original questions.
3. A 21-year-old woman hospitalized for severe toxoplasmosis awakens in the middle of the night and cries out that there is a "lion" in her room. She is relieved when a nurse turns on the light revealing that the "lion" was an armchair covered with a coat.

4. The nurses in the ward noted that from time to time the 40-year-old patient with AIDS "was not making any sense – he talks about unrelated things." On closer evaluation, it was found out that the patient could not even recognize his own children. He believes the nurse is his deceased sister.
5. For the past 2 months, a 22-year-old college student has been increasingly convinced that a well-known music star, Tilahun Gesese, is in love with her. They have never met or talked to each other. She claimed that people are preventing him from openly declaring his love for her. She is otherwise functioning well and attends to her class regularly.
6. A patient has been standing, immobile, for several hours. One of his arms is stretched up ward; the other is wrapped around the patient's neck. The patient does not appear aware of his surroundings and actively resists any attempt to make him change position.
7. A 35-year-old secretary, through her tears, complains of having no energy and no desire for anything. Her hair is unkempt and she is wearing unclean clothes. She has lost body weight in the past two months and has poor sleep. In the last two weeks she stopped going to work.
8. A 37-year-old male with a chronic psychiatric disorder suddenly seems to forget what he wants to say, in the middle of a sentence.
9. A patient insists that the whole world has ceased to exist.
10. A 31-year-old male schoolteacher has not been able to stop intrusive thoughts about germs on his hand. He thinks his thoughts are irrational but he could not resist the fear of contamination. He frequently washes hand untill his hands become dry and cracked.
11. A 33-year-old patient describes witnessing a terrible car accident that resulted in the death of many passengers and smiles and laughs while telling the story.
12. A patient responds to the examiner's question with the same response he has given to a variety of previous questions.



Module 1 Activity 7: *Case study*

Purpose: to practice approach to patient care

Instruction: Read each of the following cases and think of questions you might ask each patient or their family, and think of observations you might make in order to reach at a diagnosis. Then use the flow chart on figure 1.2 to decide what next steps to follow. Do this exercise for 15 minutes for each case.

Case 1

W/t Tsehay is a 25-year-old woman, a secretary, who has a 5-year history of recurrent psychotic illness - schizophrenia. She periodically stopped taking her psychotropic medication, but it was effective while she was taking it. When she relapses after stopping medication, she stops going to work and disappears from home for days. About a year ago, she started experiencing body aches and she was easily fatigued and had low energy with occasional fever. Evaluation by the General Practitioner at the health center, which included

various lab tests, showed no abnormality. A detailed personal history revealed that Tsehay had, during her relapses, frequent unprotected sex with strangers. HIV serology subsequently revealed that she was HIV positive. Now her family has brought her to see you because neighbors found her wandering late and night, and though they were old friends of hers, she did not seem to recognize them.

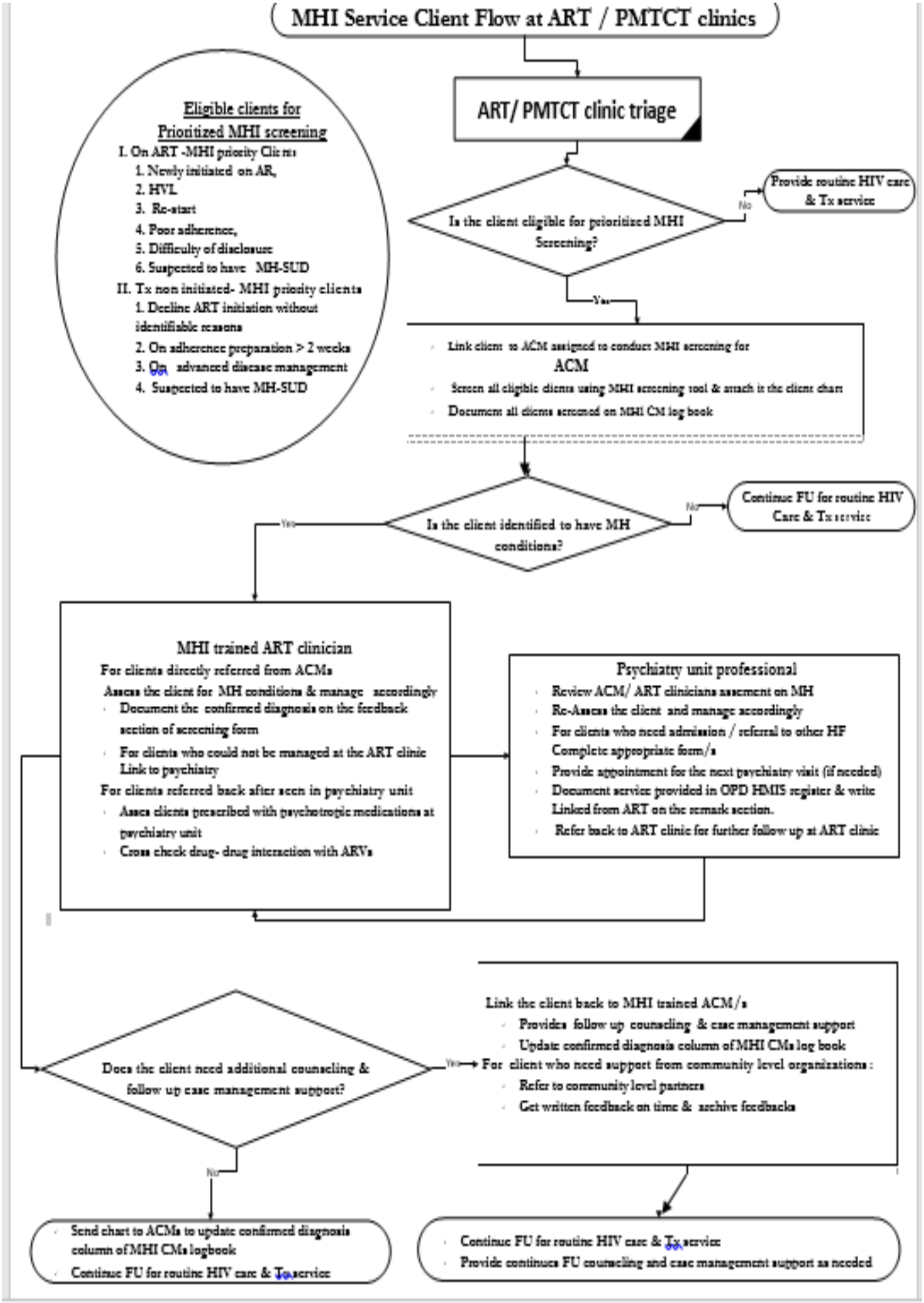
Case 2

Ato Tollosa is a 34-year-old divorced business man from Ambo. He found out two years ago that he was HIV positive, but kept it a secret. Just one month ago, his CD4 count became very low and his viral load increased. His doctor recommended that he start ART. Since then his behavior has changed. He says that he cannot concentrate on his business. He has isolated himself from any social interaction, and says that at times he has felt so sad that he has contemplated killing himself.

1.9. Introduction to the client flow in HFs where HIV care is provided

At an ART/PMTCT service unit, there is a need to structure and standardize the client flow. This process of standardizing and structuring the flow is important because PLHIV clients are vulnerable to stigmatization, and there is a tendency to be shy to use the services and may leave without getting the service if they are not sure what to expect from the service unit, how and where to get the service. The other reason is that, the ART service units are usually busy, and unless structured in a manner, there is a tendency to become disorganized and suffer chaos, which frustrates clients and staff. The other reason is, there are various service providers with differing roles and qualification level. Therefore, the roles and responsibilities need to be defined and made clear to everyone. With this purpose, the following client flow chart is recommended for use in each ART/PMTCT service units (see figure 1.3 below).

Figure 1.3: Client flow chart


MHI Service Client Flow at ART / PMTCT clinics
ART/ PMTCT clinic triage
Eligible clients for Prioritized MHI screening
I. On ART -MHI priority Clients
1. Newly initiated on ART,
2. HVL
3. Re-start
4. Poor adherence,
5. Difficulty of disclosure
6. Suspected to have MH-SUD
II. Tx non initiated- MHI priority clients
1. Decline ART initiation without identifiable reasons
2. On adherence preparation > 2 weeks
3. On advanced disease management
4. Suspected to have MH-SUD
Is the client eligible for prioritized MHI Screening?
No
Provide routine HIV care & Tx service
Yes
Link client to ACM assigned to conduct MHI screening for ACM
Screen all eligible clients using MHI screening tool & attach it the client chart
Document all clients screened on MHI CM log book
Is the client identified to have MH conditions?
No
Continue FU for routine HIV Care & Tx service
Yes
MHI trained ART clinician
For clients directly referred from ACMs
Assess the client for MH conditions & manage accordingly
Document the confirmed diagnosis on the feedback section of screening form
For clients who could not be managed at the ART clinic Link to psychiatry
For clients referred back after seen in psychiatry unit
Assess clients prescribed with psychotropic medications at psychiatry unit
Cross check drug- drug interaction with ARVs
Psychiatry unit professional
Review ACM/ ART clinicians assement on MH
Re-Assess the client and manage accordingly
For clients who need admission / referral to other HF Complete appropriate form/s
Provide appointment for the next psychiatry visit (if needed)
Document service provided in OPD HMIS register & write Linked from ART on the remark section.
Refer back to ART clinic for further follow up at ART clinic
Does the client need additional counseling & follow up case management support?
Yes
Link the client back to MHI trained ACM/s
Provides follow up counseling & case management support
Update confirmed diagnosis column of MHI CMs log book
For client who need support from community level organizations :
Refer to community level partners
Get written feedback on time & archive feedbacks
No
Send chart to ACMs to update confirmed diagnosis column of MHI CMs logbook
Continue FU for routine HIV care & Tx service
Continue FU for routine HIV care & Tx service
Provide continues FU counseling and case management support as needed

Module 1 Activity 8: *Reflections*

Purpose: to check for any participant concerns

Instruction: Raise any questions or comments about the module.

Have you answered the questions in activity 1?

Time: 5 minutes

1.10. Module summary

- Through a skilled interview, clinicians can gather data necessary to understand and treat patients, and in the process, increase the patients' understanding of, and compliance with, the clinicians' advice.
- There are specific techniques which make the information exchange between the clinician and the patient easy, open and constructive. The major ones include:
    - Open-ended vs. close-ended questions
    - Reflective listening techniques
    - Empathic comments with appropriate reassurance
    - Getting a full list of concerns and helping the patient prioritize their agenda
    - Giving advice thoughtfully
- It is good to have a short list of questions that you can ask every patient at intake or periodically during their care to help open up discussion of mental health concerns.
- If a concern is raised by the patient or family, the brief mental status exam allows a rapid but systematic way of gathering history, observations, and symptoms that can help decide what category of mental health problem may need to be addressed.

Module 2: Psychosis and neuro-cognitive disorders (delirium and dementia)

Duration: 240 minutes

Module description: This module deals with mental health disorders, which manifest mainly by problems of thinking, perception and cognition. It mainly considers the onset of those disorders in PLHIV. Those disorders are psychosis, delirium and dementia.

Primary objective: At the end of this module, participants will be able to manage disorders of psychosis and neuro-cognitive disorders (NCDs) in PLHIV.

Enabling objectives: at the end of this module, participants will be able to:

- List symptoms and signs of psychosis and neuro-cognitive disorders;
- Manage safety issues in clients who have psychosis and NCDs;
- Identify possible medical causes of the psychosis and NCD;
- Administer antipsychotic treatment for individuals with psychosis and NCDs when indicated;
- Provide psychosocial support to the patient and family members with psychosis and NCD;
- Identify when to refer patients with psychosis and NCD to mental health specialists;

Outline

2.1: Introduction
2.2: Types of thought problems
2.3: How these patients would be noticed in PLHIV
2.4: Problems with cognition
2.4.1: Delirium
2.5: Approach to treatment
2.6: Follow-up care
2.7: Referral and consultation
2.8: Module summary

2.1. Introduction

Module 2 Activity1*:* Individual reflection

Purpose: to assess level of participant and stimulate learning
How do patients with psychosis manifest?
How do patients with neuro-cognitive disorder manifest?
Time: 5 minutes

NB: Psychosis, delirium and dementia are not the most common mental health problems

encountered (and are even less common among children), but they are among the most frightening and difficult for families and general medical personnel. In addition, some of these problems can be signs of serious medical illness in people with HIV – and thus they are important place to start talking about mental health problems seen in ART clinics. In the final module of the manual we will talk about milder (but still serious) thinking problems that occur for many people living with HIV, even when they are doing well on treatment.

Module 2 Activity 2: *Case study*

Purpose: to introduce participants using a case to the discussion subject
Instruction: In your groups read the following case for 2 minutes and answer the following questions.

Case
Bogale is a 22-year-old young man with a 2-month history of strange behavior characterized by talking to the television, accusing local police of bugging his room, and carrying on conversations with himself. His mother also says that he has shown progressive withdrawal from social activities and dropped out of college.

- Have you ever met or heard about someone like Bogale?
- What do people think about people with problems like Bogale's?
- What do people assume are the causes of these sorts of problems?
- If people try to help people like Bogale, what do they do or suggest?
- What gets in the way of getting help for people like Bogale?

2.2. Types of thought problems

There are three main kinds of thought problems that can occur individually or all at the same time:

- Those that are primarily caused by a mental illness,
- Those that occur because of a medical condition, drugs or alcohol, or a medication that has affected how someone's brain is working.
- Those caused by a brain problem that mostly affects memory – where people have trouble remembering names, how to do things, and even important things about themselves.

The reason for telling these apart is that the treatments are different, even though sometimes the symptoms may look a lot alike at first.

2.3. How these patients would be noticed in PLHIV

Patients with psychosis and neuro-cognitive disorders are often brought by family members or noticed by staff because they are acting strangely, or because there has been a change in the way they care for themselves. What you or the family might notice in them are provided below.

2.3.1. Changes in speech

- Uses recognizable words but which make no sense
- May be very animated and talk very quickly
- May not answer questions – is silent or gives answers that don't really relate to the question you asked
- Shows a lack of connection between ideas
- Says the same things over and over again

2.3.2. Changes in mood

- Is irritable, suspicious, or angry in a way they have not been before
- Seems inappropriately happy, energized, thinks they are famous or very powerful
- Very changeable mood without apparent provocation

2.3.3. Changes in behavior

- Has poor self-care, improper clothing
- Friends and family cannot predict what the person will do next
- Roams aimlessly, may collect garbage or other items that don't seem to be of use
- Becomes aggressive and destructive
- Might give things away or spend all resources without thought
- May be sexually promiscuous or inappropriate
- Can't seem to do or figure out things that were previously easy

If you talk to people who exhibit these behaviors, they may or may not be willing to tell you about unusual thoughts. If they will tell you, it can be important to both deciding that they have a thought problem and also to understanding their distress.

It is important to realize that strange thoughts and perceptions may seem real to the person who is ill, but at the same time the person may realize that you will think them strange if they tell you, so they may not talk about their experiences or how much they are troubled.

What the person may describe if they do talk with you:
Hallucinations are things seen, heard, felt, smelled, or tasted that can't be perceived by another person; the person perceives them as real:

- Hearing a voice constantly commenting on oneself, or hearing voices of two people talking about you; voices telling you to do something (often violent)

- Seeing things that others do not see
- Feeling that bugs are crawling on the skin

You can ask, “Do you see or hear things that other people don’t see or hear?”

Delusions are strongly held, false beliefs or convictions that cannot be changed by rational arguments or evidence and are not shared by people from the same social, cultural and religious background and experience.

- The most common tend to be “persecutory” –belief that people, or the government, are trying to harm them, are following them, or constantly spying on them.
- Delusions can be “grandiose” --- belief that one is great or powerful or can do things that would be unusual for them – this often occurs when people also seem inappropriately happy or energetic.
- Delusions of jealousy/infidelity: belief that the spouse or partner is being unfaithful.
- Delusion of reference: belief that objects, events or the actions of other people have special significance for the person; e.g. the announcer on the radio is talking directly to the person as if they know that the person is listening.
- Somatic delusions – beliefs that there is something foreign inside the body, or that a part of the body is not working correctly.

Reading:
You can sometimes hear about these thoughts by asking people to explain their behavior, or to tell you why they are feeling upset. Often, the best way to hear about them is to just give the person some time to talk while only showing interest in what they are saying, but not commenting.

Delusions can be very hard to separate from the truth or from strongly held religious beliefs. It can be helpful to talk to family members or a religious leader from the patient’s faith before deciding if what the patient believes is a sign of a thought problem. The more time the patient spends thinking about the belief, and the more the belief has a harmful impact on their life, the more likely it is to be a delusion.

Somatic delusions can sometimes be hard to separate from medical symptoms such as pain and fatigue for which there isn’t a ready medical explanation, but which are not symptoms of a thought problem. When symptoms or concerns are odd (“my inner body parts have been replaced by plastic”) they are more likely to be delusions. See the low mood module for information on somatic presentations of mental health problems and for an approach to medically unexplained symptoms that are not delusional.

Module 2 Activity 3: ***Video illustration on assessment of patient with psychosis***

Purpose: to demonstrate presentation of psychosis
Watch the video on psychosis from the mhGAP.

Time: 30 minutes

2.4. Problems with cognitive functioning

Module 2 Activity 4: ***Group reading on section 2.4 and present to others***

Purpose: to read and understand memory problems and diseases causing them
Instruction: In your groups read session 2.4 (including 2.4.1 and 2.4.2) for 10 minutes and select one participant from the group to give 5-minute presentation to the class.

Cognitive functioning refers to multiple mental abilities, including learning, thinking, reasoning, remembering, problem solving, decision-making, executive function, orientation and attention. Preserved cognitive functioning is an integral component of maintaining a healthy, active and independent lifestyle for adults. Whether it is managing multiple medications, learning new skills and hobbies, or managing finances and paying bills, many everyday activities require complex cognitive processes. Loss of memory is usually given due emphasis when discussing neuro-cognitive disorders; however, it is not the only cognitive function impaired in patients with those disorders. Problems with memory can be hard to detect. People have to lose a lot of their ability to remember before they have trouble answering simple questions about familiar things (even though sometimes they are making up the answers). However, if you ask, the family may have already noticed that the person is having some trouble with new tasks, or with things that seem complicated – like remembering to take medicines or forgetting fasting days, holidays or other important appointments. Problems of cognitive function can be characteristic of delirium and dementia. We will talk more about that below.

2.4.1. Delirium is a special kind of neuro-cognitive disorder that occurs as part of serious medical illness and with alcohol withdrawal. It is characterized by cognitive problems that come and go, and by varying states of alertness – the patient is intermittently confused and disoriented, not recognizing where they are, the time or day, and often not recognizing familiar people. The key features of delirium are: acute onset, underlying severe medical illness or substance intoxication/withdrawal, fluctuation of severity of cognitive problems throughout the 24-hr period (symptoms seem to be easing during the day and severe during

the night) and clouding of consciousness (not coma). Alcohol withdrawal delirium (delirium tremens) has features of delirium together with features of autonomic hyperactivity (eg tachycardia, hypertension) after alcohol withdrawal, in a person who has had alcohol dependence and usually having underlying medical illness.

Thought and cognitive problems that are part of medical illness (and especially delirium) are potential emergencies – they usually mean that a person is very sick.

In persons with HIV infection, a number of infections can cause changes in cognitive functioning. They are all, to one extent or another, accompanied by other neurologic or medical symptoms, but some can be hard to diagnose even when laboratory tests and brain scanning are readily available. Table 2.1 lists the most common possibilities. We do not expect that you will memorize the list, but consulting it may then make it easier to find diagnostic and treatment information in other manuals. In working with the table, we will assume that you already have some concern for a change in the person's cognitive functioning. So the next step will be based on whether you believe the person has an abnormal neurologic exam, or if there is concern that the patient has had seizure (when they had not had seizures before).

Other acute medical issues to consider, besides the infections in the table, include:

- Recent head injury
- Brain tumor
- Substance abuse
    - Alcohol withdrawal
    - Stimulant use or overdose (khat may be the most common)
- Medication side effects or overdose (see also module on low mood and agents associated with suicide attempts)
    - Steroids
    - INH
    - Digoxin
    - In HIV care, the side effects of medications, especially AZT, 3TC, efavirenz, abacavir, and nevirapine

2.4.2. Major neuro-cognitive disorder (Dementia)

Major neuro-cognitive disorder (previously known as dementia) refers to the problem of significant cognitive decline, including memory problem, from a previous level of performance. Cognitive domains which become affected besides memory problem include attention, executive functions (planning and carrying out of activities), learning, language, problem-solving, and orientation. The cognitive deficits which occur in patients with dementia result in difficulty of doing day-to-day activities, and interfere with independence in everyday life. Unlike in the case of delirium, the cognitive problems in dementia occur in clear sensorium. The causes of dementia could be degenerative such as Alzheimer's disease, vascular such as repetitive incidences of cerebro-vascular accident (stroke), or HIV-

associated as in HIV-associated dementia (HAD). Neuro-cognitive disorder (dementia) of the Alzheimer type is the commonest form of dementia. In persons without HIV, dementia most commonly occurs in old age, or after many years of heavy alcohol use. Dementia can happen in advanced HIV infection, in which case it can strike at any age. Prior to HAART, it was very common among persons with AIDS. Since HAART, severe dementia is much less common, but milder forms of thinking problems have become more common and may occur in as many as a half of those on HAART.

When they begin to experience manifestations of major neuro-cognitive disorder (previously known as dementia), patients may complain of forgetfulness, inability to figure things out, or of feeling depressed, but they may be unaware of memory loss. Families may ask for help initially because of failing memory, disorientation, and change in personality or behavior. In the later stages of the illness, they may seek help because of behavioral disturbance: wandering, incontinence, irritability and aggression, apparent carelessness that is dangerous (leaving a fire unattended, leaving gates unlocked).

If there is concern, a screen for memory and orientation may be helpful. You can ask some of the following questions.

- Ask the person to remember three words (for example, “ball,” “cat”, “table”) and repeat them back to you. Tell them you will ask them to recall the three things again in a few moments.
- Ask someone to:
    - Give their age (make sure you know whether they are correct).
    - Give the time to the nearest hour.
    - Give their address (woreda, kebele, house number).
    - Give the year and season.
    - Give the name of the place where the conversation is taking place.
- Ask the person to tell you the three things you asked them to remember.
- Ask the person to recognize and name two people who are present in the clinic.
- Ask for some facts that most people know (you can make it harder if you think the person is well-educated).
    - Give the year of the fall of the Derg regime.
    - Name the present head of the government.
- Count backwards from 20 or say the days of the week backwards.

If the person has difficulty with more than two or three of these tasks, and there is no other explanation (very anxious, hard of hearing, medically ill, known to be developmentally delayed) then there is concern for dementia.

The major neuro-cognitive disorder (aka dementia) associated with HIV differs from the kind that usually strikes in old age in that it also involves changes in the speed with which people can think and do things with their hands. HIV-associated dementia (HAD) manifests with:

- Cognitive problems: difficulty with memory, concentration, and sustained attention, can lead to difficulty doing routine things; tasks take longer; it takes longer to learn new things
- Motor problems: slowing of repetitive movement, trouble with balance
- Behavioral changes: "impoverished" thought and emotions – less spontaneous, less initiative, more quiet and passive
- More common with a low CD4 count (under 100) and high viral load

Module 2 Activity 5: *Group discussion*

Purpose: to practice symptoms and signs of psychosis and neuro-cognitive disorders
Instruction: In your groups complete the worksheet below and submit one for each group**.**
Time: 5 minutes

Worksheet 1

Presentations of thought, perception and memory problems	Sign and symptoms
Changes in speech	
Changes in mood	
Changes in behavior	
Changes in perception (hallucinations)	
Change in behavior	
Delusions	
Difficulties with insight, judgment, and memory	

Module 2 Activity 6: ***Case study***

Purpose: to practice assessment and approach to patient with neuro-cognitive disorders
Instruction: In your groups read and discuss cases given below for 5 minutes each and answer the questions associated with them**.**

Case 1

Ato Tollossa Gemechu, a 27-year-old merchant, is brought to a hospital by his wife. Two years ago, he found out that he was HIV positive. Six months ago, he was started on antiretroviral drug treatment. His overall health condition was in good shape until two weeks ago at which time he started to show intermittent restlessness, agitation, incoherent speech, confusion, disorientation and at times vivid visual hallucinations. Such periods alternate with periods of relative normalcy during which time he became calm, coherent with no memory impairment, hallucination or delusion. Physical examination showed no abnormality except low-grade fever.

- What is the most likely psychiatric diagnosis?
- What will you check in physical examination?
- What are the possible causative factors?

Case 2

A 61-year-old male Ethiopian high school teacher, who was well experienced and an enthusiastic teacher, appeared to lose interest in his usual work and made gross errors in home financial management. On several occasions, he became lost while he was driving in areas that were formerly familiar to him. On examination patient was alert and cooperative. He was disoriented to time and place, he could not recall the names of his sons and daughters, and he could not remember the name of his college from where he graduated. His speech was fluent, but he had difficulty finding words, and used many long, usually meaningless sentences.

- What is the likely diagnosis?
- When you interview the relatives, what information would you check?
- In what components of the mental state examination you expect to find abnormality?

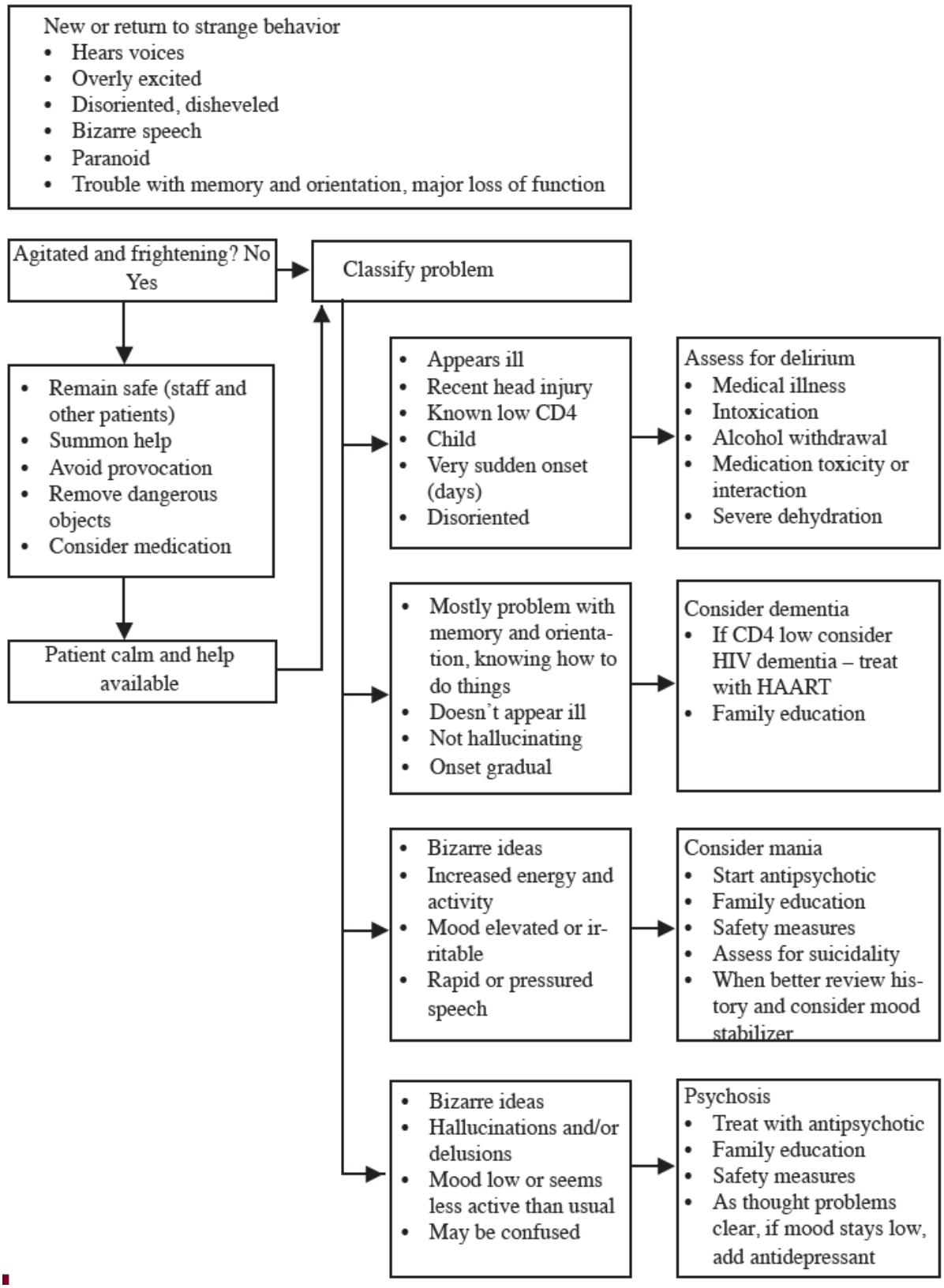
2.5. Approach to treatment

Module 2 Activity 7: Reading

Purpose: to practice the flow chart for psychosis and neuro-cognitive disorders
Instruction: In your groups, read and discuss the flow chart on figure 2.1 for 5 minutes**.**

Do you have questions or comments?

Figure 2.1: Flow chart for psychosis and neuro-cognitive disorders


New or return to strange behavior
• Hears voices
• Overly excited
• Disoriented, disheveled
• Bizarre speech
• Paranoid
• Trouble with memory and orientation, major loss of function
Agitated and frightening? No Yes
Classify problem
• Remain safe (staff and other patients)
• Summon help
• Avoid provocation
• Remove dangerous objects
• Consider medication
Patient calm and help available
• Appears ill
• Recent head injury
• Known low CD4
• Child
• Very sudden onset (days)
• Disoriented
Assess for delirium
• Medical illness
• Intoxication
• Alcohol withdrawal
• Medication toxicity or interaction
• Severe dehydration
• Mostly problem with memory and orientation, knowing how to do things
• Doesn't appear ill
• Not hallucinating
• Onset gradual
Consider dementia
• If CD4 low consider HIV dementia – treat with HAART
• Family education
• Bizarre ideas
• Increased energy and activity
• Mood elevated or irritable
• Rapid or pressured speech
Consider mania
• Start antipsychotic
• Family education
• Safety measures
• Assess for suicidality
• When better review history and consider mood stabilizer
• Bizarre ideas
• Hallucinations and/or delusions
• Mood low or seems less active than usual
• May be confused
Psychosis
• Treat with antipsychotic
• Family education
• Safety measures
• As thought problems clear, if mood stays low, add antidepressant

Issues to consider in the approach

1. ***Is there an urgent need for treatment?*** We start by not worrying about the cause, but whether the patient is (or seems like they could become) aggressive or do something impulsively to harm themselves (for example, run out into traffic).

- Stay safe yourself – keep your distance, never let the patient get between you and an escape route, call for help quickly, involve family members
- Keep the environment calm and avoid confrontations
- Trust your instincts if you are frightened
- Having multiple team members can be calming to the patient if you are all calm and firm
- Consider use of a medication to treat the disorder
    - Low dose of haloperidol 2-5 mg orally or intramuscularly followed by maintenance dose once the cause seems clearer
    - Lorazepam 1-2 mg orally or parenterally (iv/im) then switching to an antipsychotic once the cause seems clearer

2. Does the patient seem to have recently become medically ill?

Thought and cognitive disorders caused by medical illness usually come on relatively suddenly (over a few hours to days). Though there are exceptions, this is a handy rule to guide decision-making. If the thought problem is caused by a medical problem, do follow the national guideline for the management of opportunistic infections and other conditions, though in some cases the kind of treatment described above for emergencies may also be needed to control agitation and still be warranted in the short term.

See the substance module for what to do about alcohol withdrawal.

3. ***If the person is not medically ill***

Consider whether they have a primary mental health problem. In this case, the onset will usually have been more gradual, and the most common symptoms will be hallucinations and delusions. Again, though it's not 100% reliable, the hallucinations in primary mental health problems are most often visual and auditory, while those in thought problems caused by medical conditions can also be visual or auditory but additionally involve tactile hallucinations – often that there are things crawling on the skin or inside the body.

- Primary mental disorders e.g. schizophrenia causing thought problems can occur at any stage of adulthood, but the peak age of first symptoms is in the late teens/early 20's; sudden onset at older ages raises more concern for medical causes
- First onset is often gradual, over a period of weeks

Mental illness causing thought problems include the following:

- ***Schizophrenia*** (a chronic condition involving episodes of thought, mood, and behavioral disturbance along with more persistent problems with slowed thinking and changed personality)
- ***Mania*** (increased energy, elevated mood, rapid speech, often evolving into delusions and sometimes hallucinations; when it alternates with depression is called "bipolar disorder")
- ***Psychotic depression*** (the development of delusions and sometimes hallucinations among those who are very depressed)
- ***Delusional disorder*** (just strong delusions –usually persecutory or suspicious -- without hallucinations)

Reading:
Some people develop what is called "***brief psychotic disorder***." They experience hallucinations and change their behavior, usually after a serious loss or traumatic event. There is no evidence of any change prior to the trauma, and no sign of medical illness. Sometimes the patient or the family will make a link between the onset of the symptoms and the trauma. With this type of presentation, it may be reasonable not to give antipsychotic medication if the patient appears safe and can be supported. The symptoms, by definition, should resolve within 4 weeks. If antipsychotic medication has been started and the patient has stabilized rapidly, it is reasonable to try to taper off the medicine. Despite the presentation, if symptoms linger longer, another cause should be investigated (primary e.g schizophrenia or secondary, caused by a medical condition).

It is also important to remember that healthy people can have experiences that sound like psychotic symptoms but are not. Most commonly, these are seeing, talking with, or hearing from close relatives who have passed away. Most of the time these non-psychotic symptoms are benign, but they may also be sources of distress depending on the patient's belief about what they mean or what the relative is communicating.

While the long-term treatment of the primary mental illnesses is different from the treatment of thought problems caused by medical illness, the initial treatment is often the same.

The approach to management:

Start with an assessment of severity: we will assume that you have already decided that the person is not a threat to themselves or others, and is not medically ill. But we want to know how much their life is impaired by the problems and how much of an impact there is on their family. This will give you an idea of whether you feel you need to offer medication right away and/or get a mental health consultation.

Start with "psycho-education" – explaining the condition to patients and their families is often the single most effective thing you can do at the outset. Points to tell them include:

- The agitation and strange behavior are symptoms of an illness, not something that the person is choosing to do
- Treatment is effective, with better results than confinement or non-treatment
    - The sooner initiated after onset and the more consistently the treatment is taken, the better the results will be
- Treatment response takes time
    - Hallucinations often go away rapidly
    - Delusional beliefs may go away more gradually and can persist at low levels for a long time, but seem to be less troubling
    - It may take several weeks until mood and thinking return to normal
    - The longer someone has been ill, the longer recovery usually takes

Families can help – their collaboration increases the effectiveness of medications (and thus helps minimize the dose needed). Use the following points to give psycho-education to families:

- Minimize stress on the patient
- Try to avoid directly confronting odd beliefs; let them fade away and the patient gets better
- Support the patient to gradually return to regular roles but try to avoid frustration by keeping demands simple
- Provide reassurance that recovery is taking place; be encouraging
- If medication seems to be working, watch for signs of relapse – what are the earliest signs that unusual thinking or behavior is taking place?
- Help make sure that psychotropic medication is consistently available
- Avoid substance use – e.g. khat, marijuana, alcohol – since they may trigger psychosis or alter effects of medications

Medications are very effective for many people with primary thought problems (schizophrenia, bipolar disorder, etc.)

- Medications often help reduce severe agitation within minutes to hours
- Clearing of other thought problems can take days or weeks – allow at least 2 and up to 4 weeks at a recommended dose before declaring a medication to have failed (up to 30% may fail one medicine but respond to another)
- It can be up to 6 months to show a full response
- Some episodes may get better on their own, but treatment may cut the one-year relapse rate from 80-90% to 25%.

Use of antipsychotics

- Start low and go slow, especially in people who may have an underlying illness like HIV (regardless of whether or not you think that HIV is a cause of the thought problems)
- There is little likelihood of increased beneficial effects for doses that are higher than recommended
- In more advanced AIDS, the risk of side effects ("EPS" – extra-pyramidal symptoms) is increased when using "typical" antipsychotics – consider risperidone instead if available.

"Typical" antipsychotics –
- Haloperidol
- Chlorpromazine

"Atypical" antipsychotic
- Risperidone
- Olanzapine

Common antipsychotic side effects

1. Acute dystonia results from painful contraction of axial muscles resulting in torticollis, trismus, tongue protrusion, grimacing, difficulty swallowing – can be very uncomfortable and sometimes interfere with breathing). These need to be treated:
   - Diazepam: 5-10mg IV slowly

2. Stiffness of the arms and legs, resting tremor, bradykinesia (pseudoparkinsonism). These can be prevented or treated by starting one of the following medications, or sometimes by lowering the antipsychotic dose.
   - Benzatropine: start with 0.5-1mg a day and increase over days if needed
   - Benzhexol (trihexyphenidyl): start with 1 mg a day and increase over days if needed

3. Somnolence sometimes goes away or gets a lot better as a person takes the medication for a longer time – giving the medication before bedtime can help with sleep and avoid daytime sleepiness.

4. Chlorpromazine especially can cause a form of fainting when someone stands rapidly ("orthostatic hypotension") – this can be prevented by suggesting that the patient drink a lot of water and get up slowly from sitting or reclining.

5. In some cases, chlorpromazine can cause urinary retention (anticholinergic effects). Lowering the dose should help.

If the person is not acutely ill, and has changed behavior but is not having hallucinations or delusions:

- Consider whether the person could have major neuro-cognitive disorder (**dementia)**.

Treatment for dementia depends on the cause. For HIV-related dementia, treatment of the HIV often can produce a lot of improvement. If the person is taking any kind of medication, think about which ones could be responsible for changes in thinking (for example, too-high doses of antipsychotic medications or medications used to treat their side effects).

For the dementias associated with older age, there are no known therapies that will reverse the losses, but there are things that families can do to help:

- Help the person stay oriented by reminding them of the day and time
- Having family routines and simple, familiar tasks that the person can do or assist with
- If the person uses glasses, remind them to use them and try to keep them from being lost
- Provide additional supervision, though this may have to be gentle if the patient comes to resent being watched or accompanied all the time. Help the patient avoid dangerous situations – don't place them in charge of children; don't let them be alone where they could be injured, lost, or victimized.
- Get a specialist consultation – sometimes what looks like dementia in old age is, in fact, very severe depression. In that case, treatment may be of help.

The family will have a lot of additional work caring for the patient, who will require more assistance and supervision over time. Help them think about how to organize this work so that no one person is worked too hard. Ideally, help them get a consultation from a specialist to confirm the diagnosis. Be on the alert for depression or other signs of strain among the patient's caregivers. Provide caregivers with the necessary emotional and psychological support.

Sometimes people with dementia have episodes or prolonged periods of time when they are agitated and might harm themselves or others. Unfortunately, there are not many good choices for medication. Haloperidol, in the smallest dose that seems effective (0.5 to 1 mg a day to start) may be the safest, but there is concern that long-term use of antipsychotics in demented patients leads to increased mortality. Risperidone 1-2 mg a day is an alternative. Benzodiazepines are considered a second choice, but again in very low doses because they can have an effect opposite to the one desired (that is, cause increased confusion and distress).

Module 2 Activity 8

Purpose: to discuss and learn the effect of opportunistic infections of mental health

Instruction: Discuss in your groups based on table 2.1 and present to others**.**

Time: 10 minutes

Table 2.1: Opportunistic infections and tumors in HIV

	Condition	Mental status changes	Onset	Other physical findings	Assessment
Focal neurologic signs present and/or new seizures	Toxoplasmosis	Decreased alertness	Rapid, less than 2 weeks	Fever and headache	As per national guideline
	PML (JC virus)	Impaired speech, vision, motor function	Slow, over weeks or months	No fever or headache	
	Primary CNS lymphoma (EBV)	Personality and behavior change	Moderate, over 2-8 weeks	Headache but no fever	
	Tuberculosis	Decreased alertness	Rapid-moderate – days to weeks	Fever, headache	
Variable neurologic signs	Neurosyphilis	Memory loss, personality changes, dementia	Insidious	"Argyll Robertson" pupil (small, accommodates but no reaction to light); may be loss of DTR's or other neuro signs; headache, but may be few signs.	As per national guideline
Few/no focal signs	CMV	Delerium, lethargy	Rapid, under two weeks	Headache, stiff neck, photophobia	As per national guideline
	Cryptococcal meningitis	Usually alert, not usually associated with behavior change	Rapid, under two weeks	Cranial nerve palsies, fever and headache but not stiff neck	

Table adapted from Bartlett et al. Medical management of HIV infection, 2009-2010, and WHO IMAI District Clinician manual.

Module 2 Activity 9

Purpose: to practice dose, side effects and drug-drug interactions of antipsychotic drugs
Instruction: Discuss in your groups based on table 2.2 and present to others.
Do you have questions?
Time: 10 minutes

Table 2.2: Antipsychotic drugs, side effects, and interactions

Medication	Dosing	Common side effects	Medication interactions
Haloperidol	Adults: Starting dose 1.5 – 3mg/day Increase by 0.5 or 1 mg at a time Usual daily dose: 3-15mg; lack of evidence that dose over 10mg a day increases effectiveness Child 3-12 yrs: Agitation: 0.01 to 0.03 mg/kg/day divided into two or three doses Psychosis: 0.05 to 0.15 mg/kg /day, divided into two or three doses Child > 12 yrs: Starting dose: 1-5 mg/dose Usual daily dose: 1-15 mg/day divided bid or tid. Raise dose slowly and use minimally effective dose.	Prolonged Q-T interval (avoid if prior history of heart disease), extra-pyramidal side effects (tremor, stiffness)	PIs can increase haloperidol level; NNRTIs can decrease haloperidol level. Level reduced by carbamazepine and phenobarbital.
Chlorpromazine	Adults: Starting dose 75mg/day Usual daily dose: 75-300mg/day Child > 6 months: 2.5-6mg/kg/day orally divided into three or four doses	Drowsiness (potentiates effects of sedatives), jaundice, lowered threshold for seizures, hypotension, prolonged PR interval	Potentiates effects of sedatives. Data not available on ART interactions.

Risperidone	Adults: Starting dose: 0.5 to 1mg twice a day Increase by 1-2 mg per day at intervals of 2-3 weeks Usual daily dose 4-6mg/day divided into two doses Child > 20kg: 0.5 -1 mg a day to start; after 4 days increase by 0.5 mg every two weeks; 2-3 mg a day thought to be maximum effective dose in children	In higher doses (over 6 mg a day in adults) has similar side effects to typical antipsychotics	Some PIs may increase risperidone levels. Avoid use with or adjust dose of risperidone accordingly when co-administering with ritonavir-boosted protease inhibitors. Some ARV drugs reduce risperidone levels; adjust dose of risperidone when co-administering with efavirenz.
Olanzapine	For schizophrenia; the recommended starting dose is 10mg/day For mania: the recommended starting dose is 15mg/day in monotherapy and 10mg/day in combination therapy Lower starting dose 5mg/day should be considered for elderly of age >65 year, and those with hepatic and renal impairment Olanzapine is not recommended for use in children and adolescents of age <18 year.	Metabolism and nutrition disorders (wt gain, elevated triglyceride levels); CNS (sedation); GI (dry mouth); hepatobiliary (elevated liver transaminases)	Some PIs reduce olanzapine levels. Adjust olanzapine dose according to response when co-administering it with ritonavir-boosted protease inhibitors
Benzatropine (for EPS)	Adult: Initial dose: 0.5-1mg a day Usual daily dose 1mg twice a day Child: 0.02 to 0.05 mg/kg/dose once or twice a day	Constipation, dry mouth,	Potentiates sedative effects of other medications

Benzhexol (for EPS)	Adult: Recommended initial dose: 1mg/day; failure of the extrapyramidal manifestations to resolve in a few hours could prompt an increase in dosage until a satisfactory control of symptoms is observed. Total daily dose ranges from 5-15mg/day	Occular effects (mydriasis with blurred vision or narrow angle glaucoma); CNS effects (headache, dizziness, drowsiness and vertigo; anxiety and nervousness in higher doses; peripheral anticholinergic effects (impaired sweating, dry mouth, nausea, urinary retention and constipation)	No interactions reported.

Notes: suggested doses from WHO mhGAP; APA Textbook of Psychiatry; Harriet Lane Handbook (child doses); It is important to note that dosing may be lower in Ethiopia – *good rules include giving the medication time to take effect (once agitation has improved, days to weeks for psychotic symptoms to resolve) and using the lowest possible dose that seems effective*.

Module 2 Activity 10: ***Role play***

Purpose: to practice skills of assessment and management of psychosis and neurocognitive disorders

Instruction: In your groups you will be provided with one of the cases given below. Study the case and take turns being the patient, clinician and family member and do a role play. Focus on practicing in skills of assessment and appropriate management including psycho-social support.

Time: 10 minutes

Case 1

Kebede is a 21-year-old college student. He is currently living with his mother in Addis Ababa. He has three siblings and has not had contact with his father since he was very young. College study becomes very difficult. In the last three months, he stopped going to classes. He is being interviewed at the OPD; his older sister has come with him. He is very passive and never initiates conversation during the interview, but attempts to answer any questions from the interviewer. He becomes very confused about what to say in response to abstract

questions. If asked, he admits to hearing voices during the interview. The voices tell him that he has to protect himself from evil people, and that maybe the interviewer is evil too.

Case 2
You are the spouse of Ato Mehari, a young man in his late 20s, who has been treated in the ART clinic for two years and has been adherent to his treatment. You have brought him in because, in the course of a few weeks, he started to act strangely. He has begun to talk in ways that do not make sense**,** he seems to act as if you are plotting against him – when you come into a room where he is, he looks at you strangely and may even appear afraid or angry, even though you do not do anything provokative. His sleep is disturbed; he seems to see things no one else sees. Your mother has said that this has been caused by the medicine that he is taking for HIV and thinks that you should take it away from him and, instead, take him for more Holy Water.

Case 3
W/ro Askale really does not know what to do. Her husband Ato Mengasha is not his old self any more. He talks nonsense. He asks the same question again and again. He once got lost in the city. The police brought him home. His sleep is disturbed. He gets up in the middle of the night and tries to open the door and get out. These days he becomes so challenged that he cannot even wear his clothes correctly. She is not sure, after 23 years of marriage and 5 children between them, whether he recognizes her or not. She cannot leave him alone lest he get lost, or do something unexpected. Her life has become miserable.

2.6. Follow-up care

Patients with newly diagnosed thought and cognitive problems, who are well enough to be treated as outpatients, should be seen frequently until they seem stable. This initial frequency depends on the severity of their illness and the certainty of the diagnosis.

If the patient has good family support, then initially seeing them at one or two-week intervals will usually be enough. Once it is clear that they are improving, visits can usually be monthly until a long-term treatment regimen is established, so long as the patient and family are willing to come back sooner if they think that there has been a relapse. After that, visits every three months are usually sufficient.

At follow-up visits, assessments can focus on:

- Is the patient responding to whatever treatment has been started? Are they less agitated, getting more regular sleep, starting to return to some of their normal activities?
- Is the patient experiencing and, if so, tolerating side effects of medication?
- Are there any signs of an emerging underlying medical illness that wasn't obvious when the patient was first assessed?
- Is family stress reduced, is the ability to tolerate and support patient increased?

If there seems to be progress, no change in medications should be made. In primary mental disorders, improvement can take weeks to months and will not be hastened by using higher doses of medications so long as there already seems to be improvement. If there is only a little improvement or none, the dose can be raised a little, and questions can be asked to reconsider the initial diagnosis.

Long-term follow-up for any condition that has caused persistent psychotic symptoms:

- Treat for at least 6 months after symptoms seem to have cleared and the person is back to normal.
- After that time
  - If this is a first episode, symptoms were mild, and if close follow-up is possible, try a very gradual taper (cut dose by about 10% a month); stop the taper if symptoms start to return.
  - If the initial episode was severe or prolonged (or if there has been more than one episode, consider the need for long-term medication. In that case, the goal is to use the smallest effective dose of medication. Try a small taper (10%) and wait at that dose for several months before deciding if a further taper is possible.

2.7. Referral and consultation

Ideally, because of the severity of these problems, any time that a patient is thought to have a new thought or memory problem, the general health practitioner should have a chance to review the case with a mental health specialist. This review can include discussion of other observations to consider medical issues, and make plans for clarifying the diagnosis during follow-up visits.

If routine review of all new thought and memory cases is not possible, then consultation or referral can be considered if:

- Symptoms have not clearly seemed to get better within four weeks at optimal dose of medication.
- At the time of follow-up, the patient is suicidal or seems threatening to others.
- The patient seems to be dementing but the case does not fit the pattern usually seen with HIV.
- Medications are helping but side effects are not tolerable.
- There is diagnostic challenge.
- The patient needs inpatient treatment.

Module 2 Activity 11:*Reflections*

Purpose: to check for any participant concerns
Instruction: Forward any questions or comments about the module

Have you answered the questions raised in activity 1 of this module?

2.8. Module Summary

- In cases of psychosis you will find disturbances of thought, perception, and changes in speech, mood, or behavior.
- Psychotic individuals usually do not recognize that they are ill; however, they can be aware that something is wrong with what they are experiencing and fearful of disclosing their concerns.
- Schizophrenia, mania, psychotic depression, and delusional disorder are primary psychotic disorders.
- Psychotic states can also be caused by medical illnesses or in association with use of drugs – medications or drugs of abuse.
- Neuro-cognitve disorders (delirium and dementia) manifest with problems of cognition including memory, language, orientation, judgment, impaired problem-solving skills, etc
- Delirium is characterized by the acute onset of fluctuating cognitive impairment with disturbance of consciousness. It is more prominent at night.
- Dementia is a condition in which there is a progressive impairment of cognitive functions occurring in clear consciousness.
- Treatment in both delirium and dementia includes:
    - Identifying and treating the primary cause (though in non-HIV dementia there may be no treatment).
    - Pharmacologic treatment of insomnia, agitation/restlessness, delusions or hallucinations, etc.
    - Supportive and educational psychotherapy to both the patient and the family/care takers.

When giving pharmacologic agents in those with HIV, one should be cautious of the drug-drug interaction between ART and psychotropic drugs and of the mental side effects of ART and related drugs.

Module 3: Depression

Duration: 195 minutes

Module description: This module will enable the training participants to understand normal mood and differentiate between normal and abnormal mood symptoms related to medical conditions that may be contributing to low mood and prevention of suicide in PLHIV. It deals with mental health disorder, which manifests mainly by problems of low mood, loss of interest in pleasurable activities and suicidal behavior. It mainly considers the onset of this disorder in PLHIV. This type of disorder is known as depression.

Primary objective: At the end of this module, participants will be able to identify and treat depression and prevent suicide in PLHIV.

Enabling objectives: at the end of this module, participants will be able to:

- List symptoms and signs of depression;
- Manage safety issues in clients who have depression;
- Identify when a treatable medical illness may be the cause of the depression;
- Identify severity level of depression;
- Provide appropriate psychosocial interventions;
- Administer antidepressant treatment for individuals with depression when indicated;
- Identify when to refer patients with depression to mental health specialists;

Outline

3.1: Introduction
3.2: Etiology and types of depressive disorders
3.3: Presentations and detection in PLHIV
3.4: Diagnostic criteria for depressive disorders
3.5: Assessing suicidality
3.6: Approach to treatment of depression in PLHIV
3.7:Follow-up and monitoring
3.8:Referral criteria
3.9: Module summary

3.1.Introduction

Module 3 Activity 1: ***Individual reflection***

Purpose: to assess level of participants and stimulate
What is depression?
Time: 5 minutes

This module introduces detection and treatment of problems associated with low mood. Depression is among the most common mental health problems all over the world. By some estimates, as many as one in every 10 people will have an episode of depression during their lifetime. Spells of depression range from mild and brief episodes where people feel a lack of joy, optimism, and energy but can carry on with their lives, to prolonged periods of incapacity marked by a total lack of desire to do anything and thoughts that life is not worth living. Depression is common in both children and adults, but its manifestations are different.

Depression in pregnant women and mothers is thought to be one of the most common causes of preventable problems with child health, development and mental health. A study in Ethiopia found that children of depressed mothers were more likely, than children of non-depressed mothers, to have diarrheal illnesses in early infancy, and more likely to have developmental delays (Ross).

In addition, as we noted in the introductory module, studies in many parts of the world, including Ethiopia, found that rates of depression are many times higher among individuals with HIV compared to similar individuals who are HIV negative.

Module 3 Activity 2: Case study

Purpose: to stimulate and induce participants to the subject
Instruction: In your groups read the following cases and answer the questions that follow.
Time: 10 minutes

Case 1

Munira is 35 years old, single, an accountant who had refused to marry several times but now finds herself wanting a partner but unable to find one. Recently, she has lost her appetite, has developed early morning awakening, lost all the drive and energy to go to work, and she gets easily irritable and frequently quarrels with her colleagues. Sometimes, she feels that she would prefer dying to living in this situation.

- List the problems Munira is having.
- What is the likely diagnosis of Munira's condition?
- Have you ever met or heard about a case like that of Munira?

Case 2

Etenesh is a 12-year-old girl whom, recently, was forced to move to a new neighborhood because her grandmother died and the family's economic situation changed. Prior to this incident, she had been a cheerful girl who attended school and was helpful with her younger siblings. In the last month, she has been refusing to help or getting angry when her mother

asks her; she also has frequently said that she is not hungry and does not want to eat with the rest of the family. Her mother is worried about her, but also very annoyed that Etenseh is not being helpful in this time when the family must adapt to new surroundings. Etenesh's mother does not understand the change in her daughter and thinks it might be because she is becoming an adolescent.

- List the problems Etenesh is having.
- What is the likely diagnosis of Etenesh's condition?
- Have you met or heard about a case like that of Etenesh's?

3.2. Etiology and types of depressive disorders

Depression can be caused by many things. It seems to be more common in some families, suggesting that some vulnerability to depression may be inherited. Depression often follows major losses or stresses and is a frequent complication of some illnesses. Many types of chronic illness and chronic malnutrition can cause symptoms that resemble depression. Some of them are listed below:

- Hypothyroidism
- Anemia
- Vitamin B12 deficiency
- Renal or cardiac failure

There are also many medications that seem to be able to cause or increase the risk of depression, including the thiazide anti-hypertensive medicines, steroids, Efavirenz and INH.

There are many variants of depression, but in PLHIV you might want to consider starting with only two big categories:

- *Severe depression* accompanied by suicidal thoughts or extreme feelings of guilt or low self-worth. This form of depression can be so severe that it is accompanied by psychotic symptoms (often delusions).
- *Milder forms* of depression that clearly cause distress but allow the patient to continue to function at some level.

People often have depressive feelings after a major loss or set-back. While this is "normal" it may still require help. People often start to feel better after a few weeks, but relapses may occur and at that point treatment may be needed. Any time low feelings last more than two or three weeks it is worth looking for a cause and offering treatment of some kind.

Since depression can be caused or worsened by medical conditions and substance use, if one of these causes is suspected, treating them first may make most sense. The excess of depression among people with HIV may be caused by a number of factors: prior depression may make it more likely that someone will get HIV, the many stresses of the diagnosis and treatment may contribute to depression, and depressive symptoms can be caused by the many medical complications of HIV infection or the medications used to treat it. Fortunately, there

is no evidence that treatment of depression among people with HIV is any less successful than treatment of depression among those who are HIV negative.

3.3. Presentations and detection in PLHIV

Depression can be hard to detect and separate from other conditions. There are many different ways in which people express their feelings of depression; sometimes they directly talk about their mood, but a lot of the time they speak indirectly. Some people just consider it a fact of life and don't talk about it at all. The feelings come and go, and they consider it normal to feel badly when there is a lot of stress in life. Often, their friends and family members tell them that they should just be strong and shake it off.

3.3.1. Somatic symptoms

Around the world, somatic concerns (aches and pains, feeling that something is not right in the body) are the most common symptoms of depression. These include feeling tired or weak, difficulty sleeping (or sleeping too much), and aches and pains. In these cases, clinicians have to be thinking simultaneously about the possibility of a treatable physical condition and the possibility of depression. They have to balance how much they try to make a medical diagnosis with how much they are willing to ask the patient about their mood.

Some common bodily concerns in Amharic-speaking areas of Ethiopia that can be symptoms of depression include:

Head-related:
Makatol – burning scalp, feeling as if bugs are crawling under skin (usually associated with anxiety)
Yikebdegnal – heavy feeling in head
Yakatilegnal– burning sensation in head (but also could be in back, hands, legs, one side of the body or the other)
Yiweregnal – crawling sensation in or on head
Wotiroyiyizegnal – feeling tight in the head
Yikezekizegnal – feeling cold inside the head
Badoyihonibgnal – feeling empty inside the head
Wustuyimbochabichibignal – as if a fluid is sloshing around inside the head

Stomach -related
Cheguarra – chronic stomach pain
Cheguaraalebign – have gastritis, stomach ulcer
Hodenyinefagnal – feeling of fullness, distended

3.3.2. Psychological symptoms

Other common ways that people in Ethiopia talk about what may be depression include:

- I am irritable with my children (*erebishachewalehu*) ("I disturb or worry my children")
- I am easily irritable (*yanechanichegnal*)
- I prefer to be lonely (*bichegnnet)*
- I feel low *(medebet*)

So if people talk about some of these concerns, one can ask about symptoms that suggest depression.

3.3.3. Severity features

Module 3 Activity 3: *Think-pair-share*

Purpose: to stimulate participants to bring and share their experience
What might lead you to think that the depression is severe?
Time: 5 minutes

Features of severe depression

1. Evidence of thought problem
    a. People who are depressed can sometimes develop thought problems that involve delusions and sometimes hallucinations
        1. In this case, treat the thought problem first
2. Suicidal thoughts
    a. Many depressed people have feelings that they might as well not live, and may have even thought briefly about harming themselves. Most, however, will not have ever made a plan to harm themselves or actually tried. These latter two characteristics are the ones considered to indicate high risk. So the most important three questions are:
        1. Are you thinking of hurting yourself now?
        2. Have you ever actually tried to hurt yourself?
        3. Have you ever developed a plan to hurt yourself? (thought about what you would do, either started to or gathered what you might need)

        If the answer to any of these questions is "yes", then the depression should be considered severe.

b. If there is a concern that the person will harm themselves:
    1. Assess and implement realistic possibilities for close support and supervision
    2. Ask about and try to get others to remove things that could cause harm: weapons, insecticide, cleaning chemicals, or medications that might be harmful in overdose.
    3. If the suicidal thoughts seem to have been triggered by a shame, loss or shock (for example, getting the diagnosis of HIV, hearing that the CD4 count has fallen, rejection by partner or the death of someone close) counsel the patient addressing the issue
    4. If there is concern that a medical condition might be involved, treat it
    5. Make definite plans for some further assessment and treatment.
    6. Make a plan for the patient to get some kind of help as rapidly as possible if suicidal thoughts return – this might be calling a hot line, coming to the clinic, or talking to a friend.
    7. Consider starting medication (see below).

3.4. Diagnostic criteria for depressive disorders

The "official" defining features of depression are the following:

- Low or sad mood
- Loss of interest or pleasure in life, which, often is seen by others as pulling away from normal activities or interactions.

At least three or four of the following associated symptoms should be present, to make a total of at least five symptoms:

- Disturbed sleep (trouble falling asleep, frequent awakening, awaking too early in the morning and not feeling rested)
- Poor concentration
- Disturbed appetite (greatly increased or decreased)
- Suicidal thoughts or acts
- Guilt or low self-worth
- Loss of self confidence
- Pessimism or hopelessness about the future
- Fatigue or loss of energy
- Agitation or slowing of movement or speech
- Decreased libido
- Mood variation during the day

Because of what we said above about how common brief periods of depression can be after stresses, to start considering if someone has medically-treatable depression, the official guideline is that the symptoms should have lasted for at least two weeks, and they should be causing a major change in what the person would normally be able to do.

How might depression be different in children and adolescents?

Symptoms in children are very similar to those in adults, except that children and adolescents may have more irritability than sadness, and they are less able to describe their inner feelings. There are similar changes in behavior – lack of a desire to be with others, lack of interest in pleasurable activities, and impairment in ability to do important things (such as school-work).

Module 3 Activity 4: *Group discussion*

Purpose: to practice symptoms and signs of depression
Instruction: In your groups, list as many possible symptoms as you can in the two main categories of somatic and psychological manifestations within 5 minutes. Highlight or put a mark next to the ones you think are the most common or most important to ask about. Then, for another 5 minutes, go around the group each proposing a way to ask about each of the symptoms. Then present for 5-minutes on those ideas you have agreed upon.

Module 3: Reading assignment 1

Questionnaires

In some countries, clinicians administer questionnaires to patients to try to find those who are depressed. The problem is that questionnaires that are helpful in one culture may not work well in another. None, have yet been found that seem to be helpful across all of Ethiopia's diverse cultures and languages. But, questionnaires can be useful if you suspect that someone is depressed and want some confirmation, or you want to follow the progress over time.

- The PHQ-9 is a standard screening questionnaire to evaluate people for symptoms of depression. It has 9-items, and is widely used in Ethiopia by clinicians and researchers. It has been validated for use in Ethiopia.

Questions that seem to open up discussion of psychosocial issues:

Patients may not readily talk about their mood, especially if this is not something they have been asked to do in the past, when coming for medical care. So, there are some questions you can ask to open up this area of talk, and to show your interest in how they are feeling.

What concerns led to this visit; or what *other* concerns besides what the patient first stated?

How is sleep, appetite, energy?

How are relationships with others?

- Spouse, especially in sero-discordant couples
- How are they getting along with their children?
- For teens, ask if they have a boy or girlfriend.

- For women, ask about intimate partner emotional or physical violence, has the partner been “rude”?

Can you still do your work, or can you do it as well as you would like?
What else is happening in your life -- in particular loss or other trauma to family members?

Sexual concerns and changes in level of sexual interest are major elements of depression (and, also a common side effect of protease inhibitors). You probably need to find a staff member of the same gender as the patient to ask these questions.

- Have you felt that your interest in sexual activity has changed?
- Are you having difficulty with sexual relationships with your spouse?
- Have you had a troubling sexual experience?

Some of the most important symptoms of depression are ones that can be the most taboo or stigmatizing to talk about in front of others. Asking about these things in a non-private setting risks getting bad information, and harming the trust that you are hopefully building with the patient.

Module 3 Activity 5: *Role play*

Purpose: to practice eliciting signs and symptoms of depression
Instruction: Take turns being the patient, clinician, and an accompanying family member and make interviews based on the case given below for 15 minutes. The clinician should focus on asking questions to elicit signs and symptoms of depression so as to make a diagnosis of depression.

Case
Senait is 31, married, and has three children. When the interviewer begins to ask about what brought her to seek treatment, her voice wavers and she chokes up and has to clear her throat several times before answering. She admits that she finds herself crying several times a week, that the sad feelings seem to come out of the blue and overwhelm her when she least expects it, and that she worries a lot about her ability to be a good mother. She also admits that she has recently found herself getting irritable with her two-year-old son and that he seems to be more and more difficult to control as she seems to have less and less patience with him. She isn’t sleeping well and she feels tired all the time. Lately, she has trouble concentrating.

3.5. Assessing suicidality

Everyone who talks about low mood, or who is suspected of having low mood, should be asked if they are thinking about hurting themselves. This is a very difficult topic to talk about in any culture, and it is particularly sensitive in Ethiopia. You can start by asking some questions that get at whether someone may be having thoughts that death might be better than life.

- Have you ever thought that life is not worth living?
- Have you been feeling badly about yourself, as if you are a failure?
- Is life getting darker? *Tesfamokuret*– do you have periods of hopelessness?

Regardless of the answers to the above questions, you should also ask:

- Have you ever thought about harming yourself?

If the answer to this question is, "yes," consider the following:

What else is happening in the person's life? Suicide is more common at points of life crisis – a turning point in a serious illness like HIV, a major loss or rejection. In HIV treatment, suicidal thoughts seem to be particularly common when the diagnosis is first made, when the CD4 count first falls to the point where medication is started, when there are set-backs in treatment or new complications, and when there are chronic symptoms that make life difficult, especially pain.

What sort of mental health problems does the person have? Suicide is more common when depression or psychosis are severe, or when these conditions occur along with alcohol or drug use. The single biggest predictor of suicide is a prior attempt, especially if the person feels disappointed that the prior attempt failed.

So, the most important three questions to check for serious suicidality are:

- Have you ever actually tried to hurt yourself in the past?
- Are you thinking of hurting yourself now?
- If so, do you have a plan to hurt yourself? (thought about what you would do, either started to or gathered what you might need, given away possessions or written a farewell letter)

If the answer to any of these questions is "yes" then the risk of suicide should be considered to be high.

3.5.1. SADPERSONAS Scale

Another method of assessing a patient's risk for suicide is to use the "SADPERSONAS" scale. The scale can be a useful guide for suicide risk assessment. Having six or more of the factors below indicates substantial risk.

- Sex - (Being male puts one at more risk for suicide).
- Age – (Suicide is more common among the elderly, older teens and young adults).

- Depression- (The presence of depression shows a higher risk for suicide).
- A previous attempt- (Completed suicide was preceded by a prior attempt).
- Ethanol abuse - (Excessive alcohols and /or drug abuse increase risk for suicide).
- Rational thinking loss- (Psychosis, eg when commanding auditory hallucinations such as 'I heard a voice saying I should kill myself', increases suicide risk).
- Social supports lacking- (Poor social support increases risk of suicide).
- Organized plan- (Presence of organized plan increases risk of suicide).
- No spouse / husband or wife- (Lack of partner, e.g. separated / divorced/ widowed increases risk).
- Availability of lethal means- (If lethal method is available, the risk of suicide is higher).
- Sickness- (The presence of medical illness or terminal illness, e.g. HIV/ AIDS, Cancer, Renal failure, HD/ CHF increases risk of suicide).

 **Module 3 Activity 6: *Role play***

Purpose: to practice risk assessment for suicide
Instruction: Take turns being the patient, clinician, and an accompanying family member and make interviews for suicide assessment based on the cases given below. The clinician should focus on asking questions in line of SADPERSONAS scale and make a decision based on the result.

Case 1
Almaz is 35 years old. She is divorced. Three weeks ago, she discovered that she has HIV. Since that time, she has developed loss of appetite, early morning awakening, and says that she has no desire or energy to go to work. She gets irritable easily and frequently quarrels with her colleagues, which she says is OK because she prefers to be alone. She says that she finds herself crying a lot, and sometimes she feels so sad that she would prefer dying to living in this situation.

Case 2
Solomon is a 30-year-old man who has been on ART for three years. When he first started treatment, soon after his HIV diagnosis, he had a small shop and seemed to be coping well. However, over the last year he has been using more khat and drinking more beer. He has been putting in less time at the shop and business has gotten bad. Recently, his wife said that if he was not able to pay more attention to the shop and his affairs that she would take their children and return to her family in another city. At this visit, Solomon tells you that he ran out of HIV medicine two weeks ago and did not think of coming for more. He says that he is thinking of stopping the treatment, because he knows that he will die of HIV sooner, or later.

Reading:
Other factors that might make even lesser degrees of suicidal thinking seem dangerous include:

- The person is intoxicated
- The person is very upset or agitated
- Someone in the person's family or a close friend (especially among adolescents) has attempted or completed suicide.

Special concern for suicidal individuals who may have taken an insecticide:

- They may say they are suicidal and appear intoxicated or agitated
- This is a medical emergency
- Start plans for transfer to a hospital
- Avoid any fluids by mouth except if less than an hour after ingestion and then give activated charcoal and atropine
- Treat seizures if present

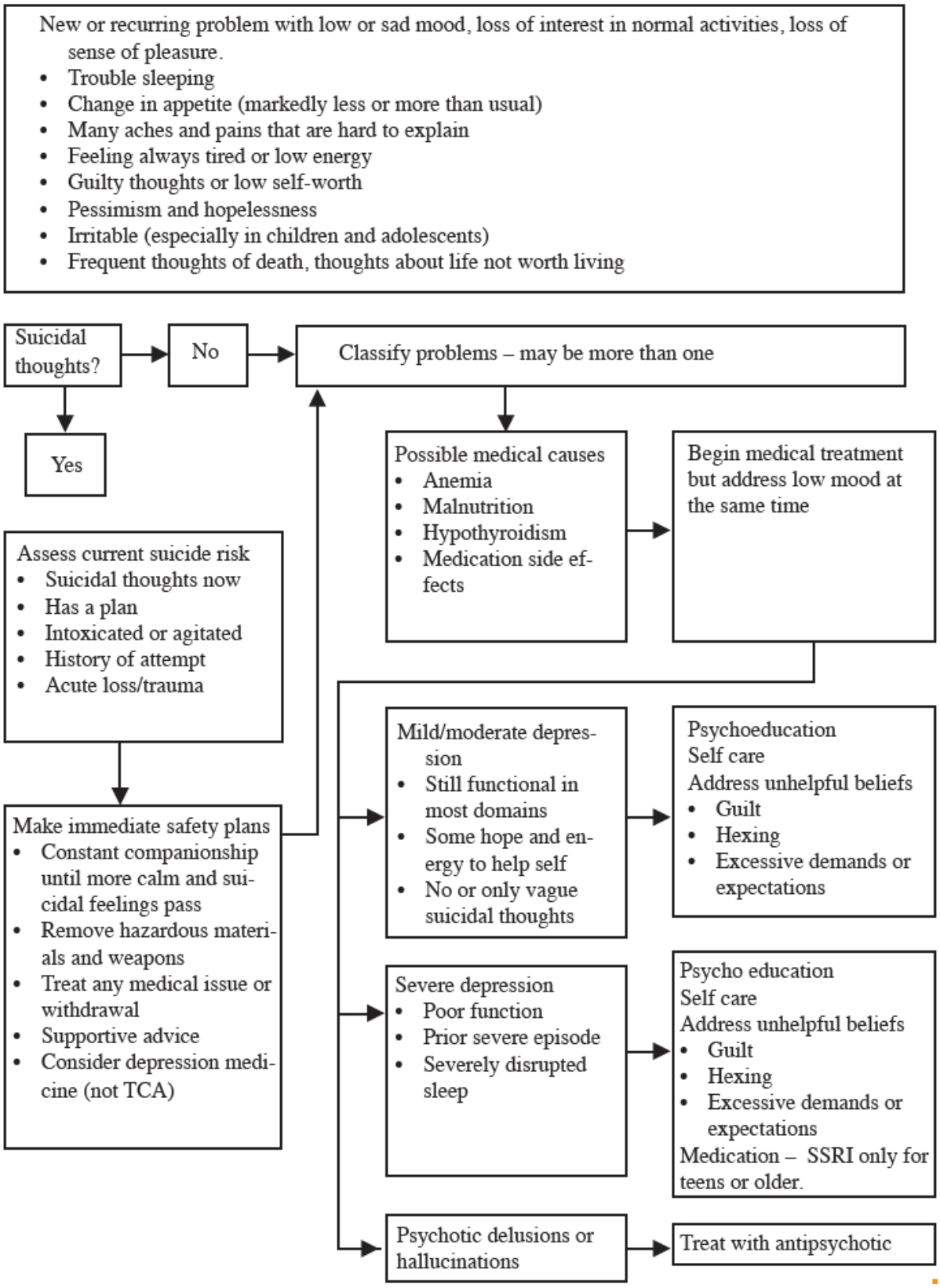
3.6. Approach to treatment of depression in PLHIV

Module 3 Activity 7: Group discussion

Purpose: to practice using the flow chart for depression
Instruction: In your groups, read and discuss the flow chart on figure 3.1 for a client who has new or recurring problem with low or sad mood, loss of interest in normal activities, loss of sense of pleasure and after assessment the client has been diagnosed with depression.

Do you have questions or comments based on your discussion?
Time: 5 minutes

Figure 3.1: Flow chart for a client with new or recurring problem with low or sad mood, loss of interest in normal activities, loss of sense of pleasure.



3.6.1. Psychosocial treatment approaches

Psycho-education is often helpful in itself – for both the patient and for family members – and even when there are medical causes. Points that you can emphasize include:

- Depression is a common problem and effective treatments are available.
- Depression is not weakness or laziness.
- Depression can affect patients' ability to cope – when they are not depressed they will be able to do more for themselves.
- It is normal to feel "down" or briefly hopeless when life is difficult, but that does not mean that there are no ways to try to feel better.
- If physical symptoms (headache, abdominal pain, aches and fatigue) are the main way the patient is experiencing their depression, discuss the link between physical symptoms and mood. It is necessary to acknowledge that the symptoms are troubling to the patient; that they are not imaginary. Attempts to link physical symptoms to emotional or psychological origins should be done after conducting appropriate evaluation for the possibility of medical disease. Patients can be receptive to the idea that the physical symptoms are linked to stressful events. As an example, if someone has a headache you can say that it is reasonable that the stressor is causing you pain, or that a more serious stressor would cause you pain everywhere.
- If there are strong beliefs about the feelings being caused by Satan, hexing, or the consequence of some bad conduct, you can respect those beliefs without having to directly agree; suggest that what you are proposing may still be effective.

Brief advice can be helpful

- Identify current life problems or stresses. Focus on small, specific steps to take towards reducing or managing these problems, even if it's only a little. Talk about ways to lighten the person's load temporarily, if that is possible.
- Avoid major decisions or life changes – provide assurance that it is OK to put these off until feeling better. Encourage the patient to resist pessimism and self-criticism and not to act on pessimistic ideas (e.g. ending marriage, leaving job), and not to concentrate on negative or guilty thoughts.
- Plan short-term activities that give the patient enjoyment or build confidence.
- Exercise may be helpful both to lift spirits and prevent low mood.
- Advise reduction in caffeine intake and drug and alcohol use.
- Support the development of good sleep patterns and encourage good nutrition if possible.
- For teens and children, explore ways to reduce conflict with parents; see if teens can find other adults who would be acceptable sources of support (teachers, elders).

Be a good listener. Even in a very short interaction it can be helpful to:

- Give the patient time to explain their feelings

- Empathize with their difficulties
- Find something positive to say – at least, compliment them on their willingness to talk and to seek help

Community referrals. What organizations can help with practical matters including housing, work, transportation, food, HIV support?

- Worry about food and shelter is a major cause of depression and anxiety
- Encourage the family to think about other things they feel would be helpful including holy water or other traditional approaches, but assess with them whether there is a chance for harm (for example, use of herbal medications that might interact with current medications).

Make a definite plan for a follow-up visit, especially if this mood change is in response to a new stress (for example, new HIV diagnosis or change in status); try to differentiate acute mood change from depression).

Module 3 Activity 8: Group *Discussion*

Purpose: to bring participant experience and encourage sharing
Instruction: In your groups discuss about the following questions for 5 minutes and select one person to give a 5-minute presentation to the class.
Which community support organizations are you aware of in your area?
What type of services do they provide?
Have you ever had contacted them?
If ever contacted them, what is your experience?

Module 3 Activity 9: *Role play*

Purpose: to practice providing psychosocial interventions
Instruction: In your groups read the case given below for 2 minutes.Then take turns being the clinician, patient and a family member and do role plays to practice how to provide psycho-education and brief advice.
Time: 15 minutes

Case
Teklu is a 16-year-old student from Nazareth. The teenager has many aches and pains, and is tired all the time. He says he has lost interest in going to school and he avoids any social interaction. He remains in his room for hours. The weekly premier-league football game he was crazy about does not give him any pleasure. The family has been through many adversities – the father had been imprisoned for a long time and his grandmother, who raised

him, is very ill.

3.6.2. When to consider medication

Consider using medications under the following conditions:

a. Function is severely impaired
b. Concern that there might be some delusional thinking
c. Persistent and severe suicidal thoughts
d. There was a previous time when the person had low mood that lasted more than a few days and that was hard to help and/or that resulted in problems in function.

Medications for children and adolescents

- There is very little evidence that any are effective for low mood; there is better evidence if there are anxiety symptoms
- The only evidence is for SSRI's (for example, fluoxetine or sertraline), and this is only for older adolescents.

Module 3 Activity 10:*Group discussion*

Purpose: to study antidepressant dose, side effects and interactions
Instruction: In your groups discuss on table 3.1 for 10 minutes and present to the others about your group's discussion results for another 5 minutes.

Table 3.1: Antidepressant dosages and side effects

Antidepressant Drug	**Dosage**	**Common side effects**	**Interactions**
Amitriptyline	Adults Starting dose: 25-50 mg a day given at bedtime Increase by 25 mg a week Usual maintenance dose: 100-150mg/day in single dose at night or divided into two doses; maximum 200mg a day Adolescents and children:	Dry mouth, sedation, postural hypotension, weight gain; **can be fatal in overdose**. Do not use in men with prostate enlargement or in anyone with heart disease.	OK with NNRTIs and NRTIs OK with PIs except LPV/r, RTV where those medications can raise the level of the antidepressant so try to use fluoxetine. Steroids can increase the level of the antidepressants (including contraceptives) Phenobarbital and

	Not recommended		carbamazepine can decrease levels.
Imipramine	Adults Initial dose 25-50mg at night; can raise by 25mg a week Usual adult dose 100-150 mg at night or divided into two or three doses; maximum 200mg a day Adolescents and children: Not recommended		
Fluoxetine	Adults Starting dose: 10-20mg a day (morning or night depending on side effects); wait 4-6 weeks before deciding to increase Usual maintenance dose: 10-40mg/day Adolescents Starting dose 10mg a day; increase by 5 or 10mg in 1-2 weeks only if no response at all Usual maintenance dose: 20mg a day	Headache, restlessness, agitation, insomnia or sedation, GI symptoms, sexual dysfunction.	Never give along with amitryptyline or imipramine (can lead to overdose of those drugs) Potential for increased levels of SSRI with atazanavir and lopinavir Interacts with many medications so check before using.
Sertraline	Adults 50- 200mg/day Adolescents- Starting dose 50mg a day Children 6-12 - Starting dose 25mg a day Increase slowly	Short half-life of sertraline makes it important in higher doses to divide into more than one dose a day or can get unpleasant withdrawal feelings; sertraline needs to be tapered rather than stopped	Never give along with amitryptyline or imipramine (can lead to overdose of those drugs) Potential for increased levels of SSRI with atazanavir and lopinavir Interacts with many medications so check before using.

		suddenly.	

Reading assignment

Medication choices

All antidepressants can take time to have an effect; sometimes there is a partial response in a few days, most people need 10-14 days to see some change and longer to get the maximal effect from any particular dose. Don't consider the medication a failure until at least a month has gone by with insufficient improvement. At that point, check for adherence and side effects. If OK, consider a dose increase.

Tricyclic antidepressants in general are effective in adults. *There is no evidence for effectiveness in children or adolescents.* These medications tend to have many side effects (dry mouth, sedation, hypotension) and *can be fatal in overdose*. *Avoid using them in patients who have current or past suicidal thoughts.* Avoid in patients with known heart disease. Co-administration with ritonavir and other protease inhibitors can greatly increase tricyclic levels and thus contribute to toxicity.

- Amitrptyline: Starting dose is 25-50 mg daily in divided dose or as a single dose at bed time and it can be increased gradually (by 25 or 50 mg at a time) as necessary up to 150-200mg per day.
- Imipramine: starting dose is 25mg 1-2 times/day, increase dose gradually, and the total dose that may be given at bed time is 300mg

Selective serotonin-uptake inhibitors (SSRI) in general are all equally effective for adults. The best evidence of effectiveness for adolescents is for fluoxetine, but evidence in younger children for fluoxetine is only for anxiety. These medications are extremely safe except for concerns about interactions with other medications. Common side effects (mostly early in treatment) include stomach distress, agitation, sedation, trouble sleeping. Adults may experience loss of sexual drive.

- Fluoxetine: 10-20 mg a day starting dose. Fluoxetine has long half-life so waiting at least two weeks after starting or a dose change is reasonable to see effects; no need to taper dose if discontinuing; little worry about occasional missed dose; check interactions with other medications – in particular, giving at the same time as an tricyclic can raise the tricyclic to toxic levels.
- Sertraline has been shown to be effective for adults. The starting dose is 25mg a day and can be given up to 200mg a day, usually divided into two doses. The half-life is shorter than fluoxetine so when stopping taper by 25-50 mg a week to avoid unpleasant side effects.

Module 3 Activity 11: ***Case study***

Purpose: to practice diagnosis and management of depression
Instruction: In your groups, you will be given one of the cases given below. Use the case to practice diagnosis and treatment decisions. Do this activity for 10 minutes.

Case 1
Tirunesh is a 24-year-old young woman who works in a bank. Her long-term boyfriend died two years earlier due to AIDS, but she has been afraid to go for testing herself. She came now to her doctor with a number of symptoms, including backache, pains in the chest and abdomen and aches in the muscles. She is frequently tired and sleeps poorly. Though she tells you that her mood is not bad, she does say that she, since the death of her boyfriend, has not felt much purpose in life. She says that her motto is just to live for today, because life can be so uncertain. Her physical examination is normal.

Case 2
Hirut was found unconscious in her bedroom with an empty bottle of an insecticide containing malathion. She was sent to a hospital and after 11 hours she regained consciousness, became communicative and her vital signs were stable. Her husband told the attending physician that they both are HIV positive; in talking to the doctor, he says that he believes he contracted HIV from her and blames her unfaithfulness for their present condition.

Case 3
Ato Gebremariam is a 32-year-old male, married government employee, who was diagnosed with HIV a year back. He came to the clinic due to frequent diarrhea and weight loss. He has lost interest to work and isolates himself. He feels guilty about infecting his wife, and is sad all the time. After lab test, it was decided to start HAART.

Case 4
Abdella is a 35-year-old, single accountant who has been on HAART for the last 3 months. Four weeks ago, he was started on anti-TB drugs. In the last two weeks, after the death of his former girlfriend, he started to show behavioral changes. He stopped going to work. He is slow, spends most of his time in his bed, cries a lot, and his sleep is full of nightmares.

3.7.Follow-up and monitoring

Several aspects of depression make follow-up care very important. First, as we said before, response to treatment can be slow. Some people will feel better in a few days or a week, but most will take weeks or a month until they notice a lot of improvement. If the person is taking a medicine for the depression, this is necessary to arrange follow up visits to check benefits and side effects of the medications. So a return visit in one or two weeks is important. Early return visits are also important if there was worry about suicidal thoughts, or if the diagnosis did not seem clear.

Depression can get a lot better in a month or two, but stopping treatment at that point makes it very likely that the person will relapse. Ideally, continue treatment for at least six months after the person feels well before tapering down treatment – longer if this is not the first time the person has been depressed enough to need treatment.

Finally, people who have been depressed once may relapse, so even once they feel better, asking them about symptoms when they come back for other reasons is a good way to catch a relapse early before it becomes severe.

So, one possible plan for follow-up of someone who has been started on depression treatment would be to see them weekly for a month, then monthly for another five months, and then decide about plans based on how well they are doing. At each follow-up visit, assess for new stresses, suicidal thoughts, return to normal of sleep and appetite, and the side effects of any medications.

3.8. Referral criteria

When consultation is available, generalist clinicians may want to review with a specialist all cases of severe depression, including those where there was worry about suicidal thoughts but the patient was allowed to go home.

Referral to mental health consultant is warranted if there is:

1. Suicidal thought with a plan and likely means
2. Depression with catatonic features
3. Concern about serious acute medical illness
4. Non response to treatment and the patient remains severely affected
5. Further worsening of depression or lack of clarity about diagnosis
6. Response to medication treatment but inability to tolerate side effects.

Module 3 Activity12: Group discussion

Purpose: to discuss on possible concerns

Do you anticipate any challenges in arranging follow-up and referral of clients?

Do you have any questions so far?

Have you answered the questions on activity 1 of this module?

Time: 5 minutes

3.9.Module summary

- Depression is highly prevalent in HIV/AIDS cases
- In depression one finds both somatic and psychologic symptoms.
- Many people with depression have somatic symptoms that raise concerns for medical illness – it is important to consider both causes at the same time.
- 90% of suicides occur within the context of a mental disorder, particularly depression and substance abuse.
- Untreated depression could lead to increased non-adherence to ART, increased suicide risk, decreased quality of life of the patient, and family emotional distress.
- Effective treatments are available for depression; antidepressant medications are effective, the SSRI's are preferable
- Medical illnesses and substances causing depressive symptoms should always be identified and managed accordingly.

Module 4: Anxiety, obsessive-compulsive and trauma-related disorders

Duration: 110 minutes

Module description: This module will enable the training participants in understanding normal fear and differentiate between normal fear and anxiety symptoms. It intends to help participants to recognize and identify disorders, which manifest with marked feeling of anxiety but which are distinct from anxiety disorders (such as obsessive-compulsive and post-traumatic stress disorder) and manage those disorders. The module intends to help participants recognize when the anxiety and related symptoms are associated with medical conditions that may be contributing to it in PLHIV.

Primary objective: At the end of this module, participants will be able to manage anxiety disorders, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) in PLHIV.

Enabling objectives: at the end of this module, participants will be able to:

- Describe normal fear as compared to abnormal manifestations of anxiety in anxiety disorders, OCD and PTSD;
- List symptoms and signs of anxiety disorders, OCD, PTSD and panic attacks;
- Manage emergency presentations in clients who have anxiety, OCD and PTSD (in particular panic presentations);
- Identify the cause of the anxiety, OCD or PTSD;
- Recommend appropriate treatment;
- Provide appropriate psychosocial interventions to PLHIV who have anxiety disorder, OCD and PTSD, and their families;
- Administer medications for treatment of anxiety, OCD and PTSD disorders when indicated;
- Identify when to refer patients with anxiety, OCD and PTSD disorders to mental health specialists.

Outline

4.1. Introduction
4.2. Presentations and detection of anxiety disorders, OCD and PTSD in PLHIV
4.3. Approach to treatment in PLHIV
4.4. Medications for anxiety
4.5.Follow-up and monitoring
4.6. Referral criteria
4.7. Module Summary

4.1. Introduction

Module 4 Activity 1: ***Individual reflection***

Purpose: to assess participant level and stimulate thinking
What is the difference between fear and anxiety?
Time: 5 minutes

This module introduces detection and treatment of problems associated with manifestation of anxiety symptoms and signs. Anxiety disorders is a term used to describe a group of disorders that share features of inappropriate and/or excessive fear and anxiety, associated with related behavioral disturbances. There are various anxiety disorders which differ from each other by the specific content of the ideation which arouses the anxiety, and the type of object and situation which ignites the anxiety reaction. However, it is important to recognize that there is a tendency for the anxiety disorders to exist together in a patient as comorbid disorders.

These are among the most common mental health problems all over the world. Anxiety disorders are widespread in the general population. Along with affective and substance use disorders, they are the most common mental disorders. Lifetime prevalence ranges from 13.6% - 28.8%. The 12-months prevalence rates range from 5.6% - 19.3%. In older literature, anxiety disorders included generalized anxiety disorder (GAD), phobias, obsessive-compulsive disorders (OCD) and post-traumatic stress disorder (PTSD). In recent years (since 2013), OCD and PTSD are considered separate from anxiety disorders. This module addresses the anxiety disorders, OCD and PTSD as separate entities.

Anxiety is different from fear. Fear is a normal emotional response of all human beings to actual or perceived danger. Normal fear is adaptive and necessary for survival; for example, if a person who sees a snake feels fearfulness, he/she is more likely to run faster or jump higher; this makes the person more effective in his/her attempt to escape danger. Likewise, a feeling of worry and stress before an exam makes a person study harder. Anxiety, however, is a maladaptive form of fear reaction which occurs in the absence of actual or threatened danger. Anxiety is a situation in which the body's fear mechanisms are abnormally and inappropriately activated making the body in a heightened state of readiness for emergencies. Anxiety is known to affect all people regardless of culture, race, age, religion, gender, level of education or economic background. It is characterized by excessive fear and/ or inappropriate feelings of nervousness that can be very general (applied to nearly all aspects of life) or very focused on a particular situation.

Anxiety is frequently mixed with feelings of depression. It is often chronic, unremitting, and disabling. In many countries it goes undetected for many years after people first experience symptoms, even when mental health services are potentially available. Anxiety disorder is a

common name for a group of disorders with anxiety manifestations. Anxiety disorders include generalized anxiety disorder (GAD), panic disorder and phobias among others.

Generalized anxiety disorder is characterized by persistent and excessive anxiety and worry about various domains, including work and school performance that the individual finds difficult to control. In addition, the individual experiences symptoms such as restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension and sleep disturbance. Panic disorder is characterized by recurrent unexpected panic attacks. Panic attacks are abrupt surges of intense fear or intense discomfort that reach a peak within minutes, accompanied by physical and/or cognitive symptoms. Physical symptoms of panic attack include tachycardia, diaphoresis, shortness of breath, feeling of being choked, tremor, abdominal discomfort, etc. Cognitive symptoms include fear of dying, dissociative symptoms etc. In panic disorder there is no specific object or situation which provokes the anxiety reaction; however, some authors describe that panic attacks are the result of maladaptive interpretation of bodily symptoms as signs of danger. For example, a person with the disorder may interpret increased heart rate as a sign of heart attack and imminent death. Panic disorder is also characterized by persistent concern or worry about having more panic attacks. The individual with panic attacks shows change in behavior in maladaptive ways because of the panic attacks; for example, the individual may avoid physical exercises.

Phobias are characterized by maladaptive anxiety reaction, in which, there are known objects or situations resulting in the anxiety. There are different types of phobia: specific phobia, social phobia, and agoraphobia are some of them. Specific phobia (also known as simple phobia) is anxiety reaction associated with specific object or situation to a degree that is persistent and out of proportion to the actual risk posed. The specific object or situation provokes anxiety symptoms almost immediately on the individual; the individual, therefore avoids the specific object or situation. The object associated with the phobia could be animals (such as a spider), or situations (such as heights). Social phobia (also called social anxiety disorder) is anxiety reaction associated with social interactions or situations in which there is a possibility of being scrutinized. Possible social situations which can result in anxiety symptoms include performing in public or giving public speech. The person with social phobia avoids social situations which provoke the anxiety reaction. Agoraphobia is a type of phobia associated with situations in which escape might be difficult or help might not be available in the event of developing panic-like symptoms. The individual with such type of phobia thinks that he/she could be embarrassed due to panic symptoms in the situation from which he/she cannot escape before being noticed. Situations which are avoided by persons who have agoraphobia include public transport, being in a crowd, etc. The individual could, however, be in those situations without distress if a trusted person accompanies him/her.

Anxiety reaction is also a characteristic symptom of disorders which are not classified in the category of anxiety disorders, such as obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

The mental health literature recognizes many distinct types of anxiety and related problems. They may sometime co-occur and some of their symptoms overlap. However, treatment principles are very similar across the range of different types. Rather than focusing on the different types, we will focus on assessment of three main decision points that will have an influence on treatment:

- Level of dysfunction – anxiety problems vary in the number and intensity of the things feared or avoided, but what matters most is the extent to which they have an impact on a person's day-day-to-day activities and mood. Depression is a common part of anxiety. While suicidal thoughts are less common than in severe depression, they can occur. Another possible emergency is if the anxiety is occurring in relationship to trauma.
- Are there possible medical causes?
- Are there "panic attacks" which occur alone or with other anxiety symptoms?

Module 4 Activity 2: Case study

Purpose: to induce participant to the subject using cases

Instruction: Read the following case in groups and answer the questions asked about it.

Time: 5 minutes

Case

Abebaw is a 30-year-old man who has been in HIV care for some time and has been doing well medically. However, at his last follow-up visit, he told you that he has been out of work for a month; he was dismissed for poor attendance. He says that this has caused him much stress, and he sometimes forgets his ART medications. You ask him what might have changed in his life. He says that he had not told you, but about 6 months ago, the minibus he was riding in was hit by a speeding truck. He was thrown free and was shaken but otherwise unharmed. However, several people on the bus were killed, and he has vivid memories of seeing their bodies trapped in the wreck. Since that time, he has found it difficult to get to work. He can only take the bus if he can go with a friend, and sometimes he cannot get himself to get on the bus at all.

- What is the likely diagnosis of Abebaw?
- Have you ever met someone with similar problem to Ababaw?

4.2. Presentations and detection of anxiety disorders, OCD and PTSD in PLHIV

As with depression, some of the most common ways that people start to talk about anxiety involve difficulties with physical feelings or sleep. This is particularly true with children, who will often say that they have headaches or stomachaches when anticipating something that they fear. We can divide the symptoms of anxiety into physical symptoms, mental symptoms, and behaviors.

Physical symptoms

- Restlessness
- Headaches and stomach-aches
- Inability to relax or fall asleep
    - Too many thoughts in their head to fall asleep, or awaken and then worry
- Panic attacks
    - a fast or pounding heart, chest pains or tightness, sweating, trembling
    - comes on suddenly, often without warning but sometimes triggered by a worry, lasts a few minutes
    - often have several a day
    - followed by anticipation anxiety

Mental symptoms

- Worry, feeling tense or nervous, poor concentration, fear that something dangerous will happen and the patient won't be able to cope
- Hyper-arousal: always monitoring what is going on, over-reactive to sudden changes or loud noises (may be manifested by irritability or sudden anger with changes of plans or unforeseen events)
- Repetitive, intrusive mental processes: praying, counting

Behavioral symptoms

- Not wanting to leave home or a safe place
- In children, not wanting to separate from parent or guardian, refusing to go to school
- Avoidance of things that are reminders of feared objects or situations (for example, taking medications for HIV)
- Speaking only in front of certain people (usually close family members)
- Repetitive behaviors – frequent washing
- Irritability (and in children especially can be manifested as bad behavior)
- Unwillingness to discuss an injury

Questions to ask the patient

Often you have to ask if you suspect that there is an anxiety issue: You can ask screening questions in the following way:

- Are there things that excessively worry you?
- Are there things that you fear excessively? You may have to suggest some examples to get the conversation started. Commonly feared situations include: fear of crowds, fear of open spaces, fear of traveling in cars, fear of speaking in front of strangers, fear of heights, fear of being contaminated (will not touch things they believe are dirty)

Since anxiety problems are so common, it is important to ask how much the problems interfere with function. In ART, it is common for patients to be so anxious that they cannot look at medicine bottles or come to clinic. Some will begin to vomit if they know that a pill is related to HIV treatment. These are common causes of not following through with ART. Other ways to assess severity include asking if the symptoms get in the way of work,

socializing, shopping, school, or relationships with family members. The more severe the interference, the higher priority it is that treatment be offered.

Anxiety can also be related to past psychotrauma – sometimes this seems to be a particularly common cause of unexplained worry about physical problems. Chronic lower abdominal or genital pain is, for example, a common symptom of past sexual violence among women in some countries. Studies in Ethiopia have found that as many as half of all women experience some form of violence during their lifetime. Gender-based violence may be even higher among women living with HIV/AIDS. Sexual assault may be the way that a woman becomes infected with HIV, and women with HIV may be more likely to assaulted.

Most of the time, people will not say readily that they have been victims of violence. It is good to ask about the following:

- Physical or sexual violence between partners
- Sexual assault
- Physical violence by a parent
- Events during war or displacement
- Witnessing violence
- Being bullied or assaulted
- Witnessed or involved in a traumatic event (for example, an automobile accident)

How would you ask about these things among your patients? Which patients might you think of asking? This is a sensitive issue that we will practice in role plays.

Module 4 Activity 3: *Group discussion*

Purpose: to discuss symptoms and signs of anxiety, OCD and PTSD
Instruction: In your groups, list as many possible symptoms as you can in the three main categories (mental, physical, behavioral) within 5 minutes. Highlight or put a mark next to the ones you think are the most common or most important to ask about. Then, go around the group each proposing a way to ask about each of the symptoms for 5 minutes– are they being experienced and what is their impact on the patient's function.

Module 4 Activity 4: *Group discussion*

Purpose: to discuss sources of anxiety among PLHIV

Instruction: In your groups list as many possible sources and situations of anxiety and related disorders as you can for 5 minutes. Then, go around the group each proposing a way to ask about each of the situations and sources you have listed for another 5 minutes.

Module 4 Activity 5: Case study

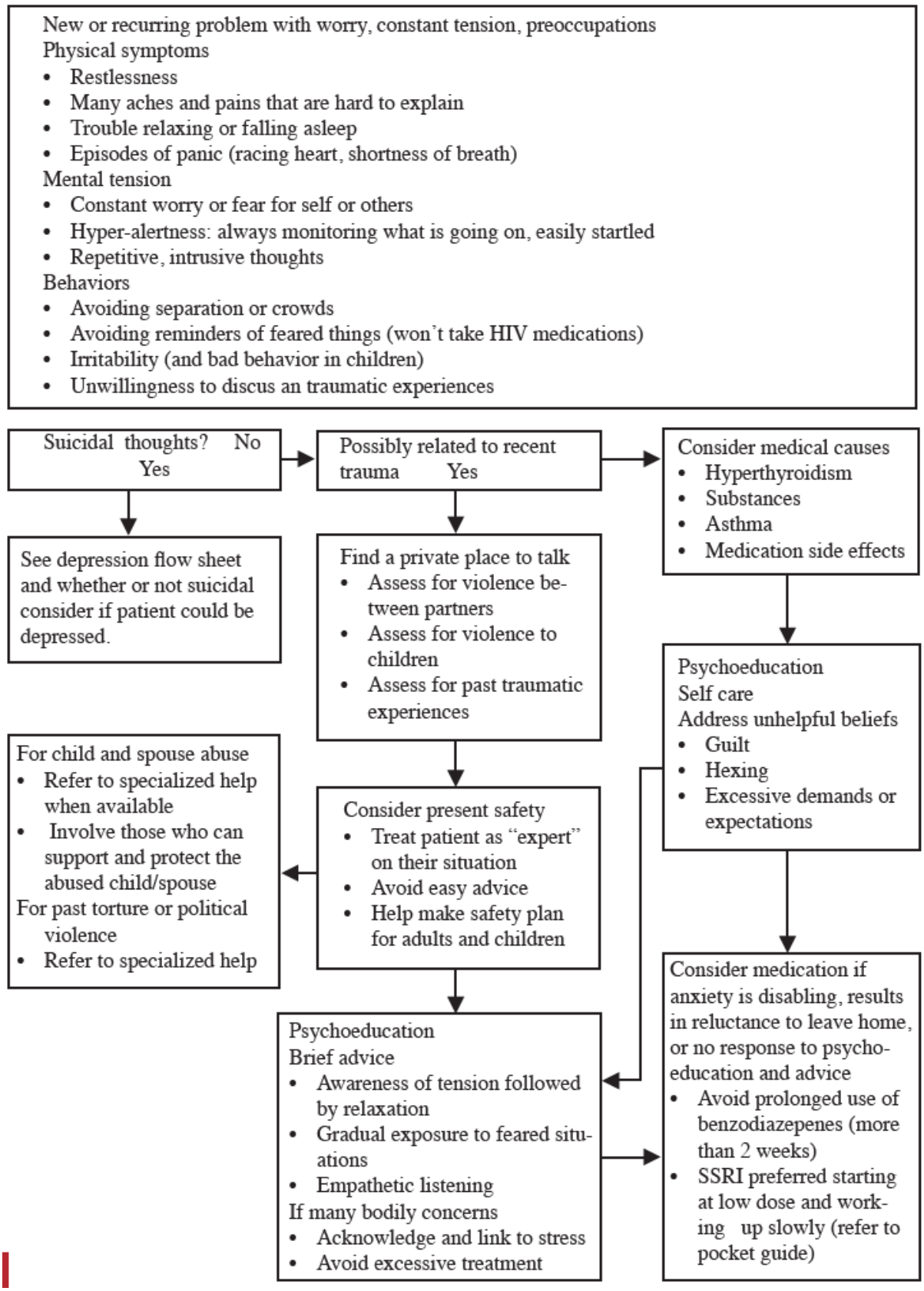
Purpose: to practice approach to make decision based on case of anxiety
Instruction: In your groups read the following short case and decide what you would do next. Do this activity for 10 minutes.

Case
Senayt is a 28-year-old woman who has been coming to your clinic for regular care. She and her husband are HIV positive; they know of each other's diagnosis but you are aware that this has been a source of tension between them. You saw Senayt today and she seemed subdued but otherwise well, and you sent her to the laboratory for blood work. The nurse in the laboratory sent Senayt back to you for re-assessment. When Senayt rolled up her sleeve for the blood draw, the nurse observed multiple bruises, some fresh and some old. The nurse asked Senayt what had happened, and Senayt began to cry.

4.3. Approach to treatment in PLHIV

Module 4 Activity 6: ***Group discussion***
Purpose: to practice using the flow chart
Instruction: In your groups read and discuss the flow chart on figure 4.1for 10 minutes. Then select one person from your group to present results of your discussion to the class for 5 minutes.

Figure 4.1: Anxiety, OCD and PTSD



One way to think about anxiety and related problems is to divide them into four main groups. Although treatment has much in common, there can also be specific treatments for each kind
1. Anxieties and worries not related to psychotrauma
2. Anxieties and worries when there seems to be a link to psychotrauma
3. Panic attacks
4. Obsessions and compulsions

4.3.1. Thinking through anxiety treatment

1. Function/level of severity

a. Are there real/immediate threats that need to be discussed?
Anxiety problems do not often present as emergencies, but when they occur along with depression they may involve suicidal thoughts, so it is important to ask about. Suicidal thoughts may also occur when someone has suffered a very shameful traumatic event, such as a sexual assault.

See the discussion of suicide in the depression module

Another potential emergency is if the anxiety is related to violence.

- Is there ongoing violence in the home or another form of threat from others?
- Again, this may not be disclosed readily, especially if the patient is not certain about confidentiality or has been threatened with harm if they disclose the trauma. So the approach may include:
    - Find a more private place for the discussion
    - Consider matching gender – in many countries women may not divulge marital or sexual trauma to male providers
    - Hearing the story in an empathetic way is often the most that can be done immediately

What are definitions of and responses to child or spouse abuse in your community?

    - Resist giving advice and ask the patient what they have thought of doing. People often tolerate ongoing violence because there is no obvious easy solution.
    - Offer opportunities to come back to the clinic
    - Refer to community organizations that might be helpful if they are available

b. Impact on function

Anxiety problems can be very disabling. Think about the main areas of people's lives – home, social relationships, work, and leisure.

How do the problems create difficulties in these areas?

How would the person's life be different if they did not experience the anxiety symptoms?How do the problems interfere with caring for or living with HIV? Possibilities include:

- Fear of death or illness triggered by looking at ART medicine bottles, trying to swallow pills, or coming to clinic
- Fear of medications being discovered at home

2. Could there be a medical condition producing the symptoms?

Some symptoms that are experienced by patients as anxiety involve medical conditions or substance use.

- Hyperthyroidism
- Asthma or other conditions that make it hard to breath
- Using too much coffee or khat
- Medication side effects
    - Theophylline or other medications given for asthma
    - "Akathesia" – a disturbing feeling of anxiousness and not being able to stay still that can be a side effect of medications (haldoperidol, chlorpromazine, others) used for thought problems

3. Are there panic attacks?

Panic attacks are sudden episodes that have both physical and emotional symptoms. Physically, there is usually a feeling of being short of breath, of a rapid heart-beat, and often sweating or shaking. Emotionally, there can be a feeling of intense fear, or even that the person is about to die. Panic attacks can be "triggered" by a thought or situation, or they can happen without any apparent trigger. They usually last a few minutes and then fade away. One complication of panic attacks is that people may be afraid to leave home or some other safe place because they fear having an attack in public, where they may not be able to get support or where they will feel embarrassed.

Try to estimate the frequency of attacks and whether fear of having an attack is keeping the individual from going out or doing day-to-day activities. If not too severe:

- Describe the condition, re-assure that it is more like a medical problem, the body over-reacting to a thought about harm, talk about the relationship with stress and worry.
- Identify current stresses and worries and how to approach them
- Teach relaxation and other self-care skills (see below)

If the attacks are frequent and especially if they are "un cued" – that is, the person doesn't have an idea of what worries trigger the attacks, consider:

- Treat with a medication if available to try to suppress the attacks (see below)
- Consider referral for exploring how to treat the related anxiety problems.

4.3.2. General treatment for most anxiety problems

1. Psycho-education – this is a first and most important kind of treatment for all mental health problems – helping people realize that their condition is common, treatable, and not something to be ashamed of.

- These sorts of problems are very common
- It is not a form of weakness – our bodies are designed to have these sorts of reactions
- Though most of these problems will not vanish, they almost always get better, though it can take time

2. Teaching skills to reduce the effects of stress is the most effective relief. Help people become aware of when they are anxious and what seems to provoke it. This seems obvious but anxious behaviors can be a habit and not noticed.

- Anxious people may always be trying to do things too fast or doing too many things at the same time.
- Anxious people may always holding their body in a tense position, clenching their fists or jaw
- For some people, impulsively eating is a sign of anxiety (or smoking a lot of cigarettes)

So when the patient is aware of being anxious or of cues to anxiety, try a method of relaxation:

- Take a few slow, deep breaths
- Have a motto or something to think about that reminds them to be calm
- Count slowly to 10 and then continue with whatever they were doing

3. Try "active coping" - If there is a feared issue or thing, try to work on dealing with it rather than avoiding (but all the while acknowledging that it's hard).

- Think of who can be a role model or partner
- Try gradual and supported exposure to the feared object or situation, coupled with relaxation. At each step, do the activity over and over until it's comfortable.

  For example, if someone is afraid to get on a bus, first spend some time looking at the bus go by, trying to stay calm. Next, talk to the driver or conductor without getting on. Then, if possible, get on the bus and get off before it moves on. Then, go for a short ride accompanied by a partner, and finally, a short ride alone.

  For children (or even adults), reward brave behavior

4. Suggest a medication if the symptoms seem severe (see below).

Anxiety related to fear of HIV disclosure (or of other stigmatizing issues)

Many people with HIV, and other stigmatizing experiences or conditions (for example, experiences during the reign of the Derg) live with the fear of what would happen if others

were to find out. It is not always clear what is the right thing for them to do in these situations. Sometimes it seems that disclosure, at least to partners and close friends, would be of comfort and reduce anxiety, but the consequences of disclosure can't always be predicted.

In HIV care, fear that the doctor will insist on disclosure is one of the more common reasons patients don't come back for care. As with other forms of trauma, this is a situation in which good communication skills can help:

- listen to and empathize with the patient's concerns, and especially the difficulty of deciding about disclosure
- get permission from the patient to give information – the risks of non-disclosure, the possible benefits – but give information in a neutral way, and don't expect a decision right away

Approach in PLHIV:

1. Try to get an idea of the waxing and waning of severity over time. People often seek help when the condition is at its worst. If, over time, the symptoms are generally not too severe:

    a. Describe the condition, re-assure that this is more like a medical than mental illness, talk about relationship with stresses.
    b. Identify current stresses, think about how to try to reduce them.
    c. Teach relaxation and other self-care skills.
2. If relatively severe, consider referral for initiation of medication and specific cognitive treatment. If referral is not available:

    a. The medications noted below may be at least partially helpful.
    b. Trying the gradual exposure method described above may also work if there is a helpful partner and coach. The "target" of the method, this time, is the intrusive thought or impulse. For brief time (a few seconds) and then longer periods, and with the help of the coach in trying to relax, the patient should try to resist the thought or impulse (for example, needing to clean the hands).

Module Activity 7: Case study

Purpose: to practice approach to decision making using the flow chart
Instruction: In your groups, you will be provided with one or more of the cases given below. Read and discuss in your groups for 5 minutes. Use your training and the flow chart to reach a decision about what you might need to do for the patient.

Case 1

Almaz is a 45-year-old woman who presented for evaluation of her “nerves”. She described herself as a lifetime “worrier’. She worried about everything -- her health, physical appearance and her cooking skills. The problem had worsened in the last two years. She acknowledged feeling keyed up, sleeping poorly, experiencing daily headaches and tension in her muscles. Over the last three months her anxiety and irritability have had a negative effect on her marriage and her relationship with her two children.

Case 2

A 26-year-old woman presents to the emergency department in an acutely distressed, nervous state. The emergency department staff is unable to calm her down or gain an adequate history from the patient. She complains of terrible anxiety. She is sweating a lot, tachycardic, and her pupils are mildly dilated. She is on no medications.

Case 3

A 23-year-old school-teacher started to experience episodes of excessive fear with tremulousness, sweating, dizziness, and tingling in his extremities. He reported that these episodes occur when he crosses the Kelebet Road Bridge. He is now becoming fearful of crossing bridges and has to take another, longer route to go to his work.

Case 4

Habtamu is an anesthetist working in a general hospital. He came for evaluation because of his obsession with dirt or germs. Whenever he has touched something, for example doorknobs, people's hands, or telephones, he feels contaminated and has to wash his hands excessively with soap many times per day. If he cannot wash his hands immediately, he will develop anxiety symptoms. Lately he stopped shaking hands with people, and has stopped going to operating theatre due to the fear the air is full of germs. He said that, as a health professional he believes that his excessive washing is really unnecessary, but unless he washes his hands he could not control his fear and worry.

Case 5

Abeba was only 16 when she was attacked by three men on the way home from school. They took turns screaming abuse at her and then they each raped her. Finally, one of the men, who was holding knife, threatened to stab her. He would almost certainly have succeeded had a passer-by not intervened. Feeling frightened and humiliated, Abeba did not tell her family what had happened; she made up a story about why she was upset and late coming home. For three months after this event, she was not herself. She felt irritable and depressed, withdrew from her friends and was unable to keep the memories of the attack out of her mind. During the day, she would recall all the unpleasant details while at night she would have terrible dreams of being attacked and would wake up screaming. She began taking a longer route back home from the school as the usual route took her past the site of the attack. She felt as though her emotions were numbed, and as though she had no real future. At home she was

easily startled by a door banging or any loud noise and was always watchful of any person who walked down her street past the house.

4.4. Medications for anxiety

Module 4 Reading assignment 1

Selective serotonin reuptake inhibitors (SSRI's)such as fluoxetine and sertralineare the first choice and thought to be effective for general anxiety, obsessions/compulsions, posttraumatic stress disorder, and panic attacks in children, adolescents, and adults.

- Effectiveness varies and response is not usually 100%
- Onset of anti-anxiety effect can be slow – similar to with depression or even slower.
- Remember to consider interactions with other medications
- Start at low doses (10 mg of fluoxetine, 25 mg of sertraline a day) for people living with HIV and be prepared for patients to worry about side effects or to tell you that they stopped the medicine because of side effects.
- Gradually increase the dose every few weeks to try to get symptom control.
- Doses higher than depression doses may be required to help with anxiety, but you may see some improvement on a low dose, especially if combined with counseling/advice.
- Once symptoms have been suppressed for a period of weeks to months, try a gradual taper.

Tricyclinc antidepressants (TCAs) such as amitriptyline and imipramine have some evidence for effectiveness for anxiety in people living with HIV but patients are usually frightened by the side effects, so willingness to continue is diminished.

- There are more risks of side effects during using high dose

Benzodiazepines (diazepam, lorazepam) can be used for immediate relief (they act within minutes of being taken) but there can be problems with dependence and a worsening of symptoms when stopped.

- Benzodiazepine drugs can also impair judgment and alertness, and they have an additive and sedative effect with alcohol(together they can be fatal).
- They are probably best used when anxiety is keeping someone from a single event such as a visit to a specialist, undergoing an operation so that use will be short term.
- Benzodiazepenes can also interact with other medications – (lorazepam, oxazepam, and temazepam are the safest for use along with ART).

Module 4 Activity 8: Group discussion

Purpose: to discuss about dosage, side effects and drug-drug interactions of anti-anxiety drugs

Instruction: In your groups read and discuss anti-anxiety medications based on table4.1for

total of 15 minutes and take extra 5 minutes to present to the class.

Table 4.1: Drugs for treating anxiety- dosages, side effects, and interactions

Drugs for anxiety	**Dosage**	**Common side effects**	**Interactions**
Fluoxetine	**Adults** Starting dose: 10-20mg a day (morning); wait 4-6 weeks before deciding to increase the dose Usual maintenance dose: 10-40mg/day **Adolescents** **Starting dose** 10mg a day; increase by 5 or 10mg in 1-2 weeks only if no response at all Usual **maintenance dose** for anxiety: 20mg per day **Children over 5 years** (for anxiety) 5-10 mg a day	Headache, restlessness, agitation, Insomnia, GI symptoms, sexual dysfunction. Short half-life of sertraline makes it important in higher doses to divide into more than one dose a day or can get unpleasant withdrawal feelings; sertraline (but not fluoxetine) needs to be tapered rather than stopped suddenly.	PIs (ATAZANAVIR, DARUNAVIR,and LOPINAVIR) had potential to increase the SSRI's level but NNRTIs like EFAVIRENZ had potential to decrease SSRI's level. Be cautious during prescribing SSRI's drugs with ART due to their potential drug -drug interactions and adverse effects of the medications
Sertraline	**Adults** 25- 200mg/day **Adolescents** (for anxiety) Starting dose 50mg a day **Children 6-12** (for anxiety) Starting dose 25mg a day Increase the dose slowly		
Diazepam	**Adults** 5 mg at night for trouble sleeping	Drowsiness, high risk for drug dependence and withdrawal symptoms;	All PI's can increase levels of diazepam and bromazepam, as can

	5 mg two or three times a day Usual maximum 20mg a day **Children** 0.12-0.8 mg/kg/day divided into 3-4 doses; under 5 years old maximum 5 mg a day, over 5 years old maximum 10 mg a day	combined sedation and respiratory depression with alcohol. Bromazepam may have even higher potential to create dependence because of rapid onset of its effects.	(NNRTI) such as efavirenz can decrease levels. INH, intraconazole, ketoconazole can all increase benzodiazepene levels. Benzodiazepenes can increase dignoxin levels.
Bromazepam	**Adults** 1.5-3 mg/day (maximum 6 mg a day; maximum 3 mg a day for elderly or ill patients). **Children**: not recommended		
Amitryptyline	**Adults** Starting dose: 25-50 mg a day given at bedtime Increase by 25 mg a week Usual maintenance dose: 100-150mg/day in single dose at night or divided into two doses; maximum 200mg a day **Adolescents and children:** Not recommended	Dry mouth, sedation, hypotension; risk of overdose	OK with NNRTIs and NRTIs OK with PIs except lopinavir/r, ritonavir, where those medications can raise the level of the antidepressant; so try to use fluoxetine instead. Steroids can increase the level of the antidepressants (including contraceptives) Phenobarbital and carbamazepine can decrease levels.
Imipramine	**Adults** Initial dose 25-50mg at night; can raise by 25mg a week Usual adult dose 100-150 mg at night or divided into two or		

	three doses; maximum 200mg a day **Adolescents and children:** Not recommended		

Module 4 Activity 9: Role play

Purpose: to practice assessing and managing anxiety disorders, OCD and PTSD.
Instruction: Read and discuss one of the cases assigned to your group by the facilitator for 5 minutes. Then, within your groups take turns being the patient, clinician, and an accompanying family member and do role play for 10 minutes.

Case 1
Mengistu is a 32-year-old engineer working as private contractor in Addis Ababa. His work takes him to different construction sites in the country. He is not married yet. He has been sick for the last six months. He admits to a growing problem with focusing his attention on his work and concentrating while he makes designs. His stomach has been the greatest source of consistent trouble to him. His symptoms include a lack of appetite, heartburn, frequent headache and stomach bloating. He worries too much for trivial things, and become easily irritable. About a year ago, in one of his field trips, he got drunk and had unprotected sex with a prostitute. Since then he is worrying about HIV.

Case 2
A teenager has headaches and stomach aches many mornings and does not want to go to school. She worries a lot about her schoolwork, and is afraid that she will not do well on her exams. Her parents are starting to get irritated with her because many mornings there will be a "scene" before she is ready to go to school.

4.5. Follow-up and monitoring

Anxiety problems tend to be chronic. They get better and worse over time, often in response to general life stress or re-exposure to trauma. Thus, even after current symptoms are improved, it is important to anticipate upcoming challenges and expect that there will be relapses.

If the treatment provided is psychosocial, then frequent visits can be helpful to go over relaxation skills, to provide support, and to consider if medication would be helpful.

If the patient is taking a medication for anxiety, initially they can be seen every 2-3 weeks to adjust the dose. Once they are feeling better, they can be seen every few months. Tapering the

medication can be attempted after a few months of reduced concern.

It can be important to keep up good, open communication during treatment for anxiety – it is likely that patients will share additional details and problems that they did not feel comfortable talking about initially.

4.6. Referral criteria

- Severe, incapacitating anxiety symptoms persists after 6 weeks of treatment
- Suicidal ideation persists
- Side effects from medication are not tolerable
- The patient appears to be in immediate danger from someone else
- There is co-occurring drug or alcohol abuse

Module 4 Activity 10: *Discussion*

Purpose: to discuss on challenges anticipated about follow up and referrals

Instruction: Raise for discussion anticipated challenges and suggest practical solutions regarding the arrangement of follow-ups and making referrals to specialists.

Module 4 Activity 11: *Reflections*

Purpose: to address participant concerns

Instruction: Forward any questions or comments about the module

Have you answered the questions raised in activity 1?

4.7. Module Summary

- The psychological symptoms of anxiety include tension, fear of going crazy, worry, panic, fear of dying, feelings of unreality, fear of losing control
- The physical symptoms are trembling, breathlessness, light headedness, dizziness numbness, tingling sensation, nausea, stomach pains, heart pounding, muscle tension, and sweating
- Anxiety disorders are classified into many subtypes based on the various characteristics of anxiety response.
- A number of medical illnesses can cause anxiety symptoms. Anemia, endocrine dysfunctions, Vitamin B_{12}deficiency, chronic infections, cerebrovascular diseases, alcohol and drugs are some of the conditions.
- Anxiety disorders are common in HIV infection and there are certain periods in the course of the HIV/AIDS progression with increased risk of developing anxiety disorders.

- Effective treatments for anxiety include both pharmacologic and non-pharmacologic measures.
- Relaxation methods, graded exposure to feared situation, positive thinking approaches, structured problem-solving strategies,exposure and response prevention are some of the non pharmacologic treatments of anxiety.
- Anxiety problems tend to be chronic and therefore long term follow-up and monitoring should be instituted.

Module 5: Substance use disorders

Duration: 100 minutes

Module description: This module is intended to help the training participants in recognizing substances of abuse, differentiate between problematic and non-problematic use of substances, to identify and manage when there is problematic use of substances in PLHIV.

Primary objective: At the end of this module participants will be able to manage problematic substance use in PLHIV.

Enabling objectives: at the end of this module, participants will be able to:

- Apply screening questions about substance use when indicated;
- Identify medical and mental health symptoms with substances that require urgent treatment;
- Apply assessment for relative level of use/ risk;
- Provide brief counseling, including recommendation to quit or cut back, strategies to quit or cut back

Outline

5.1. Introduction
5.2. Background on the most common substances used in Ethiopia
5.3: Etiological factors of substance related problems
5.4. Presentations of problematic substance use in PLHIV
5.5. Approaches to treatment of problematic use of substances in PLHIV
5.6. Follow-up and monitoring
5.7. Referral criteria
5.8. Module Summary

5.1. Introduction to the module

Module 5 Activity 1: ***Individual reflection***

Purpose: to assess participant level and to stimulate
What are psychoactive substances?
When do we say substance use is problematic?
Time: 5 minutes

Substance use problems are the most prevalent of mental health problems – even more prevalent than depression, especially if one considers nicotine (smoking). In this module we talk about five commonly used "substances" – alcohol, tobacco, marijuana, khat, and inhalants. Other substances are used in Ethiopia, but these are the most common.

Intravenous substance use is relatively uncommon in Ethiopia. It is important to note, however, that in other countries (such as the USA), use of intravenous drugs (such as heroin) is a major source of HIV transmission. HIV can be transmitted through sharing or re-use of needles and syringes, using contaminated equipment to prepare drugs for injection, or sexual activity with IV drug users who have become infected with HIV.

Substance use is defined by the use of one or more of the 11 designated classes of pharmacological agents including alcohol; amphetamines or similarly acting agents; caffeine; cannabis; cocaine; hallucinogens; inhalants; nicotine; opioids; phencyclidine (PCP) or similar agents; and a group that includes sedatives, hypnotics, and anxiolytics. Some of the drugs are illicit (meaning it is illegal to use them) such as cocaine and opioids such as heroin; while others are licit (meaning it is not illegal to use them in most countries) such as alcohol, caffeine, nicotine, etc.

Addiction (or dependence) is a state where the brain and body have adapted to the use of the substance to the point where it is difficult to stop or even cut back on intake. When users try to stop or cut back, they experience strong feelings – and sometimes, physical illnesses – that compel them to resume use. For many people, addiction also means that they need more and more of the substance to feel its effects or avoid the ill effects of stopping (this is called "tolerance").

Chat and alcohol use is linked to unprotected sex, putting young people at risk of unwanted pregnancy, abortion and HIV/ ADIS infection (United Nations and drug abuse control *et al*., 1987). Several studies indicate that substance use among Ethiopia adolescents is considerably rising (Wechsler) Now days, alcohol and chat are widely consumed among high school and college students in Ethiopia. Of the young segment of the Ethiopian population, college and university students are the most at risk of using alcohol and other substances such as chat and tobacco. Most often, stimulant medications are increasingly used by college and university students as a means to improve academic performance (Kassaye*et al*., 2011).

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This module introduces detection and treatment of problems associated with problematic use of substances.

Module 5 Activity 2: Case study

Purpose: to induce participants to the subject
Instruction: In your groups, read the following cases for 2 minutes each and answer the questions given below. Do the activity in a total of 10 minutes.

Case
Demisse is a 40-year-old man who works as a delivery truck driver. When you ask, he tells you that some nights after work he will leave the truck at the depot and stop on the way home to drink several bottles of beer with friends. Then he walks the rest of the way home. Once, he stumbled in the dark, fell, and had a bad cut on his head. His wife is angry that he spends money on beer that she feels they need to buy clothes and books so that their children can attend school. He told you that when he comes home after drinking he sometimes falls asleep without taking his evening dose of ART medications.

- Have you ever met or heard about someone like Demisse?
- What do people assume are the causes of these sorts of problems?

5.2. Background on the most common substances used in Ethiopia

5.2.1. Alcohol

Alcohol is dangerous for several reasons. In the short term, it impairs judgment, increases risky and sometimes violent behavior, and often uses up money that would otherwise go to important household needs. In the long run, it can have many serious medical effects, the most serious of which is lethal damage to the liver.

Harm from drinking can occur in the absence of dependence

- Most of the people who are harmed by and who harm others through drinking are not "dependent"
- These people are frequently not recognized as having an alcohol problem

ICD definitions are useful in thinking about the level of treatment needed

- Hazardous use: creates risk to physical or mental health by making other conditions worse (perhaps through not taking medication), impairing judgment, making it more likely that someone will engage in high risk behaviors (sexual, driving, harmful social relationships)
- Harmful use: already see some damage to health (physical or mental) or to others.
- Dependence/addiction: strong desire to drink, difficulty controlling use, continued use despite harmful consequences, priority to drinking over other activities, increased tolerance, physical withdrawal.

"Early" detection and intervention seem to be effective ways of helping people before they

get to the dependent stage or suffer serious harm. Again, you don't have to be dependent to be harmed. For example, many young drinkers, especially in low-income communities but across the economic spectrum, do not drink constantly and thus don't develop dependence. But they will drink very large quantities of alcohol periodically at social events (sometimes to quell anxieties about meeting others). The resulting disinhibition can lead to risky behavior, and the speed with which they drink can lead to acute alcohol poisoning, with death resulting from passing out and not breathing, striking their head, or choking on their vomit.

5.2.2. Cannabis/marijuana

The marijuana that is smoked comes from the tops and leaves of the plant *Cannabis sativa.* Hashish is a more concentrated resinous form of the plant. Marijuana can also be brewed as a tea or mixed into food. The extent of its effects depend on the concentration of the main active ingredient, THC (delta-9-tetrahydrocannabinol), so that (like khat) marijuana from different sources will have greater or lesser effects. In some countries, the marijuana may be sprayed with other chemicals or drugs to enhance its effect (or make up for low-concentrations of THC).

After smoking, the onset of effects is within 1-3 hours. Users experience

- relaxation
- increased appetite and thirst
- difficulty concentrating
- problems with learning and memory
- loss of coordination
- poor judgment, inappropriate social behavior
- at higher doses there can be hallucinations

Many of these effects are mild or subtle, and regular users enjoy the feeling of relaxation and tolerate or partially compensate for the negative effects. It is not uncommon for users to smoke marijuana throughout the day nearly every day that they can get a supply.

There is a relatively mild withdrawal syndrome experienced by some after prolonged or frequent use. It is uncomfortable but not life-threatening. Individuals feel mildly ill and experience difficulty sleeping, irritability, low mood, and nervousness.

One of main risks of using marijuana seems to be its possible role in precipitating or exacerbating psychotic disorders. It's thought that marijuana use may increase the risk of becoming schizophrenic in people with a family history or other risk factors. Use of marijuana also makes management of schizophrenia and bipolar illness more difficult because it contributes to mood changes and impairs the ability to take medication regularly.

5.2.3. Khat/Chat

Khat is derived from a plant that is widely grown in east Africa. It contains chemicals (cathinone and cathine) that are similar to the stimulant amphetamine. Cathinone, the main chemical thought to be behind its effects, breaks down quickly after the leaves are picked, so there is a premium on chewing fresh leaves. In many areas, khat is picked in the morning and then rushed to market for sale and use later in the morning or early in the afternoon. There is a synthetic version, methcathinone, sometimes called goob, crank, or CAT.

Khat is not illegal in Ethiopia and it is readily available and easily grown. It is widely used to try to maintain alertness and reduce fatigue or avoid falling asleep, and by some to increase concentration during prayer. Some people also think that it increases sexual potency. One survey in rural Ethiopia estimated that about a third of adults used khat (and about 10% of pregnant women), other surveys have found rates among men at 50-75%. Chat is often chewed in social settings over the course of few hours.

When khat is chewed there is a three-phase set of reactions. Initially, after about an hour, khat causes mild euphoria with feelings of alertness and excitability. In the second phase, there is increased talkativeness and sociability, but accompanied by impaired ability to concentrate and make decisions. Sometimes there are poorly connected thoughts ("flight of ideas"). In the third phase there can be low mood, irritability, loss of appetite, and difficulty sleeping. Chewers typically will report being tired the next morning. Symptoms seem to fade a few days after stopping.

Problems with khat use, especially at higher doses:

- Subsequent use of alcohol, benzodiazepenes ("Roche"), or marijuna to self-treat the irritable, sleepless final phase (if there has been heavy use of benzodiazepenes consider tapering over 2-3 months if possible. If there is evidence of acute withdrawal from benzodiazepines or alcohol, seek a consultation and initiate treatment as for alcohol).
- Development of thought problems, including grandiose delusions, hallucinations, and paranoia. With prolonged use some people report experiencing a kind of waking but dreamlike state in which, as they go about their business, they see or hear things that others do not experience. This can happen even when they are not actually chewing.
- Constipation, poor sleep, loss of appetite, blurred vision, dry mouth, and poor sexual function.
- Khat use is thought to be a contributor to road accidents because drivers who use it to stay alert develop impaired judgment and irritability.
- In some countries, use is so constant, especially among men, that it becomes a major drain on family income.

Khat does not seem to cause physical dependence – that is, there do not seem to be severe withdrawal effects if someone suddenly stops using it. Chronic users may experience some fatigue or nightmares when they stop. However, there is psychological dependence; users like how it makes them feel and are drawn to continue use. There are also strong social cues to use khat – in many places it is a regular part of the social routine.

Khat also is associated with some medical risks – it is thought to be a cause of oral cancer, stomach ulcers, and can cause low birth weight or spontaneous abortion when used by pregnant women.

Important considerations for PLHIV

- Consider khat as a cause of symptoms when evaluating someone for a thought disorder
- Consider chat as a contributor to poor sleep and next-day fatigue
- There do not seem to be any "treatment" programs designed specifically for khat; the general steps outlined below to help people overcome cravings or cut down on use may be effective
    - It may be easier to help reduce use among truck drivers and others for whom use is directed at maintaining alertness versus people whose use is predominantly social

5.2.4. Tobacco

People with mental health problems are more likely to smoke than the general population. Smoking is a health hazard to the smoker and to those around him or her. Risks to others come from smoke and, with cigarettes, the risk of fire if the person smoking falls asleep before a cigarette is put out.

Smoking increases the risk of developing a number of health problems including asthma, heart disease, and a number of different forms of cancer. Use of shisha is thought to be even more harmful than cigarette smoking because, despite the use of a water filter, the smoke inhaled is stronger than the smoke of cigarettes. Shisha is sometimes also mixed with marijuana.

There is both psychological dependence and physical nicotine dependence with an unpleasant (though not dangerous) withdrawal syndrome.

5.2.5. Inhalants

A range of readily available, volatile solvents and gases are used as inhalants including aerosol sprays, butane gas, petrol, glue, paint thinners, solvents, and amyl nitrite ("poppers"). In many parts of the world, these substances are widely used among children living on the street or not in families. They are inexpensive and easy to purchase (or to take from places of work), and produce powerful and rapid effects.

- They have a combination of sedative and hallucinogenic effects.
- They can be acutely fatal – for some of the chemicals, nearly any exposure would be considered an "overdose"
- Most are capable of causing irreversible brain and liver toxicity.

Module 5 Activity 3: ***Group discussion***

Purpose: to list manifestations of harmful use of substances and dependence on substances
Instruction: In your groups, list as many possible symptoms as you can in the two main categories, namely 'harmful use' and 'dependence' on substances. Highlight or put a mark next to the ones you think are the most common or most important to ask about. Then, go around the group each proposing a way to ask about each of the symptoms – are they being experienced? And, what is their impact on the patient's function? Do this activity for 10 minutes.

Module 5 Activity 4:*Group discussion*

Purpose: to discuss on the impact of substance use on HIV
Instruction: In your groups, discuss how substance abuse can influence acquisition of HIV and adherence to treatment for 5 minutes. Then select one participant from your group to present to the class for another 5 minutes.

5.3. Etiological factors related to substance use problems

There three major ethological factors of substance use problems.		
Biological Factors	Psychological Factors	Social Factors
➢ Family history of substance use ➢ Comorbid psychiatric disorder ➢ Comorbid medical disorder ➢ Reinforcing effects of drugs ➢ Biochemical factors ➢ Withdrawal effects and craving	➢ curiosity need for novelty ➢ poor impulse control ➢ High sensation seeking ➢ low self-esteem ➢ poor stress management ➢ child hood trauma/loss ➢ relief from fatigue ➢ escape from reality	➢ Peer pressure ➢ Modeling ➢ Ease of availability of substance ➢ Strictness of drug law enforcement ➢ Interfamilial conflict ➢ Poor social support ➢ Rapid urbanization ➢ Perceived distance with in the family

5.4. Presentations of problematic substance use in PLHIV

People who drink (or use other substances) often appear quite normal. One of the big difficulties helping substance users is that they minimize the extent to which it causes them problems, and they rarely spontaneously volunteer that they drink or smoke (tobacco or marijuana). This is especially the case in cultures where smoking or drinking are stigmatized

or go against religious beliefs and culture or gender norms. Thus, asking patients about substance use seems to be the best way to find out about possible problems.

Depending on how often medical providers ask about substances, there may be worry that patients will take offense – especially patients that seem to be at little risk. It can be helpful to say something like, "we ask everyone these questions."

Being called a "drunkard" is a very serious and shameful thing in Ethiopia and many patients will not think that asking about drinking is something that should happen at a medical visit. So think about how you can approach this subject tactfully, and make a case that it is something important to discuss.

- For alcohol, the "CAGE" questions have use to assess problematic use, including dependence. The letters CAGE stand for "cut down, annoyed, guilty, and 'eye opener'," the key concepts of the four questions when asked in English. The questions don't have to be asked using exactly these words:
    - Have you ever thought you should cut down on your drinking?
    - Have you ever been annoyed by other people's criticism of your drinking?
    - Have you ever felt guilty about your drinking?
    - Do you drink alcohol as an eye opener?
- If the person answers yes to any of these questions, consider asking:
    - Are there things that you have done while drinking that you later regretted?
    - Have you ever driven a car, walked along a busy road, operated any kind of machinery while drinking?
    - Have you ever gotten into any social or sexual relationship while drinking?

Identifying level of harm/severity: ask about whether the substance use interferes with these aspects of the person's life.

1. Social – does it disrupt relationships; has it caused embarrassing behavior? Has the individual been engaged in violent behavior while intoxicated?
2. Physical – has the person been injured while under the influence of a substance, or is there evidence of medical consequences (for example, medical problems from smoking or drinking, getting into a fight while drinking)
3. Economic – is the substance use diverting money needed for other causes, or interfering with work?
4. Legal – has there been involvement in illegal acts to obtain substances?
5. Withdrawal: does client have hand shaking when not taking alcohol?
6. Tolerance: has the client increased the amount/strength of substance in order to get the desired effect?

It a patients has withdrawal and tolerance; he might be suffering from alcohol dependence and has to be managed accordingly.

Special considerations for adolescents

1. Experimentation is common and the majority of youth who try substances do not go on to use heavily or at all; non-punitive counseling about the risks of substance use is probably most helpful.
2. As noted above, adolescents are more likely to engage in "binge" use of alcohol: that is, they don't necessarily use often but when they do, it is a lot and associated with high risk behaviors (in the case of alcohol there can be a risk of fatal alcohol poisoning – loss of consciousness and respiratory depression or aspiration – from rapidly drinking large quantities).
3. In the setting of comprehensive HIV care, treatment and support care, there is worry about the relationship of substance use and sexual exploitation of some kind – it's not unusual for young people to exchange sex for a substance supply, or to be more vulnerable to exploitation after using substances.
4. Past inhalant use may be hard to detect, but youth who are examined for acute lethargy or changes in consciousness may smell like the material that they inhaled.

Module 5 Activity 5:*Group discussion*

Purpose: to practice using the 'CAGE' questions
Instruction: In your groups write down the "CAGE" questions for alcohol; ask a partner from your group the questions and then say what you would ask in addition if any of the answers were "yes." Say how you would ask about other substance use a) for a patient you had just met; b) for a patient who has told you in the past that they drink alcohol or use khat. Do this activity for 5 minutes.

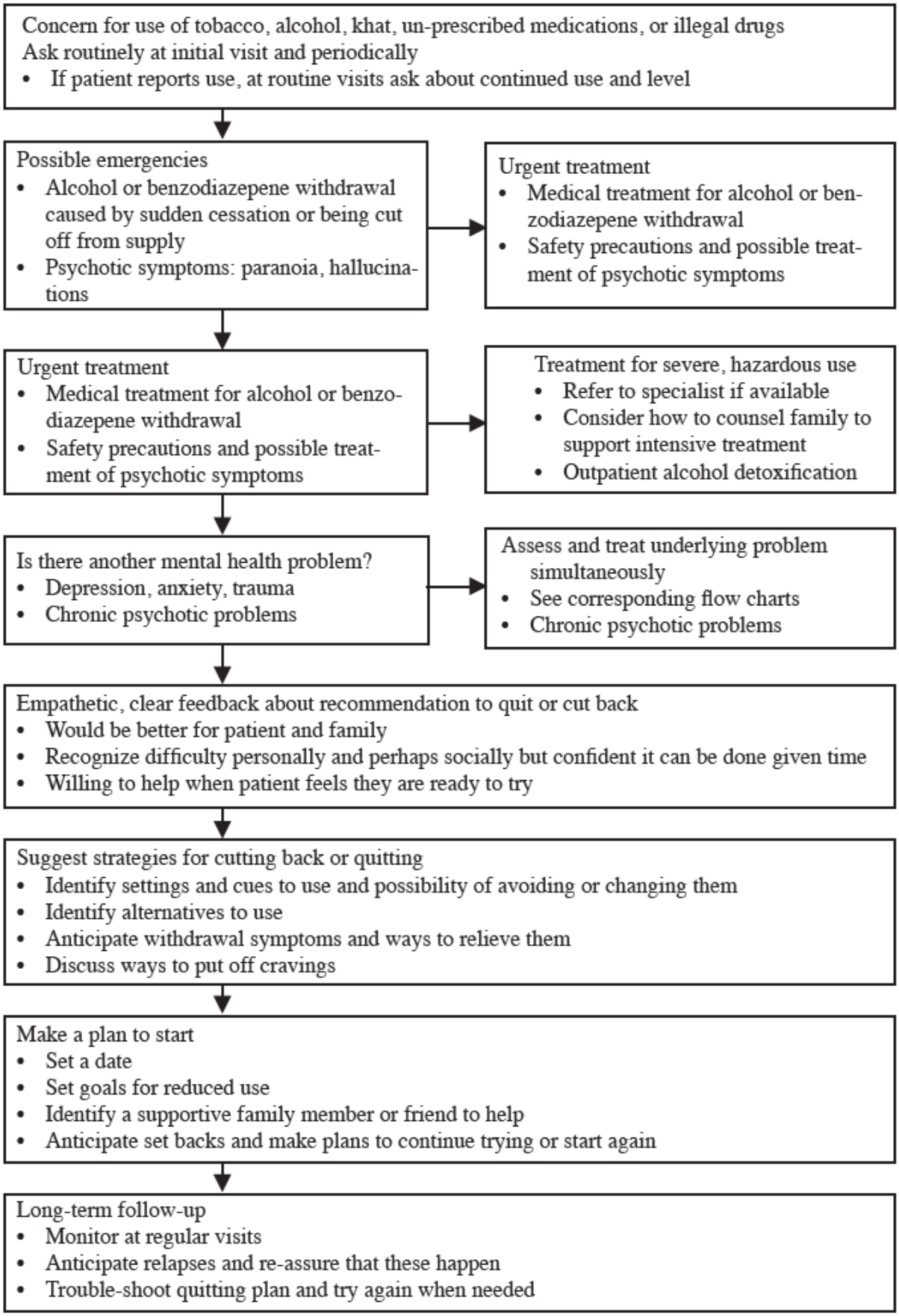
5.5. Approaches to treatment of problematic use of substances in PLHIV

5.5.1. General approach to treatment

Module 5 Activity 6: ***Group discussion***

Purpose: to practice using the substance use flow chart
Instruction: In your groups read and discuss the flow chart on figure 5.1 for 10 minutes. Then select one person from your group to present results of your discussion to the class for another 5 minutes.

Figure 5.1: Substance use flow chart



5.5.2. Emergency situations

Perhaps with the exception of cigarettes, all substances can lead to behavioral "crises" where people become agitated, irrational, and sometimes violent or suicidal. See the "thought problem" module and the suicide section of the depression package for thoughts about management. In general, trying to keep the person safe and calm until the crisis passes is all that can be done.

The main exception to this approach to treatment is if you suspect that someone who has chronically used a lot of alcohol (probably on a daily basis) has suddenly stopped drinking. This may happen because they run out of money, have some social crisis that cuts them off from their supply or drink, or become ill and cannot drink. Alcohol withdrawal is a serious medical condition and can lead to fatal seizures.

Emergency care for alcohol withdrawal

Individuals who drink on a daily basis are at risk for dependence.

- Signs of withdrawal include hands shaking, nausea, sweating, feelings of anxiety, increased heart rate and blood pressure, and can include visual and tactile hallucinations. Symptoms usually start within 24-48 hours of stopping drinking but can start as long as five days later.
- Seizures are an ominous sign.
- Watch pulse and blood pressure; if they begin to be elevated and if there are other symptoms:
  - Treat with benzodiazepenes since they target the same receptor as alcohol
    - diazepam or lorazepam are drugs of choice because don't require metabolism by the liver
      - lorazepam dose 1 mg every 2 hours as needed to control symptoms for first day, then same total daily dose (usually 6-10mg) divided every 4 hours the next day, then slowly taper over 3-5 days watching pulse and blood pressure
      - diazepam 10 mg every 3 times per day and taper gradually over 5-7days - Alcoholics are also at high risk for dementia from nutritional deficiency
    - Give thiamine 50-100mg IM or IV (or 100mg orally with 1mg folate orally) as soon as possible and before any IV fluids that might contain glucose then continue oral thiamine 100mg/d for 7 days followed by vitamin B complex for 60-90 days.

A second exception involves depressed consciousness from acute alcohol poisoning or inhalants. These individuals need close monitoring to maintain their respirations and blood pressure.

5.5.3. Care for hazardous or harmful substance use in primary care

It is important to ask about substance use routinely, at least at intake/initial evaluation. This is not just for detection – It helps to create the "norm" that it would be good to stop and makes it a reasonable topic for conversation in the medical setting. There is good evidence that brief counseling is effective for lesser severity substance use. Take an empathetic and non-judgmental but clear stand.

1. It would be better if you cut down or abstained from using these drugs
2. I understand the difficulty of doing it but I am optimistic that you can succeed
3. I am willing to help you make plans and provide some ideas on how to do it
4. I am willing to help you think about where this falls in relationship to other goals and priorities

Based on what you have found out when getting the history of use:

1. Give empathetic but clear feedback about the risk of harm to themselves or others.
2. Clearly state that the person should make a change in their use, but don't be judgmental – that is, you should make a change, but not because you are a bad person, just because, given what you have told me about the consequences, it is the right thing to do.
3. Suggest a range of strategies that the person might use to change their behavior. Some examples include:
   - Identify the settings where someone is at high risk to drink or use the substance and plan to avoid them. Who is it with, where does it take place?
   - When there is use, what kind of rules can the person make to limit their consumption?
   - What alternatives to use might there be?
   - Is there a family member or friend who will help you cut back?
4. Ask the person to set a goal for cutting back: when will it start, what will be goals for amount used at any one time or in a week?
5. Provide advice on reducing or ceasing use – all of the substances discussed (including smoking) have unpleasant physical and emotional sensations associated with quitting
   - Recognition of withdrawal symptoms and advice for coping, such as using a toothpick for desire to smoke
   - Try putting use off for even 10 minutes – sometimes a craving will pass
   - Suggest other strategies for managing stress or for feeling comfortable in social interactions (frequent reasons cited for smoking, drinking, and use of marijuana).

Module 5 Activity 7: ***Case study***

Purpose: to practice managing a patient with substance use disorder
Instructions: The facilitators will provide your group with selected cases from the cases below. Review each of the cases provided to your group for 5 minutes noting which details are present in the case description and what other questions you might ask the patient or family. Then use the flow chart to reach a decision about what you might need to do for the patient. Describe your treatment or counseling of choice. Make sure you think not just about substance abuse but other conditions that can develop along with it or the possibility of complications. Take a total of 10 minutes for each case

Cases

Case 1
A 35-year-old taxi driver is brought to the clinic by his wife. She says that he has been acting oddly at home and claiming that he sees rats climbing the walls. He looks ill and worried. His pulse is 100 beats per minute, his blood pressure is 170/95 mm Hg, and he is shaking and sweating. He says he has not been able to sleep for two nights. He has been a daily drinker since age 19, but, after a near miss on the road where he came close to running down an old woman, he vowed not to drink and has not had any alcohol in the last 3 days.

Case 2
Mimi is a 17-year-old girl who has come for the evaluation of abdominal pain. The nurse thought that she was a little unsteady as they took her weight and signed her in to the clinic. She admitted to smoking marijuana and tobacco that she obtained from "friends."

Case 3
Ato Bedru brought his nephew, Jemal, to the clinic because of a two-week period of unusual and frightening behavior. Jemal is a 25-year-old trader from Wolkitie who has been chewing khat since his early teens. In the last six months, he has increased his consumption. He now chews every afternoon and evening. He lost property worth 5000.00 Birr six months ago. Two weeks ago he stopped going to his kiosk altogether. He is sleepless, restless, talks to himself, and shows suspicion towards his uncle. He is convinced that the property he lost was taken by the police because they were notified by his uncle.

5.6. Follow-up and monitoring

When people are actively using a substance, it is unlikely that you will convince them to stop with a single discussion. Again, using good communication skills to understand their motivation for using drugs or alcohol will help. There is good evidence that patient reminders about the desirability of quitting, and gentle but truthful information about harms, will help people stop.

Once someone has engaged in an attempt to quit, be prepared for relapses. Most people will make several attempts to quit or cut down before being successful. Relapse doesn't mean that the prior plan was bad, but that it may need renewed support and commitment or analysis of new stressors or situations.

5.7. Referral criteria

1. Severe alcohol dependence and withdrawal, or concern that the patient has been drinking heavily and steadily and could experience withdrawal
2. If the patient is suicidal
3. Substance use seems complicated by other mental health problem (anxiety, trauma, depression)
4. Multiple attempts to reduce use with brief counseling and community support have failed.

Module 5 Activity 8: *Role play*

Purpose: to practice assessing and managing a patient with substance use disorder
Instructions: Take turns being the patient, clinician, and an accompanying family member and do role play based on the case given below. The clinician can then consult with colleagues about a possible diagnosis and treatment plan, including what you would do for follow-up. The clinician should then explain the diagnosis and plan to the patient and accompanying family member. Do this for 15 minutes.

Case
You've been talking to Ato Geremew, a patient in his 40's. He is here with his wife. For the last 7-years he has been working as a steward in a local "Tej bet". When he arrives, he is shabbily dressed, smells of alcohol, and he has lots of bruises on his head. He responded vaguely to your question about whether he ever drinks alcohol, but does say that he'd like to cut back. Ask him some other questions that might get at his drinking history, and giving him some advice on how to do it.

Module 5 Activity 9: *Reflections*

Purpose: to address participant concerns
Instruction: Raise any questions or comments based on the module you just covered.
Have you answered the questions raised on activity 1?

5.8. Module summary

- Psychoactive substances are chemicals which, when taken into the body, alter its function psychologically.
- Each psychoactive substance when taken can lead to acute disturbances, like intoxications, or to long-term consequences like harmful use, or dependence which could be psychological and/or physical.
- Alcohol is one of the commonest substance which can cause multiple forms of psychiatric manifestations including delirium, dementia and psychosis.
- Early detection, through rapid screening tools (e.g. CAGE), intervention counseling and drug treatment for specific condition like alcohol withdrawal, and alcohol induced psychosis are the major components of management of alcoholism.
- Adolescents and young adults are more and more affected by cannabis use. Its use can lead to acute delusional symptoms as well as withdrawal symptoms.
- Khat is a milder psycho-stimulant widely used in Ethiopia.
- Khat causes mainly psychological dependence rather than physical withdrawal symptoms.
- There is high comorbidity of substance use and HIV.
- Substance use can complicate the course of HIV disease and adherence to ART treatment is negatively influenced by substance use.
- Apart from emergency management, like in the case of alcohol withdrawal, a long-term treatment approach is the mainstay of combating problematic use of substances.

Module 6: Seizure disorder

Duration: 180 minutes

Module description: This module is intended to help the training participants in recognizing seizure disorder, differentiate between seizures and psychogenic seizures, to identify and manage when there is seizure disorder in PLHIV.

Primary objective: At the end of this module, participants will be able to identify and treat seizure disorder in PLHIV.

Enabling objectives: at the end of this module, participants will be able to:

- Identify seizures by history and if directly observed
- Manage appropriately when a seizure is witnessed
- Identify situations in which some rapid medical intervention is needed for a seizure
- Prescribe an initial medication for seizure treatment and understand when treatment is appropriate
- Educate patients and families about the causes of seizures, their lack of relationship with mental health problems, their treatment, and prognosis

Outline

6.1: Introduction
6.2: Definition, etiology, classification
6.3: Presentation/detection in PLHIV and history-taking at primary health care level
6.4: Management of seizure related emergency situations
6.5: Psycho-education and psychosocial intervention in epilepsy
6.6: Pharmacotherapy of epilepsy
6.7: Specific and comorbid conditions in patients with seizure disorder
6.8: Case management and long-term follow-up
6.9: Referral
6.10: Module Summary

6.1. Introduction

Module 6 Activity 1: Think-pair-share

Purpose: to assess level of participant and stimulate
What causes seizure disorder?
Have you ever witnessed seizures before? describe what you observe
Duration: 5 minutes

Seizures are very common, affecting up to 1 in 100 people, half of whom are thought to have active seizures (had one in the last 2 years) (Berhanu, 2004, 2009). Probably only 10% of Ethiopians with epilepsy ever get treatment. Seizures are even more common among people living with HIV because of the increased risk of infections and stroke associated with the illness.

Seizures are caused by abnormal impulses in a part of brain that change behavior, movements, and consciousness. In many countries, seizures are not considered mental health problems, but traditionally in Ethiopia they have been treated by psychiatrists. However, for reasons that are not understood, people with epilepsy do seem to have a higher prevalence of mental health problems than those in the general population.

Module 6 Activity 2: Case study

Purpose: to induce participants to subject
Instruction: In your groups, discuss the case below and answer the questions provided.

Case
Ato Girma, a 51-year-old chauffeur from Addis Ababa, came with a 2-year history of repeatedly falling down, loss of consciousness and generalized convulsions. Just before falling down he develops a deviation of his head to the right side. When he regains consciousness, he develops a severe headache and transient weakness of the right side of the body. In the last 8 months he additionally has had headaches at other times and marked forgetfulness. He has neither diabetes nor hypertension. There is no family history of epilepsy
Have you ever met or heard about someone like Girma?
What do people think about people with problems like Girma's?
What do people assume are the causes of these sorts of problems?
If people try to help people like Girma, what do they do or suggest?
What gets in the way of getting help for people like Girma?
Duration: 5 minutes

6.2. Definition, etiology and classification

6.2.1. Definition and etiology

Seizure is a clinically condition resulting from the synchronous and excessive discharge of a group of neurons in the brain. Seizure and epilepsy are not the same. Seizure is a single incident, and when 2 or more unprovoked seizures occur in 1 year period it is called epilepsy (Epilepsia (2014) 55- 4, 475–482 Fisher et.al.). The word unprovoked denotes that the seizures should not occur in association with acute neurologic or medical condition, for example acute stroke, acute CNS infection, acute head injury, etc. These conditions could lead to increased risk of epilepsy after the acute phase is over, which could be months or years after these illnesses.

The clinical presentation is variable depending on the location of the brain affected. Symptoms include alteration of consciousness; motor symptoms, e.g. convulsions, sensory symptoms – e.g. numbness, and/or behavioral and perceptual disturbances.

The commonest acquired causes include perinatal hypoxia/asphyxia, perinatal intracranial trauma, metabolic disturbances, congenital malformations of the brain, CNS infection, alcohol and drug abuse, and head injuries. See Table 6.1

Table 6.1: Causes and beliefs about epilepsy

Cause of epilepsy	Traditional concepts regarding epilepsy
Brain tumor Perinatal injury to brain Head injury Cerebrovascular disorder - stroke Brain infections Alcohol - Chronic intoxication, withdrawal Genetics – familial Hypoglycemia	It is insanity Possession by evil spirits Bewitchment, sorcery It is contagious (especially if you hold or are near someone with a seizure) You can treat it by lighting a match or burning something, or by writing something and erasing it

Module 6 Activity 3: Group discussion

Purpose: to discuss etiology of Seizure
Instruction: In groups, one group lists as many medical causes as they can think of for 5 minutes and the other group lists common beliefs for 5 minutes. Both groups present in class for 2 minutes each. Then, the first group tries to explain "idiopathic epilepsy" to someone in the other group for 3 minutes.
Time: 15 minutes

6.2.2. Classification of Seizures

Seizures are basically classified into three major groups. Generalized from onset seizures are defined as "originating at some point within, and rapidly engaging, bilaterally distributed networks." Focal-onset seizures are defined as "originating within networks limited to one hemisphere. They may be discretely localized or more widely distributed. A third group includes where a seizure is of unknown onset. The two major types of seizures, as well as "Pseudoseizure or psychogenic non-epileptic seizure" will be discussed here (Epilepsia, 2017: 1-12, Fisher et.al.).

1. **Generalized onset seizures:** Generalized seizures resulting in immediate loss of consciousness – once the seizure starts, the person is completely unaware of what is

happening. There are two common types;

Grand mal seizure: It is the most common form of generalized seizure (and the one that most people think of when they hear the term "seizure" is the "grand mal." In generalized onset grand mal seizures it occurs suddenly without any aura symptoms.

A prodromal subjective phenomenon could occur for minutes, hours or days prior to the generalized convulsive seizure. It may be manifested as a change in mood – irritability, depression, or being easily startled.
The seizure itself has three phases that usually last a few minutes.
Tonic phase- tonic contraction sudden cry, tongue biting may occur, urine incontinence
Clonic phase - clonic jerks, frothing of saliva, generalized sweating
Terminal phase - remain unconscious but no convulsion.
In the post ictal phase - headache, drowsiness, confusion state, etc, could occur, while the patients have no memory of the seizure itself.

Petit mal or "absence" seizure - This is another form of generalized seizure which is harder to detect. They usually start in childhood (ages 5-9). In contrast to grand mal seizures, there are fewer visible movements and they last only a few seconds. They can be very difficult to detect. Also in contrast to grand mal seizures, people may remember what happened and they rarely will be incontinent or harm themselves. Clinically:
No aura symptoms
Sudden interruption of consciousness - patients become motionless, stop alking, stare blankly, cease to respond – but only for a few seconds
May have some slight clonic movements- eyelids, facial muscles, fingers, but these are subtle and pass quickly. Sometimes they resemble "normal" actions such as licking the lips or chewing

2**. Focal onset seizures:** Focal onset seizures involving either no loss of consciousness or loss is delayed after the start of the seizure. They are sometimes considered as a cause of odd behavior because they can involve longer (2-3 minute) periods of what can look like "normal" behavior even though the person is not aware of what they are doing and will not remember it. Focal onset seizures can have three components;
• An aura, often accompanied by hallucinations
• The seizure which can involve:
a. Alterations in psychic function- perceptual distortions
b. Motor disturbance – simple automatism like lip smacking, sucking or turning the head
c. Complex automatic behavior – e.g. laughing, running, picking, undressing
• Post-ictal phase – amnesia for the seizure, deep sleep, headache.

Table 6.2: Characteristics of most common types of seizures

Type of seizure	Aura	Activity during seizure	Amnesia	Post-ictal phase
Generalized onset seizure				
Grand mal	None	Tonic-clonic followed by unconscious terminal phase	Yes	Headache, drowsiness, etc.
Petit mal	None	Very briefly (only seconds) motionless, stare, stop responding	variable	None, rarely confused
Focal onset seizure				
with loss of awareness	Can include hallucinations,	2-3 minutes of behaviors ranging from small motions of head or face to complex activities	Yes	Headache, deep, sleep, etc.
Without loss of awareness	No aura	Motor or Sensory or Autonomic symptoms	No	None
Focal- to-bilateral	Brief Motor, Sensory, etc. symptoms	Tonic-clonic generalized, with loss of consciousness	Yes	Headache, drowsiness, etc.

3. Psychogenic seizures: These seizures involving behavior that, to an observer, may look like a seizure but that don't seem to be associated with abnormal brain impulses.

Psychogenic seizures don't fit any of the patterns of generalized or partial seizures described above. Patients with this form of seizure may report odd and often complicated sorts of feeling and hallucinations that go beyond the visual changes that are reported in auras of partial seizures. These may include feelings of floating or that everything that has happened has happened before. They will report jerking or other involuntary movements, but will rarely if ever fall in a way that they are injured or have incontinence. Psychogenic seizures often last longer than generalized or partial seizures. People with psychogenic seizures have often seen someone else have a seizure or have heard them described.

Table 6.3: Psychogenic versus generalized seizures

Clinical feature	Grand mal epilepsy	Psychogenic seizure
Onset	Sudden	Gradual
Eye	Open, upward gaze	Closed
Tongue bite	Frequent	Very rare
Incontinence	Frequent	Very rare
Nocturnal occurrence	Common	Absent

Post-ictal confusion	Common	Absent
Injury due to fall	Common	Very rare
Pupillary reaction to light	Non reactive to light	Reactive to light

Module 6 Activity 4: Group discussion

Purpose: Review types of seizures.
Instruction: In your groups, discuss about the type of seizures and how they differ from each other.

Time: 5 minutes

6.3. Presentation/detection in PLHIV and history taking at primary health care level

Occasionally someone will have a seizure in a clinic or office, but more often they will come or be brought in after having one or more seizures somewhere else. Although there are some tests (notably a brain wave recording -- EEG) that can help with the diagnosis, the most important is getting an account from the patient and someone who saw the seizure. By asking, you are trying to fit the seizure into one of the three major patterns and also thinking about possible causes. Questions include:
Whether there was loss of consciousness or loss of awareness, body jerking all over (generalized convulsion) (versus moment of only some part of the body). This is usually accompanied by urinary incontinence

Whether there is absent-mindedness at other times (possible absence episodes).
Whether there is amnesia for the period that the seizure seems to have occurred (found in generalized seizures)

Whether any other behavioral changes have been noticed (possible partial seizures or psychogenic seizures)

Whether this is the first seizure or if there have been any in the past.

New onset of a seizure disorder outside of the syndrome of a febrile seizure in children raises the concern for an identifiable underlying problem (though ultimately about half of all seizure problems go unexplained).

At least two seizures in the past year on different days and without a cause raises the concern for epilepsy (seizure disorder without a known cause).

Are there neurologic changes, headache, fever, or history of head trauma? These might lead

to the need for more medical evaluation.

Could the patient have taken a poison or is the person taking any medication?

Module 6 Activity 5: Role play

Purpose: practice history taking in grand mal seizure

Instruction: Two participants (one patient, another witness), a third one as health care provider do role play. The health care provider conducts the interview to practice history taking about grand mal seizure.

Time: 10 minutes

A case of first seizure: Several medical conditions can provoke a seizure, and for most of these, some form of urgent treatment can be lifesaving. Causes to consider include:

- Hypoglycemia (especially if a diabetic has taken insulin and not been able to eat)
- Head injury that has caused delayed bleeding inside the head
- Stroke
- Meningitis or encephalitis (including cerebral malaria)
- Alcohol withdrawal
- Hypertension in pregnancy (pre-eclampsia)

Some medications make it more likely that someone will experience a seizure spontaneously. These include some of the antipsychotics.

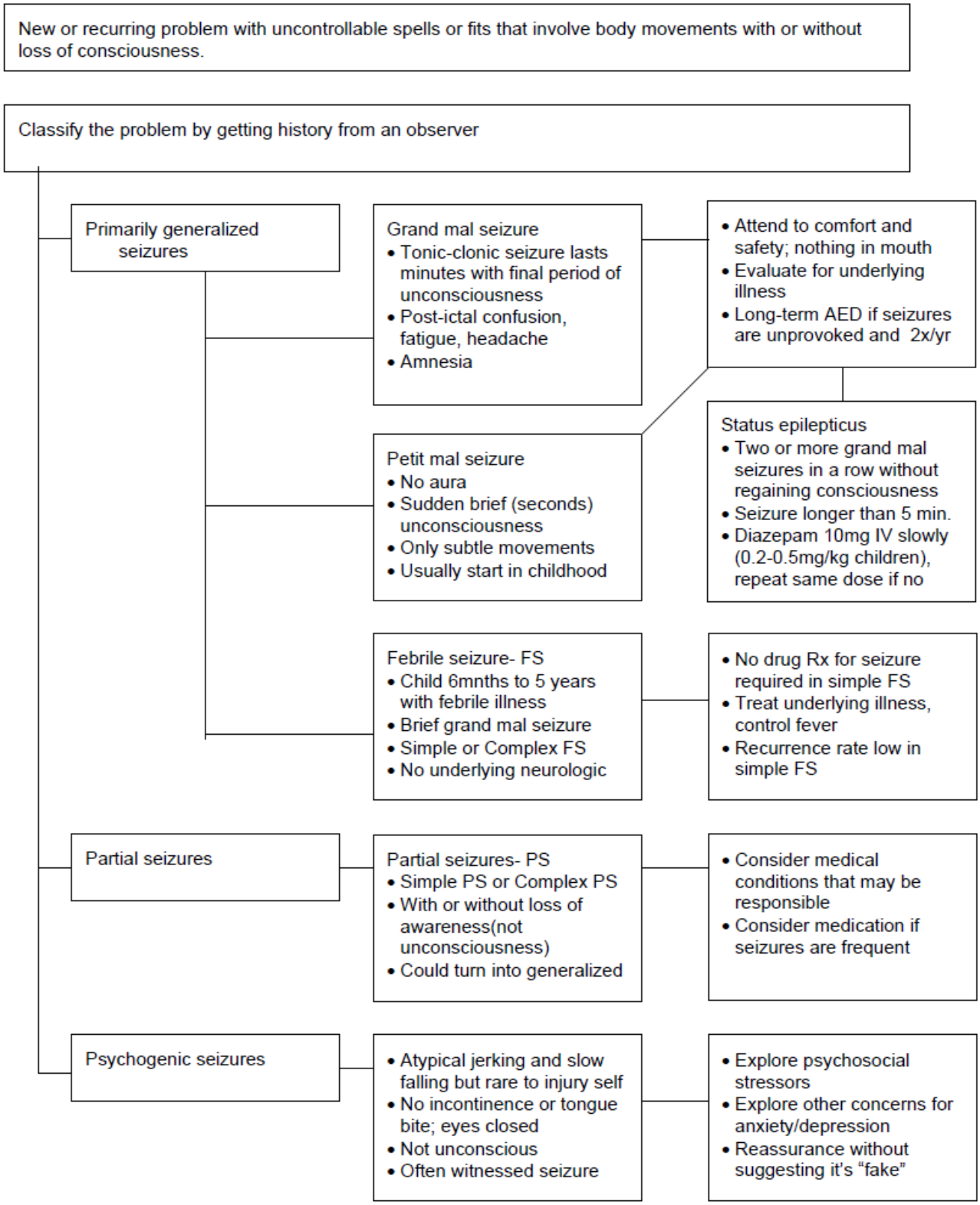
In the setting of HIV and low CD4 count, consider opportunistic infections (see Table 2.1) including tuberculosis, toxoplasmosis.
In children, febrile seizures

Module 6 Activity 6: Group discussion

Purpose: to practice using the flow chart

Instruction: In your groups read and discuss the flow chart on figure 6.1 for 10 minutes. A person from each group present results of the group's discussion to the class for 5 minutes.

Figure 6.1: Epilepsy flow chart



6.4. Management of seizure-related emergency situations

6.4.1. Management during acute convulsive grand mal seizure

If a patient is having loss of consciousness and is convulsing
You should do:
• Move patient away from water, fire, traffic, or any other hazard
• Take away any object that could harm the patient that he or she might be holding
• Loosen tight clothing, remove eye-glasses
• Put something soft under the head
• Turn patient to the side
• Remain with the patient until he regains consciousness, then begin evaluation; if it's thought that the seizure could have resulted from alcohol withdrawal, begin the treatment protocol for that immediately.
You should not do:
• Put anything (e.g. tongue plate) into the mouth
• Light matches
• Give anything to drink, including "tebel" (holy water), until the patient has completely regained consciousness
• Try to stop the convulsion by force or by holding tight
• Give diazepam or any other medication (except during status epilepticus or a series of seizure attacks)

6.4.2. Status epilepticus.

Convulsive status epilepticus is diagnosed when two or more seizures occur in close succession without consciousness being regained, or if a seizure lasts more than or equal to 5 min. It is a serious medical emergency. HIV infection increases the risk for convulsive status epilepticus (Neurology, 2005;65:314–316 Lee et.al).

General supportive measures for the unconscious - side positioning, frequent check-up of vital signs; catheterize and control input-output
Institute IV line, give 50% glucose 25-50 ml IV slowly and give thiamine 100mg IV (2-5ml/kg of 10% glucose in children)
Anticonvulsant drug treatment –Diazepam 10 mg IV slowly stat, if no response in 15-20 minutes anther 10 mg IV slowly; for children 0.2-0.5 mg/kg IV slowly
First level lab tests- FBS, CBC, hemo-parasite, organ function test, electrolytes and as required CSF, CXR, CT-scan of brain.
If no response after second dose, refer to ICU for further management
Ongoing monitoring respirations, heart rate, and blood glucose
Start on a maintenance dose of anticonvulsant (see Section 6.5. about the dose and preferred drugs for the various types of seizures)

Module 6 Activity 7: Group Exercise

Purpose: Assessing and treating a convulsing patient
Instruction: Discuss components of proper care of a patient who is convulsing continuously for more than 5 min; one group discuss the major points in class for another 5 minutes.

Time: 10 minutes

Module 6 Activity 8: Case study

Purpose: Management of status epilepticus
Instruction: In your groups, discuss the necessary initial measures in case of status epilepticus for 5 minutes; Select one person to give a 5 minute presentation

Time: 10 minutes

6.5. Psycho-education and psychosocial intervention in epilepsy

6.5.1. Psycho-education

Convulsion is caused by excess electrical activity in the brain – it is not caused by witchcraft or spirits, and it is not insanity."
It is not contagious
Epilepsy is the recurrent tendency for convulsions."
It is a chronic condition, but if you take your medicine as prescribed, in the majority of people it can be fully controlled."

Drug treatment does not contradict faith based treatment e.g. 'tsebel' (holy water), prayers
Antiepileptic drugs should not be discontinued during these religious treatments.
'Tebel' should not be given during a seizure
Long-term treatment is usually required
Provide information on how carers can manage convulsion at home (see section 6.4.1).

6.5.2. Life style issue

Physical and mental hygiene
Physical and mental hygiene seems to be able to reduce the frequency of seizures. It includes:
- Regular hours of sleep
- Avoid substances – alcohol, hashish, cigarettes
- Avoid dangerous situations- cooking on open fire, swimming alone, driving a vehicle
- Moderate physical exercise

Promote functioning
-Persons with epilepsy can have a fulfilling life in every aspect
-Epilepsy does not have to be disabling.
-Some professions may not be suitable e.g. being a chauffeur

For children
-For children with non-febrile seizures, except for some limitations, a child with epilepsy can participate in any activity.
-Most sports are safe.
-Should never swim alone (no one should, even if they don't have epilepsy).
-Should be educated, should be sent to school.
-Should not be spoiled "because of the illness".

6.5.3. Treatment of psychogenic seizures

Attempt to understand underlying issues.
Often associated with anxiety or depression– can be considered another somatic presentation of a mood problem.
Despite "non-organic" cause, most patients will not be consciously aware that the fit is voluntary.
Occasionally a form of malingering (conscious attempt to get out of something – for example, to avoid work or military service).

Make linkage with the distress; avoid use of "pseudo" label as there is a risk of provoking resistance. The goal is to help the patient feel that the underlying cause of their problems is understood and being healed, so that the seizures are allowed to stop without the patient being forced to admit that they were not "real."
- Encourage the patient to return to normal activity

Module 6 Activity 9: Group Exercise

Purpose: Psycho-education and promoting functioning of epileptic patient
Instruction: Discuss components of psycho-education and lifestyle issues in epileptics.

Duration: 5 minutes

Pharmacotherapy of epilepsy

Several medical conditions can provoke a seizure, and for most of these some form of urgent treatment can be lifesaving. Therefore, rule out the presence of underlying medical condition.
Causes to consider include:
Hypoglycemia (especially if a diabetic has taken insulin and not been able to eat)
Head injury that has caused delayed bleeding inside the head

Stroke
Meningitis or encephalitis (including cerebral malaria)
Alcohol withdrawal
Hypertension in pregnancy (pre-eclampsia)
Some medications make it more likely that someone will experience a seizure spontaneously. These include some of the antipsychotics, and antidepressants
In the setting of HIV and low CD4 count or high viral load, consider opportunistic infections including tuberculosis, toxoplasmosis, etc
In children, febrile seizures

Treatment of seizures if the cause cannot be determined or treated separately
All of what is described below applies to generalized and partial seizures – see the particular section below if psychogenic seizures are suspected. In general, if a person experiences a second seizure, or if the condition that seems to be causing the seizures can't be immediately resolved, the medical treatment is indicated.

Principle of Antiepileptic drug (AED) administration
Make sure it is epileptic seizure – not psychogenic seizure
Classify the seizure type
Select the appropriate medication for the type of seizure
Use only one medication initially
Start with the smallest suggested dose.
Gradually increase aiming for complete control of seizures at lowest possible dose.
In those with HIV infection carbamazepine, phenytoin and Phenobarbital should be avoided. All these three drugs are "inducers" and interact with ART drugs, particularly PIs, NNRTIs, and also INSTIs.

Table 6.4: Medications for seizures: doses and side effects

Drugs	**Dose range**	**Side effects**
Phenobarbital	Adult dose: 60-200 mg/day Child dose: 2-3 mg/kg/day	Mental dullness, sedation, drowsiness, skin rash, hyperactivity in children
Phenytoin	Adult dose: 100-400mg/day Child dose: 4-7 mg/kg/day	Gum hypertrophy, skin rash, hirsutism, neuropathy, ataxia, slurred speech
Carbamazepine	Adult dose: 400-1600 mg/day Child dose: 10-20 mg/kg/day	Skin rash, leucopenia, elevated liver enzymes
Sodium valproate	Adult dose: 600-1200 mg/day Child dose: 20-40 mg/kg/day	Liver toxicity, alopecia; contraindicated in pregnant epileptic woman

Diazepam for prolonged seizure (over 5 minutes)	Adult dose: 10 mg IV slowly or rectally; Child dose: 1mg/year of age up to 10 or 0.2-0.5mg/kg, IV slowly or rectally	Sedation, respiratory depression

In HIV care, sodium valproate is preferred because it has minimal interactions with antiretroviral medications. - See Table 6.4 for doses, side effects, and interactions with other medications

- Generally treat for 2-5 years after last seizure and then attempt to discontinue

Table 6.4.2 A: Medications for different types of seizures

Type of seizure	Drugs
Partial seizure	Carbamazepine, phenytoin, Phenobarbital, lamotrigine
Grand mal epilepsy	Sodium valproate, carbamazepine, phenytoin, phenobarbital, lamotrigine
Petit mal epilepsy	Sodium valproate, ethosuximide, lamotrigine
Atypical Absence, Myoclonic, Atonic	Sodium valproate
Psychogenic seizures	Usually none, possibly medication for anxiety or depression

Table 6.4.2 B: Medications for seizures: doses, side effects, and interactions

	INSTIs	**NNRTIs**	**PIs**	**RTI**
	Doulutegravir Raltegravir	Efavirenz Nevirapine	Atazanavir Lopinavir	Tenofovir Abacavir
Cabamazepine	Decreased Doulutegravir -use 50mg bid Raltegravir - use 400mg bid, not 1200 daily	Decreased NNRTI	Ritonavir boosted PIs increase CBM, Potential for decreased PI	-
Phenytoin - phenobarbital	Decreased Doulutegravir -use 50mg bid Raltegravir - use 400mg bid, not 1200 daily	Potential for decreased NNRTI Nevirapine decrease NNRTI and/ or anticonvulsants	Decreased boosted PIs; decreased Ritonavir boosted PIs Unpredictable increase or decrease of AED	-
Lamotrigine		Potential for decreased	Ritonavir boosted PIs potential for	-

		lamotrigine	decreased Lamotrigine	
Sodium valproate	Potential for decreased total Doultegravir – not likely clinically significant		Ritonavir boosted PIs potential for decreased Lamotrigine	-
Lorazepam	-	-	-	-
Bromazepam, Diazepam	-	Potential for decreased benzodiazepine	Potential for increased benzodiazepine	-

Module 6 Activity 10: Group Exercise

Purpose: Principles of AED treatment/drug interaction
Instruction: Using tables 6.4.2 A and B, discuss on properly prescribing AED, and identify risky ART-AED interactions; discussion in two groups- both topics.

Time: 10 minutes

6.7. Special conditions in epilepsy

6.7.1. Febrile seizures (young children)

Febrile seizure is most common from 6 months to about 5 years of age. It occurs while child is febrile – usually a high fever. There are two types:
Simple febrile seizure
Generalized seizure that lasts for less than 15 minutes;
Only one seizure incident in the current illness
Afterwards the neurologic exam is normal
The child has not had some other neurologic problem (other than a previous febrile seizure)
Complex febrile seizure
Focal seizure –starting in one part of the body
Lasts more than 15 minutes
More than 1 episode during the current illness

Treatment
There is no specific treatment except that the fever should be reduced and try to identify the

cause of fever (including meningitis, CNS malaria) and treat it if possible. In repeated seizures short term benzodiazepines could be given. Children especially prone to febrile seizures may be treated with the drug diazepam orally or rectally, whenever they have a fever (Pediatrics 2011;127:389–394; Brain Dev. -2009 May ; 31(5): 366–371)

Prognosis for febrile seizures
30% of those with one will have another
Prognosis is good in general, but in those with complex febrile, increased risk of developing epilepsy.

6.7.2. Epilepsy and contraception/ pregnancy

To prevent contraceptive failure among women taking an anticonvulsant.
Phenytoin, phenobarbital, and carbamazepine strong inducers and reduce the effectiveness of the contraceptives; valproate and lamotrigine are preferable, which are non-inducer or weak inducer respectively.

IUD, Progestin implant, or Depo-proveraare the preferred method of contraception.

Pregnancy and delivery in epileptic woman.

Consultation with obstetrician is necessary.

For new onset of seizures in the second half of pregnancy or up to 1 week postpartum, you should rule out eclampsia (take blood pressure). If B/P is elevated give magnesium sulfate 10 grams IM (5 grams = 10ml of 50% solution; give 5 grams in each buttock with 1ml of 2% lidocaine in the same syringe). Refer urgently to hospital.

If a woman has had seizures prior to pregnancy, achieving better control of seizure before considering pregnancy is advisable
Antiepileptic drugs should not be stopped during pregnancy, labor or breast-feeding
Avoid poly-drug seizure medication and avoid sodium valproate during pregnancy
Give fefol tab (4-mg folic acid/day) before pregnancy and during the whole pregnancy.
Weaning should be gradual to avoid withdrawal symptom from the seizure medication in the baby (Semin Neurol. 2017;37(6):611-623).

6.7.3. Depression and epilepsy

Depression is the most common mental health complication of epilepsy. As many as half of people with epilepsy (reports say 20-60%) suffer from depression at some point in their lives, and the risk of suicide is five times that of the general population. It is important to ask patients with epilepsy about their mood state. For those with depression suicide risk assessment is cruicial (see Module3).

6.7.4. HIV and epilepsy

Seizures are more prevalent in patients with HIV than the general population (Seizure (2008) 17, 27-33. Kellinghaus et.al.). This is due to direct effect of the HIV virus on brain tissue, or secondary to HIV related tumors, hemorrhages, or opportunistic infections. Seizure could occur at any stage of the illness, from sero-conversion to late stage of AIDS. In some cases the cause is no clearly identified. Most seizures are generalized onset or focal onset seizure with secondary generalization (JAPI 2000; 48: 573-576 Chada et.al.). Treatment of seizure in HIV infected patients is complicated by drug-drug interactions which could lead to toxicity and reduction of serum level of ART medication and or anticonvulsant drugs.

For new onset seizures, think about treatable causes which commonly occur in HIV infection, e.g. CNS lesions, aneurysms, tumors. Because of a higher risk of seizure recurrence among individuals with HIV who have a first seizure one should consider maintenance treatment after first-onset seizure, even if there seems to have been a cause that was treated.
Be aware of drug-drug interactions between ART and anticonvulsants
Because HIV directly infects the brain, it may be more sensitive to drugs and their side effects and drug toxicity easily occur. One should always start with low doses of AEDs. .
Carbamazepine, Phenobarbital and Phenytoin are not advisable to be given in a patient who is taking PIs and NNRTIs.

Module 6 Activity 11: Group discussion

Purpose: discussing about women and epilepsy
Instruction: based on the topic you just covered, discuss in groups about pre-pregnancy, pregnancy, and perinatal care in epileptic woman
Duration: 5 minutes

6.8. Case management and long-term follow-up

Prognosis for adults with seizure disorders.
~70% full control with medication.
5-10% has refractory seizures – despite adequate doses of medication still have seizures

After starting anticonvulsants, see initially at monthly intervals to check on effectiveness and side effects. Even if there are no further seizures, if the patient is taking ART, see them more often than you might usually until certain that there are no emerging side effects.

If general maintenance of medication for many years is required
Adherence is often a difficult problem because of side effects of medication
After 2-4 years of seizure-free time consider a very gradual taper of medications

6.9. Referral criteria

- Status epilepticus not responding to initial diazepam IV treatment (emergency transfer to hospital).
- New onset of seizures with any localizing/focal neurologic signs (emergency transfer to hospital).
- Seizures in pregnancy (emergency if elevated blood pressure).
- Seizures that cannot be controlled on a single anticonvulsant (or can only be controlled with side effects that are difficult to tolerate).
- Seizures accompanied by loss of mental or physical abilities over time (seen in some childhood disorders).
- Diagnostic challenge. Not clearly one type of seizures, or "intractable" but likely psychogenic seizures.
- Medication challenge. Combination of ART and other medications seems to make it impossible to use correct, available anticonvulsant.

Module 6 Activity 12: Reflections

Purpose: to address participant concerns
Instruction: Raise any questions or comments about the module.
Have you answered the questions raised on activity 1?

6.10. Module summary

- Epilepsy has a higher prevalence rate in HIV/AIDS cases as compared to the general population
- There are different types of epilepsy, each with a different mode of clinical manifestation
- Detailed history-taking is the mainstay of diagnosis of epilepsy
- Effective treatments are available for epilepsy; specific anticonvulsant medications are effective for specific types of epilepsy
- Status epilepticus is a medical emergency requiring immediate measure
- Drug side effects and drug- drug interactions between ART and Anticonvulsant should be monitored closely when treating epilepsy in HIV/AIDs cases
- Psycho-education is a very important component of management and should include: epilepsy is not insanity, or contagious; stigmatizing or overprotection could lead to additional mental disturbance; avoiding precipitating and dangerous situations
- Long-term drug treatment and case management is required

Module 7: Behaviour and developmental issues in children and adolescents

Duration: 100 minutes

Module description: This module will enable the training participants in recognizing behavior and developmental problems in children PLHIV and apply appropriate management strategies to help the children and their parents/caregivers.

Primary objective: At the end of this module participants will be able to manage behavior and developmental issues in children PLHIV.

Enabling objectives: at the end of this module participants will be able to:

- Identify treatable underlying problems related to child behavior, including medical conditions, attention problems, developmental and learning problems, substance use, and mood/anxiety problems.
- Identify emergencies that may be related to behavior problems
- Apply good communication skills to identify specific behavioral targets that parents would like to work to achieve
- Apply good advice-giving skills to give parents instruction in basic child behavior strategies

Outline

7.1. Introduction
7.2. Causes of child behavioral and developmental problems
7.3. Presentation of behavior and developmental problems in children PLHIV
7.4. Urgent and non-urgent behavior and developmental problems
7.5. Treatment of behavior and developmental problems in children PLHIV
7.6. Follow-up and monitoring
7.7. Referral criteria
7.8. Module summary

7.1. Introduction to the module

Module 7 Activity 1: *Think-pair-share*

Purpose: to assess level of participants and stimulate
What are behavioral problems in children?
What are developmental problems in children?
Have you seen such problems in children before? Describe what you noticed.
Time: 5 minutes

Behavior problems are very common among children and adolescents, and they are often a cause of stress for parents. There are two big barriers to helping parents with these problems. The first is that families differ a great deal in what they consider to be bad behavior, and the second is that they differ a great deal in what they believe are the best ways to change their child's behavior toward what they believe is proper. Thus, in this module, we try to outline an approach that can be adapted to the needs of many different families. This includes attention to:

1. Recognizing the parents' own needs and issues that may make it harder for them to be the kind of parents they would like to be.
2. Recognizing when the child's behaviour may be caused by some treatable problem, including developmental or learning problems, substance abuse, low mood, or trauma.
3. Collaborating with parents to develop plans to change behaviour that incorporate the parents' values.
4. Finding ways to reduce parenting stress while the behaviour change plans are put into place.

HIV creates many opportunities for children to develop behavioral or developmental problems.

- Depressed or chronically ill parents may be less nurturing or more irritable with their children; the secrecy that sometimes surrounds having HIV can lead to many difficult parent-child interactions
- Foster caretakers may be less invested in the children they care for
- Ill children may be more irritable and harder to interact with
- Even well-controlled HIV infection in childhood is thought to be associated with learning problems – especially problems with reading and language that can have an impact on school abilities
- Children who are ill a lot may miss a lot of school and fall behind
- Severe HIV infection sometimes causes developmental delay either through its impact on nutrition, opportunistic infections, or direct HIV effects on the brain. For example, children with HIV are more likely to develop cerebral complications of malaria, and these are associated with subsequent developmental problems.

See the depression and anxiety modules for information about treating those concerns in children and adolescents.

Module 7 Activity 2: *Case study*

Purpose: to induce participants to the subject
Instruction: Read the following cases in groups for 2 minutes each and answer the questions given under each of them.
Time: 10 minutes

Case 1
Aynalem is an 8-year-old girl, the middle child of 3. She has an older brother, 12, and a younger sister, 6. Recently she has been irritable and angry when her mother has asked her to get her younger sister ready for school in the morning, or to help prepare the family meal in the evening. The conflict in the evening has annoyed Aynalem's father, who has scolded his wife for not being able to control Aynalem's behavior.

- Have you ever met or heard about a child like Aynalem?
- What do people think about children with problems like Aynalem's?

Case 2
Girma is a 15-year-old boy living with his parents. He attends school, though he says that he does not like it that much. Recently, he has been coming home late from school, rather than returning home directly. He has been irritable with his parents, and when they ask him what the matter is, or to be more respectful, he refuses to talk.

- Have you ever met or heard about a child like Girma?
- If people try to help children like Girma and his parents, what do they do or suggest?

7.2. Causes of child behavioral and developmental problems

There are three major ethiological factors contributing to development of behavioral and developmental disorders in children

<u>Biological</u>

- Perinatal brain injuries or damage - prolonged labor, asphyxia
- Problems in the first year of life –, severe malnutrition, seizures
- Nutritional – malnutrition, iodine deficiency
- Toxicity – alcohol during pregnancy

- CNS infections – meningitis, cerebral malaria
- Genetic condition / increased heritability- mutations, fragile X syndrome, Down syndrome, etc.
- Physical handicap – visual, hearing, motor weakness, etc.

Environmental

- Parental Factors- parenting problem
- Lack of stimulation or prolonged emotional deprivation,
- Harsh, punitive parenting - severe physical and verbal aggression
- Chaotic home conditions
- Divorce , disruption of family
- Sociopathy, alcohol/ substance abusing parent
- Illness in the parent
- Child sexual abuse and Maltreatment
- Socioeconomic - urban environments; Unemployed parents, etc.

Psychological

- Unresolved conflicts as fueling aggressive behaviors towards authority figures(oppositional defiant disorder)
- Reinforced, learned behavior
- Poor modeling of impulse control

Table 7.1: Some of the causes for child behavioral problems

Family	Maternal depression	Ask mother about her own mood
Child physical health	Hearing or vision problem; malnutrition or food insecurity	Has the child been tested for hearing or vision? Are there times when the parents worries about having enough food?
Child development	Delayed speech	How is this child's talking compared to your other children? (and see the "Ten Questions" below)
Child emotional health	Depression or anxiety	Remind the group of the kinds of questions covered in those modules

7.3. Presentation of behavior and developmental problems in children PLHIV

In many parts of the world, parents do not consider primary medical care as a place to discuss or get information about child behavior problems. When parents do raise the issue, it may be in the context of a child not wanting to take a needed medicine, worry about whether the child is using drugs, or as a source of stress contributing to the parents' own problems. Thus, if one wants to hear more from families about these problems, one can routinely (or at intake visits) ask about:

- How is the child getting along with other members of the family?
- How is the child getting along with friends?
- Are there problems reported from school with behavior or learning?
- For younger children, are there any problems with meal or bed-time behavior?

In Ethiopia and many other countries, children who are shy and quiet are seen as good, so their problems may be overlooked. Physical punishment is also seen as useful and acceptable. So think about how to tactfully bring these subjects up.

One of the more difficult situations in primary care can be when a parent and child are seeing the provider together and the parent says critical things about the child's behavior, attitude, or character. It can be difficult to try to elicit details about the problem in a way that is respectful of the parent and also tries to reduce tension between the parent and child. Some techniques that may be useful:

- Empathizing with the parent's frustration and the difficulties of parenting
- Praising the parent for being concerned and for wanting the best for his or her child
- If the parent is very upset, suggesting that the child be allowed to leave the room so that the provider and parent can speak privately for a few minutes.

Though time may be limited, it is always important to evaluate concerns about child behavior in the context of larger family issues. Even if this is a family that you have known previously, whenever possible ask for an update on major issues including:

- Food, financial, or housing uncertainty
- Illness or death of another family member
- Difficulties between the parents
- Difficulties in the neighborhood

Again, depending on the age of the child and what you feel is best for the parent, these questions may have to be asked privately, with the child and others out of the room.

The most difficult situation for the provider is when parents report problems in a way that is either vague or makes them seem overwhelming. It is easiest to offer advice when the problem is simple and easily understood. Even in very complicated situations, try to get parents to be able to name:

- A particular behavior that the child does that is a problem (for example, he hits his little sister), rather than "he is not nice to his little sister."
- A particular alternative behavior they would like to see (for example, I would like to see him allow his sister to play with his toy sometimes).

If the parents have multiple concerns, try to get them to name the single most important

behavior they would like to see changed first.

 **Module 7 Activity 3:** ***Video demonstration***

Purpose: to demonstrate manifestation of child behavioral disorder, and child developmental disorder
Instruction: Watch the video that your facilitator will show you.

Time: 30 minutes

7.4. Urgent and non-urgent behavior and developmental problems

7.4.1. Urgent/emergency issues

1. Physical injury to the child: norms vary from family to family and in different countries about what separates acceptable from unacceptable harsh punishment of children. In general, punishment that leaves visible marks or that might reasonably be considered to be life threatening (blows to the head, blows with heavy objects, refusal of food or water) would probably be considered unacceptable.
   - Ask to speak to the parent alone
   - Ask about other violence in the family
   - Seek the parent's agreement to preventing further harm to the child
   - Explore with the parent ways of protecting the child in the short term; this might include recruiting relatives to help care for the child, or help for the family with some sort of emergency aid
   - Conduct a gentle but thorough physical examination of the child

2. Sexual injury to the child: if it is suspected or disclosed that a child has been a victim of sexual assault or has been engaged in sexual activity by an adult, proceed as with physical injury to the child.
3. Physical or emotional violence between parents: child behavior problems are common in households where there is physical violence between parents. See discussion of violence in the anxiety module.
4. Suicidal ideation: especially among adolescents, behavior problems can be a symptom of depression. In the other direction, the conflicts and crises provoked by behavior problems can be a trigger for suicidal thoughts and low mood. See discussion of suicidal thoughts in the depression module.
5. Especially in very young children, is the child's nutritional state adequate?
6. Childhood psychotic symptoms. Psychosis and dementia are very uncommon in children, but can occur among those with serious illnesses (including HIV) There are times among well children when the concern for childhood thought symptoms may be raised:

- "Normal" child behavior/symptoms
    - In many cultures, children have imaginary friends to whom they talk and play. This usually stops when children are in their early school years, and most of the time they will admit that their "friend" is imaginary (or that their doll can not really talk to them)
    - When the child is very frightened – these will mostly be visual and tactile sensations – especially in young children (2-7). What they believe will sometimes be consistent with things they have been taught by adults e.g. chirak. These do not require treatment with medication unless they are putting the child in danger (and then the treatment would be with medicines used for anxiety, not antipsychotics)
- When psychotic symptoms are caused by medications or substance abuse (especially prescribed or illicit stimulants) – these will most likely be in the form of tactile hallucinations or seeing crawling insects
- In severe illness
    - The same types of things can occur as in adults– children can become delirious
- Childhood onset schizophrenia is thought to be very rare, and usually occurs in children who already have been thought to have problems with social development
- Childhood bipolar disorder (mania) is also thought to be rare, and when it does occur there are less likely to be hallucinations and delusions but more irritability, increased activity, and increased sexual interest or behavior.
- After emotional trauma some anxiety symptoms can be mistaken for psychosis. Children will report fearful visions or worries that they can't describe well.

In children, with the exception of emotional trauma, consider severe psychotic-like symptoms to be most likely caused by a medical problem or intoxication.

7.4.2. Consider non-urgent treatable causes

1. Problems with hearing or vision that have been undetected or untreated
2. Developmental problems that limit school performance or ability to understand and comply with parental norms for behavior
    - How does this child's development compare to that of siblings? Was this child ahead of or behind relative to others in the age they first spoke or walked? (see the "Ten questions" for developmental screening, below and in the pocket manual. Also in the pocket manual are the "Draw-a-person" test, the "Gesell" drawing test, and some reading and math questions you can use to help determine if a child may have developmental or school learning problems).
    - Children who have low weight for their age are more likely than others to have developmental problems.
    - Does the child have friends of their own age?
    - If the child is in school, has he or she had difficulties all along or only recently?
3. Could there be a medical reason for the child being irritable?

- Problems with nutrition or insufficient food?
- Could the child have a chronic illness that causes pain, fatigue, or problems with sleep?
- Could the child or adolescent be using substances of some kind?

4. Is there another mental health reason for the child being irritable or exhibiting difficult behavior?
   - Consider depression, anxiety, exposure to trauma
5. Is the parent depressed or physically ill?

Module 7 Activity 4: *Group discussion*

Purpose: to practice questions to ask about child developmental disability

Instruction: In your groups, read and discuss about table 7.2 for 5 minutes and select one person to present the results of the discussion for another 5 minutes.

Table 7.2: "Ten Questions" for detection of child developmental disability

A "yes" answer to any of the following questions for children 2-9 years is an indicator of possible disability

1. Compared to other children, does or did the child have any serious delay in sitting, walking, or standing
2. Compared to other children, does the child have any difficulty seeing either in the daytime or at night?
3. Does the child appear to have difficulty hearing (needs a hearing aid, hears with difficulty, is completely deaf)?
4. When you tell the child to do something, does he or she seem to understand what you are saying?
5. Does the child have difficulty in walking or moving his or her arms or does he or she have weakness and/or stiffness in the legs or arms?
6. Does the child sometimes have fits, become rigid, or lose consciousness?
7. Does the child learn to do things like other children?
8. Does the child speak at all? Can he or she make him or herself understood in words; can he or she say any recognizable words?
9. Speaking questions by age:
    1. For 2-year-olds: Can the child name at least one object (an animal, toy, cup, or spoon)?
    2. For children 3-9: Is the child's speech in any way different from normal (not clear enough to be understood by anyone other than the immediate family)?
10. Compared to other children of the same age, does the child appear in any way mentally backward, dull, or slow?

Attention deficit-hyperactivity disorder (ADHD)

In many parts of the world, ADHD is considered to be the most common childhood mental health problem, but in Ethiopia it is not recognized as often. ADHD has both cognitive (thinking) and behavioral aspects. The thinking aspects involve difficulty being organized and sticking with one task. Children with ADHD can be very forgetful, lose things, and have a lot of trouble keeping their mind on one task, especially if it needs a lot of mental effort (such as school work). They can be easily distracted from their work by noises or the presence of others. Boys more than girls with ADHD can also have trouble sitting still, though this usually gets better by adolescence (the thinking problems may not). The behavioral counseling we talk about below can help children with ADHD, but in more severe cases medication – stimulants – seems more effective. These medications are not currently available in Ethiopia.

7.5. Management of child behavioral and developmental disorders

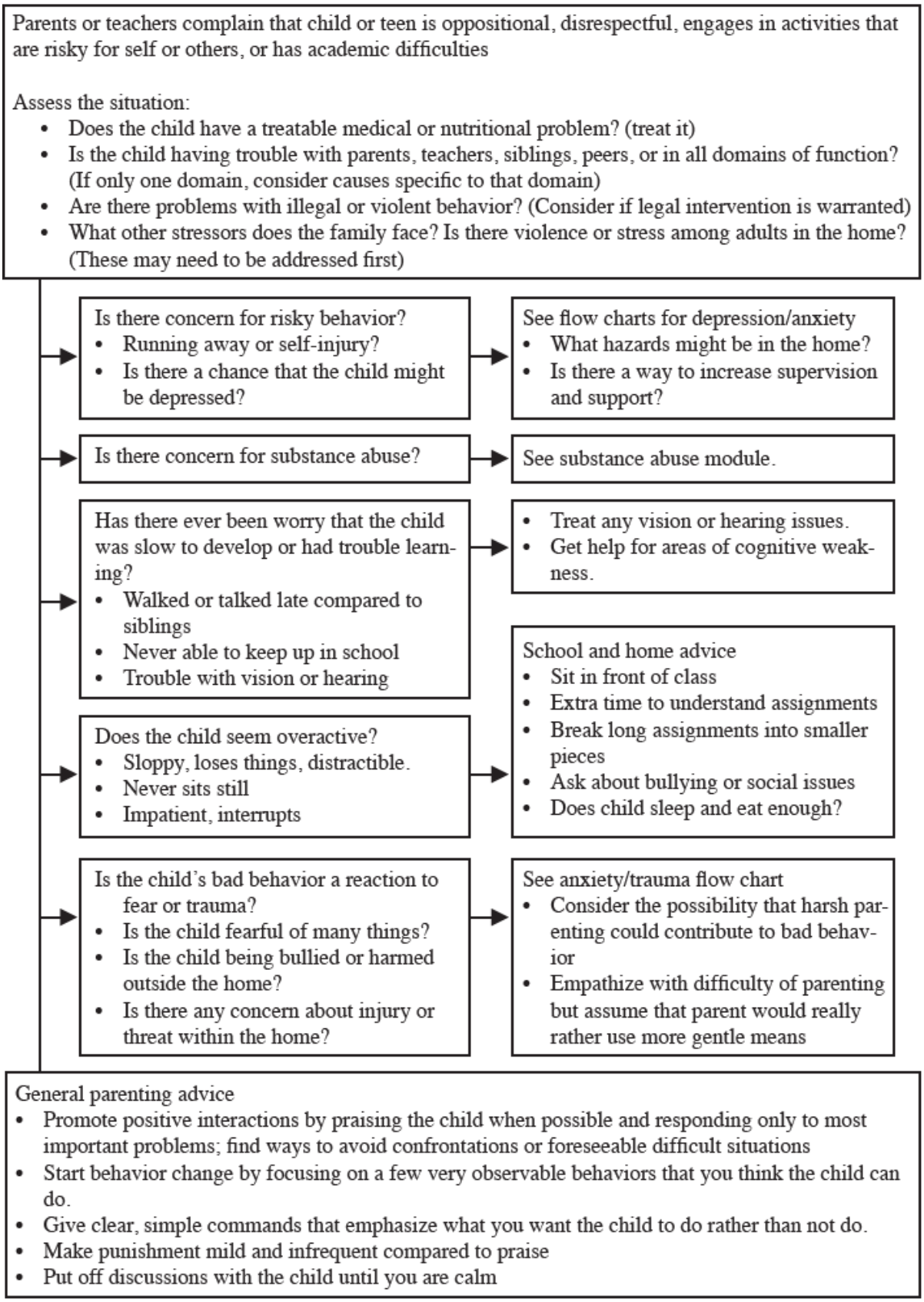
Module 7 Activity 5: Group discussion

Purpose: to practice the flow chart

Instruction: In your groups read and discuss the flow chart on figure 7.1 for 10 minutes. Then select one person from your group to present results of your discussion to the class for 5 minutes.

Time: 15 minutes

Figure 7.1: Child conduct flow sheet



7.5.1. General interventions to suggest to parents

1. Consider the environment

    1. Is the parent's health status, low mood, or drinking creating greater-than-normal demands for the child to behave? Can these problems be addressed?
    2. Are there ways for the parents to get more support for themselves in caring for what might be a more temperamentally difficult child?
    3. Do the child's caregivers have inconsistent or differing beliefs about parenting? Are these differences getting in the way of attempts to create rules, limits, or consequences?
    4. Can caretakers agree on priority behavioral problems and how to address them?
2. Promote positive interactions with children
    1. Praise the child for agreed on desired behavior
    2. Praise frequently and consistently
    3. Don't mix praise with negatives – save the corrections for later
    4. Make the praise strong and physical if appropriate – accompanied by hugs
3. Focus on priority areas. Try to temporarily ignore minor unwanted behaviors.
4. Set aside even a small time each day for child-parent activities, ideally at about the same time.
5. Promote positive behaviors
    1. When possible, reorganize the child's day to prevent trouble.
        - For example, ask someone to look after a child briefly if the parent has something to do that requires concentration or lack of interruption
        - Think of other antecedents to problem behavior and try to avoid them
2. Commands and requests
    a. Set clear rules.
    b. Give short specific commands about the desired behavior, not prohibitions about undesired behaviors. For example, say "Please walk slowly" rather than "Don't run!
    c. Advance notice can be helpful. "We will need to go in 5 minutes."
3. Punishment
    a. As infrequent as possible – save it for situations where the child has had a chance to do things correctly or has failed to respond to a request to behave
    b. Keep mild, even if it is firm – calmly and verbally
    c. Avoid long-standing consequences – children forget why they are being punished and just get angry at the punisher. "You cannot go out this afternoon, but if you are better you can go out tomorrow."
    d. Punishment should come quickly after the problem occurs, so the child knows what they are being punished for, unless the parent is too upset to stay calm when giving the punishment.

e. Avoid getting into arguments or explanations. This will merely give more attention for the misbehavior. Put off negotiations and discussions until a later period of calm.

7.5.2. Things that may help with school behavior problems or possible ADHD

- Have the child sit in the front of the class. The goal is to have the child be easily seen by the teacher and to have other children not be so visible to the child.
- Give the child extra time to stay organized. This may include giving the child extra time to write down assignments or to repeat them back to the teacher to make sure they are understood.
- Break longer assignments into smaller pieces, with opportunities for the child to check with the teacher or parent (for homework) that they are doing the work correctly.
- Inquire about bullying or other social difficulties at school.
- When possible, make sure that the child has had enough sleep and enough to eat before attending school.
- To the best of your ability, see if the school and family can provide extra help with material that is difficult (but be careful in interacting with the school not to disclose the child's HIV status when that is not needed or appropriate)

7.5.3. Treatment for possible developmental and learning problems

The most important first treatment for possible developmental and learning problems is to help parents understand that their child is likely not just lazy or "foolish." This can be a good reason to use the simple tests in the pocket manual as a way of showing what the child can and can't do.

If the child's delays or school problems seem mild, try to work out plans with the parents to get the child as much help with school work as possible, and try to get any behavioral, emotional, or medical issues taken care of.

If the delays seem more serious – especially if the child seems considerably behind others of his or her age, see if a referral is possible for more of an evaluation.

Module 7 Activity 6: ***Case study***

Purpose: to practice decision-making about behavioral and developmental disorders
Instructions: In your groups, go through the cases noting which details are present in the case description and what other questions you might ask the patient or family for 5 minutes. Then make a decision about what you might need to do for the patient. Describe your

treatment or counseling. Do this activity in a total of 10 minutes.

Case 1
Basnael is a 5-year-old boy who refuses to go to school. He cries for hours if he is forced to go. His mother has to stay in the school with him. He often complains about headaches, stomachaches, and nausea. At home, he cannot sleep without being near his mother.

Case 2
Eyoel is a 7-year-old child who has marked difficulty in school. Though he is in grade 1, he cannot read or write the alphabet. His mother stated that Eyoel is not like his older siblings. He is delayed in many ways - he was not able to walk by the age of 2 years, and he uttered his first words only when he was 18 months old.

7.5.4. The use of medications in children with behavior and developmental problems

When children with serious delays have behavior problems, it can be tempting to use medications, especially if the child's parents are very upset or stressed. Very low doses of fluoxetine can sometimes be helpful. If possible, avoid other antidepressants (especially tricyclics) and antipsychotics because of their many side effects and complications. If antipsychotics must be used, it should be for as short a period of time as possible until consultation and more support for the family can be obtained. Table 7.2 gives some dosing guidelines, side effects, and drug interactions.

Module 7 Activity 7: ***Group discussion***

Purpose: to study use of medications used in childhood disorders
Instruction: In your groups, read and discuss about table 7.3 for 5 minutes. Then select one participant from your group to make a 5-minute presentation about the results of the group discussion.

Time: 10 minutes

Table 7.3: Antipsychotics and related medications for children

Medication	Child dosing	Common side effects	Medication interactions
Haloperidol	Child 3-12 yrs: 0.01 to 0.03 mg/kg/day up to 0.15 mg/kg /day Child > 12 yrs: 1-5	Hypotension, lowered threshold for seizures, prolonged Q-T interval (avoid if prior history of heart disease)	PIs can increase haloperidol level; NNRTIs can decrease haloperidol level. Level reduced by

	mg/dose initially and then 1-15 mg/day divided bid or tid. Raise dose slowly and use minimally effective dose.		carbamazepine and phenobarbital.
Chlorpromazine	> 6 yrs: 2.5-6mg/kg/day orally	Drowsiness (potentiates effects of sedatives), jaundice, lowered threshold for seizures, hypotension, prolonged PR interval	Potentiates effects of sedatives. Data not available on ART interactions.
Risperidone	> 20kg: 0.5 -1 mg a day to start; after 4 days increase by 0.5 mg every two weeks; 2-3 mg a day thought to be maximum effective dose in children	In higher doses has similar side effects to typical antipsychotics	Some PIs may increase risperidone levels. Avoid use with ritonavir.
Benzatropine (for EPS)	0.02 to 0.05 mg/kg/dose once or twice a day	Constipation, dry mouth,	Potentiates sedative effects of other medications

7.6. Follow-up and monitoring

Fortunately, many child and adolescent behavior problems get better over time. However, just saying this to parents is not reassuring – it can be taken as an indication that you (the provider) don't really understand the parents' concerns or the seriousness of the problem. It is more helpful to:

- Ask if the parent would like advice, and if so, give it
- Make arrangements to meet again later to talk about the results – usually in two or three weeks
- If problems persist at the follow-up visit, ask the parent to talk about what they tried and why they thought it did not work. Ask if the parent has ideas about how to try the same things but in a more effective way.
- If problems are significantly worse, go back over the above lists of possible causes and re-evaluate the possibility that there are medical, mental health, or family violence issues playing a role. If the child seems to have a developmental problem, get the best evaluation possible, and then work to educate the family about the child's strengths and limitations and how best to support growth
- When possible, refer to community support groups, especially if the child is identified as having a developmental problem

7.7. Referral criteria

- Evidence of child neglect, sexual or physical abuse with concern for serious harm
- If evidence of medical or neurologic diseases are causative of behavioral change, especially if there is a loss of developmental milestones
- Behavior problem seems complicated by a mood or anxiety problem and neither condition can be well controlled
- Diagnostic challenge – confirmation of diagnosis
- Symptoms persistence or worsening after treatment
- More than mild developmental problems

Module 7 Activity 8: *Role play*

Purpose: to practice diagnosis and management of behavioral and developmental disorders
Instruction: Take turns being the patient, clinician, and an accompanying family member and do role plays based on the cases given in this section. The clinician should focus on diagnosis and management of the case. Do this for 15 minutes.

Case 1

Ato Gemechu complains that his 6-year-old child, Diriba, is difficult to discipline. He attends school but mostly gets poor marks. In class, he doesn't pay attention, and when asked about the work he will give guesses or evasive answers.

Case 2

Berhanu is a 10-year-old boy whose father died from HIV about a year ago. He is living with his maternal grandparents, his mother, and his younger sister in his grandparents' small home. Recently he has been frequently angry and refused to do any chores around the home. He insulted his grandfather and threatened to hit his sister. His mother has threatened to put him in an orphanage if he does not behave better.

Module 7 Activity 9: *Reflections*

Purpose: to address participant concerns
Instruction: Raise any questions or comments about the module
Have you answered the questions raised at the beginning of this module?
Time: 5 minutes

7.8. Module summary

- Delay in achieving key milestones, difficulty in school, difficulty playing with others, or inability to carry out instructions raise concerns for developmental or learning problems
- Addressing the whole family's situation and concerns can help understand and treat child behavior problems
- Parents can usually improve their child's behavior by focusing on a few, consistent rules and applying them firmly but calmly
- Behavioral treatment in school and at home is important in the management of children with ADHD.

Module 8: Mental health aspects of living with HIV

Duration: 110 minutes

Module description: This module is intended to help the training participants in recognizing life challenges in relation to mental health problems or their treatment in PLHIV and apply appropriate management strategies to help clients.

Primary objective: At the end of this module participants will be able to manage life challenges related to mental health problems and their treatment among PLHIV.

Enabling objectives: at the end of this module participants will be able to:

- Identify mental health problems associated with medications taken for HIV
- Identify potential interactions between ARV drugs and mental health medications
- Diagnose and manage adjustment problems experienced by PLHIV
- Identify cognitive effects of HIV (HAND) when assessing individuals for problems or challenges related to everyday functioning.

Outline

8.1. Introduction
8.2. Reaction to the diagnosis
8.3. Stigma and disclosure
8.4 Mental health side effects of ARV drugs
8.5 Mild impairment of cognitive deficit and its impact on functioning
8.6. Module summary

8.1 Introduction

Module 8 Activity 1: *Think-pair-share*

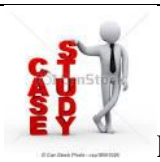
Purpose: to stimulate participants
What are the possible changes to mental health among PLHIV?
At which event or level of HIV/AIDS do mental health problems mostly appear?

Time: 5 minutes

Many of the topics discussed in this module are covered in more depth in other trainings such as comprehensive ART training. The goal of repeating them here is to be able to think about

them in the context of definable mental health conditions and mental health treatment. If there is one recurring theme in most of this module, it is a return to the discussion in the introductory module – care for "mental health" problems can involve care for all aspects of a person's physical health and social environment. The impact of finding out one's sero-positivity or the challenges of disclosing can lead to various degree of mental health problem.

Perhaps the biggest change in thinking over the past many years has been the realization of how many subtle changes in brain functioning caused by HIV can have an impact on day-to-day function even in people who are very careful to take their medications and have excellent health otherwise. Earlier in the epidemic before potent treatment was available, HIV caused serious neurological conditions such as dementia or peripheral neuropathy (HIV-associated dementia (HAD) or AIDS dementia complex (ADC)) For many, the immune system eventually became so damaged that life-threatening brain infections occurred as well, such as progressive multifocal leuko-encephalopathy (PML), cytomegalovirus (CMV), toxoplasmosis, herpes and cryptococcal meningitis. Today, those conditions are rarely diagnosed but are still possible if a person with HIV isn't in regular care and on suppressive treatment over time. As many more people are now on treatment, symptoms of brain-related damage are often much more difficult to notice or even diagnose. Today, the umbrella term HAND (HIV-associated neurological disease) is more often used to describe the various problems related to thinking, memory and mood, and sometimes physical coordination and function.



Module 8 Activity 2: ***Case study***

Purpose: to induce participants to subject
Instruction: In groups, read and discuss the following case and answer the questions that follow.

Case
Mihret is a 29-year-old, single woman who is being treated for HIV. She had a job in private company until recently; however, she was dismissed from her work. She says that she has ceased to be interested in working or much else in life. She says that her memory is failing her and, at times, it is even difficult to say whether she really knows what her medical problem is. Her mother stated that she is uncertain about her daughter's mental capacity and is getting tired of having to help her all the time.

a) What could be the major causes of Mihret's memory problem?
b) What are the risks of this "impairment"? How would you counsel the mother?

Time: 5 minutes

Below are some of the key issues to be addressed in the mental health aspects of PLHIV.

8.2. Reaction to the diagnosis

People have many different reactions to learning that they have HIV infection. They may react initially with anger, shock, or denial and these reactions can change or recur over time. As a medical provider, you can:

- Ask what is feared most about HIV and offer information (when they are willing and able to hear)
- Encourage finding someone that they can disclose to and obtain support
- Encourage and accept venting, show empathy for the difficulty of adjusting

If people **feel guilty** for something that they feel led to their acquisition of HIV:

- Reassure that no one can foresee all the consequences of what they do
- Reassure that life offers many opportunities to do good and they will have many chances in the future feel better about themselves.

For feelings of loneliness and isolation

- Note that there are millions of people living well with HIV, both in Ethiopia and other countries
- Note that they are right to be cautious about who they tell, but that over time they will find many accepting people and develop many close relationships
- Remind them that the ART site and its many services will always be a place that they can turn to for support and care

For feelings of grief and loss

- Acknowledge that this is a big change, that life looks very different
- Be optimistic that the loss will heal with time
- Express your willingness to be of support
- Suggest self-care
- Remind them that this is a treatable problem, and that you and the ART staff will be here to evaluate their concerns.

Module 8 Activity 3: Group discussion

Purpose: to discuss reaction to HIV diagnosis and its management
Instruction: In groups, one group should write the list of possible reactions and psychiatric symptoms that occur following the event of learning HIV positive test result. The other group writes the components of counseling for each reaction- about how to help a patient cope with his new HIV diagnosis. Then each group presents for 5 minutes. Do this for a total of 15 minutes.

8.3. Stigma and disclosure

Module 8 Activity*4: Group discussion*

Purpose: Discussing about stigma
Instruction: In your groups, discuss based on the following questions for 5 minutes:

1. What is 'stigma' related to mental illness? How does it manifest?
2. What can you do to tackle stigma?

Then select one person to give 5-minute presentation to the class.

Time: 10 minutes

Fear of telling others about their diagnosis is one of the greatest burdens faced by people living with HIV. HIV remains a very misunderstood condition, with many people still believing that it can only be acquired in immoral ways and that casual contact with sero-positive people can lead to fatal infection. Efforts to avoid disclosure can be very disruptive to normal life, and harmful to treatment adherence. People living with HIV often say they lead "double lives" in that they feel they are always hiding something (when they go for an appointment, why they don't feel well, why they have a medicine to take), and always trying to guess if their friends have guessed the truth. Fear of needing to disclose can discourage people from seeking friends and partners, or it can lead to unprotected sexual activity. In contrast, individuals with HIV also often have false ideas of who they should tell – for example, others where they work. ART staff can help patients understand where disclosure would seem helpful, and where it is not required.

Even when people living with HIV have been able to tell some close friends and family members, they may be burdened by changes in their appearance caused by ART medications or HIV-related illnesses. Feeling that they have an additional source of shame – a seizure problem or mental health problem – may prove to be overwhelming.

One of the biggest difficulties faced by persons living with HIV is maintaining supportive and positive relationships with family members and others who help them with day-to-day needs. Even when patients are doing well medically, they may rely on family, friends, and neighbors for many things, including financial help (money for transportation, replacement of income lost when the patient can't work), child care or other duties when the patient has medical visits, reading or interpreting instructions for care, and listening and helping with emotional concerns. When these relationships are strained patient functioning can decline in a number of ways.

As an ART clinician there may be little you can do directly about these problems. If the

patient comes with family members, you can use some of the skills discussed in the communication module to make the family feel welcome, engaged, and appreciated. You can use the opportunity to empathize with their burdens and you can explicitly thank them for their efforts. It may also be an opportunity to "trouble shoot" problems, perhaps thinking of ways to limit burdens on the patient and family (for example, changing the frequency or timing of visits).

Where available, advice from adherence supporters may give patients ideas of how to best nurture relations with people on whom they depend.

One way to help people best function in light of attitudes toward HIV (and mental health issues) is to connect them with other people who have faced the same issues. The adherence supporters in HIV clinics can fill this role. Groups (for adults and youth) offer opportunities to relax and talk with people without fear of disclosure, as well as opportunities for sharing practical information and support. In some communities in Ethiopia, "*Idirs"* have expanded their role to provide more comprehensive support to persons living with chronic illness such as HIV. Support has included small loans, help with legal advocacy, and transportation in addition to in-home care in times of illness. Referral to these organizations may be beneficial for the patient and their family.

Module 8 Activity 5: ***Case study***

Purpose: studying about the challenge of knowing one's HIV+ status
Instruction: In your groups, discuss the following case for 5 minutes, paying attention to the reactions to learning ones HIV+ status.

Case
Aman is 45 years old, father of two children who are in their teens. Recently he discovered that he is sero-positive. He did not tell anyone and he is worried that his wife might have acquired the HIV infection from him. He felt very guilty, and is blaming himself a lot. He came to you looking for some advice.

- How do you advise the client?

Time: 10 minutes

Disclosure to HIV+ children: Families often have many concerns about telling a child that he or she has HIV. They worry that the child will become depressed, or that the child will tell others and a family secret will become known. Telling a child who was perinatally infected also means that parents have to again face feelings of guilt or loss about their own illness.

Eventually, it becomes hard to keep children from knowing their diagnosis, especially when they start asking questions about the need for medication or frequent medical visits, or when they near the age where they may become sexually active. Long before this, though, many

children sense that something is the matter, and the fear caused by that secret may be worse than knowing.

The degree of stigma and risk in the child's community may determine in part on when they are told. If disclosure to outsiders is a risk, telling the child may have to wait until he or she can truly understand the idea that this is not information to tell others.

Disclosure to children usually takes place over time – often over a period of months or even years as the child matures and asks more questions. One approach is to truthfully answer questions but only with just enough information for what the child might understand at that age. The following list of explanations might be started with a young child, with each additional point being added as the child is more curious:

–Medicines keep you healthy
–Blood tests can tell the doctors if the medicine is working
–Germs (virus, etc) can make you sick
–Your body has an immune system to fight germs
–You have a virus that tries to hurt your immune system. Your medicine fights that virus to keep you healthy.
–The name of the virus is HIV. Have you heard of it?
–There are some things about ourselves and our bodies that are private – we don't tell other people.

As with adults, once children know about their diagnosis, contact with other children in similar circumstances is often a tremendous help.

Module 8 Activity 6: *Case study*

Purpose: studying the issue of disclosure in children living with HIV
Instruction: In your groups, discuss about the following case for 5 minutes.

Case
Eyoel is a 7-year old boy who had been losing some weight and saying to his mother that he was feeling tired all the time. She brought him to a clinic and after an examination and testing he was found to be HIV positive with a low CD4 count, and high viral load. He presumably acquired it from perinatal infection. His mother told him that the doctor had prescribed some medicine to help give him more energy and not be so tired. He took the medicine for a while, but then started to refuse, saying that he did not feel any better and the medicine tasted bad. His mother is asking you whether she should tell him the real diagnosis so that he will understand why he needs to keep taking the medicine.

- How would you address her request?

Time: 10 minutes

8.4. Mental health side effects of ARV drugs

Module 8 Activity 7: Group discussion

Purpose: discussing about mental health problems of ARV drugs
Instruction: In your groups, discuss based on the following questions for 5 minutes:

1. In your practice, have you come across any mental health problems related to ARV drugs?
2. If 'yes', please mention the ARV drugs most incriminated.
3. In your practice, have you come across any significant DDIs between ARV drugs and psychotropic drugs?
4. If 'yes,' mention the ARV and psychotropic drugs most incriminated.

Then select one person to give a 5-minute presentation.

Time: 10 minutes

Many of the medications used to treat HIV and related infections have mental health-related side effects. For most medications, these are not common or severe. However, it is a good idea to consider recent medication changes (new medications, dose increases) whenever someone has a new mental health problem. Even medications not thought of as having mental health side effects can have them indirectly. Many cause mild but chronic problems with diarrhea, nausea, altered appetite, and fatigue that contribute to feelings of ill health and demoralization. Many patients do, in fact, feel better when they do not take their medications until the point at which they begin to develop more severe HIV-related illness. Some medications to think about in particular are:

- AZT can cause pain and aching in muscles, especially of the thighs and shoulders, along with weakness.
- D4T can cause irreversible and painful changes in sensation and strength in the hands and feet after long use and higher doses. It has also been associated with changes in mood – mostly anxiety and depression. D4T is now being phased out of use in Ethiopia.
- Efavirenz can cause mental health-related side effects in as many as half of patients taking it. Symptoms can begin on the first day of treatment, but are likely to resolve after 2-4 weeks. Some can be very troubling, and include confusion, trouble concentrating, and vivid, odd dreams. Hallucinations and mood changes have also been seen, and depression has been reported. There is concern that these side effects can be made worse by alcohol or other substances.
- Interferon (used in the treatment of Hepatitis C) has a strong association with depression.
- INH (used in the treatment of TB) can cause hallucinations, paranoia, and low mood.

Module 8 Activity 8 : Group discussions

Purpose: discussing side effects and drug-drug interactions of ART drugs
Instruction: In groups, read and discuss about table 8.1 for 5 minutes and provide a 5-minute presentation.

Time: 10 minutes

Table 8.1 ART-psychotropic's/antiepileptic drug interactions

Psychotropic drugs	Interactions
Carbamazepine	Decrease PI and NNRTI levels; use other anticonvulsant. Carbamazepine toxicity possible if combined with RTV.
Diazepam, bromazepam	All PI's can increase levels of diazepam and bromazepam, as Efavirenz and nevirapine can decrease diazepam levels. Lorazepam, oxazepam, and temazepam are unaffected by ARV's.
Fluoxetine	No specific problems for PI's or NNRTI's. Can be some variation in the level of fluoxetine or the ARV's. But does interact with many other medications.
Haloperidol	PI's can increase haloperidol level; NNRTI's can decrease haloperidol levels.
Phenobarbital	Can decrease PI and NNRTI levels but is ok to use with NRTI's. Not recommended with LPV/r.
Phenytoin	Can decrease PI and NNRTI levels but is ok to use with NRTI's. Not recommended with LPV/r. If must use with LPV, may need higher doses of both medications.
Risperidone	Some PI's may increase risperidone levels. Avoid use with RTV.
Tricyclic antidepressants	OK with NNRTI's and NRTI's. OK with PI's except LPV/r, RTV, – those medications can raise the TCA level to toxic levels (use fluoxetine instead).
Valproic acid	No significant interactions

8.5. Mild impairment of cognitive functioning

With the advent of effective HIV treatment, the proportion of people living with HIV who develop very serious declines in mental capacity (dementia) has been greatly reduced. There is more awareness, however, that as many as half of those living with HIV, even when their illness is well-managed, have varying degrees of what has been called HAND (HIV-associated neuro-cognitive dysfunction). For most, the impact of HAND is relatively subtle and goes unnoticed by others. However, there is more and more evidence that even mild degrees of HAND can have an impact on day-to-day function.

HAND can have an impact on many areas of brain function, and there is not a lot of similarity from person to person in its effects. What seems most consistent, however, is an impact on the ability to organize one's life – to keep a focus on what needs to be done, to make the kinds of day-to-day decisions that seem simple but do require remembering, prioritizing, deciding on the order in which to do tasks, and figuring out how to achieve goals. The impact of HAND can't be explained by depression or other medical problems.

One aspect of HAND that can be particularly troubling is that the combination of brain problems tends to make people unconsciously shy away from new situations and challenges. This can be a barrier to accessing new programs and treatments that may be helpful, and can be frustrating to both the patient and clinicians, neither of whom can really understand the source of the reluctance.

When available, neuropsychological testing is the best way to diagnose HAND. However, these tests are not available in most of the world (including Ethiopia). Instead, clinicians can work with patients and families to explore the possibility that HAND could be problem. The approach is to try to understand if there has been a change in the kinds of things that the patient can do. There are not yet any standard sets of questions to ask about this kind of functioning in Ethiopia, but examples of things to ask about include:

- For women, do they now have trouble remembering the ingredients and steps involved in making traditional dishes, especially if there is some change in what needs to be done (substituting an ingredient they don't have, making food for fewer or more people than usual)?

- Does the person now have trouble organizing a shopping trip? – deciding what to buy, figuring out what to get at each shop, understanding the relationship of the price per item or kilo to the total cost?

- Does the person now have trouble figuring out how to make a trip using taxis or busses, especially if it involves figuring out how to get to a new place?

- Does the person now have trouble remembering when and how to take medicines?

None of these differences need be very marked, as they might be if the patient had dementia, but they could be enough that the patient takes more time to do the activity, finds it frustrating, or avoids it. At this point, treatment of these "mild" forms of HAND involves:

- Optimizing HIV treatment

- Looking for any untreated infections or medical conditions

- Looking for unrecognized medication side effects

- Inquiring about substance use that may be having an additional impairing effect

- Helping the patient to develop ways around the impairments – breaking tasks into smaller, manageable steps; getting help from family and friends; using pill boxes and calendars to stay organized for medications and other tasks

- Providing extra support at times of change or where new tasks must be accomplished – for example, escorting the patient to a visit with a new clinician at an unfamiliar hospital; arranging a meeting with a representative of a community support group at a place familiar to the patient.

Module 8 Activity 9: *Role play*

Purpose: to practice interviewing and management approach to a patient with HAND
Instruction: Using the case given to your group, take turns being the patient, clinician, and an accompanying family member. The clinician should interview the patient. The clinician can then consult with colleagues about a possible diagnosis and treatment plan, including what you would do for follow-up. Make sure that you ask questions that might get at whether there is a problem with HAND if that seems appropriate. The clinician should then explain the diagnosis and plan to the patient and accompanying family member. Do this activity for 15 minutes.
Case
Ato Abreham is a 35-year old man who was working at an office that prints a local tourist magazine. About a year ago, he started feeling poorly, and lost weight. He was diagnosed with HIV and, was started on ART. He has had a good response in terms of lowered viral load, higher CD4, and he has regained much of the weight he lost. However, he continues to feel that he is not ready to go back to work. He becomes more and more forgetful, and at times gets lost in the middle of a conversation.

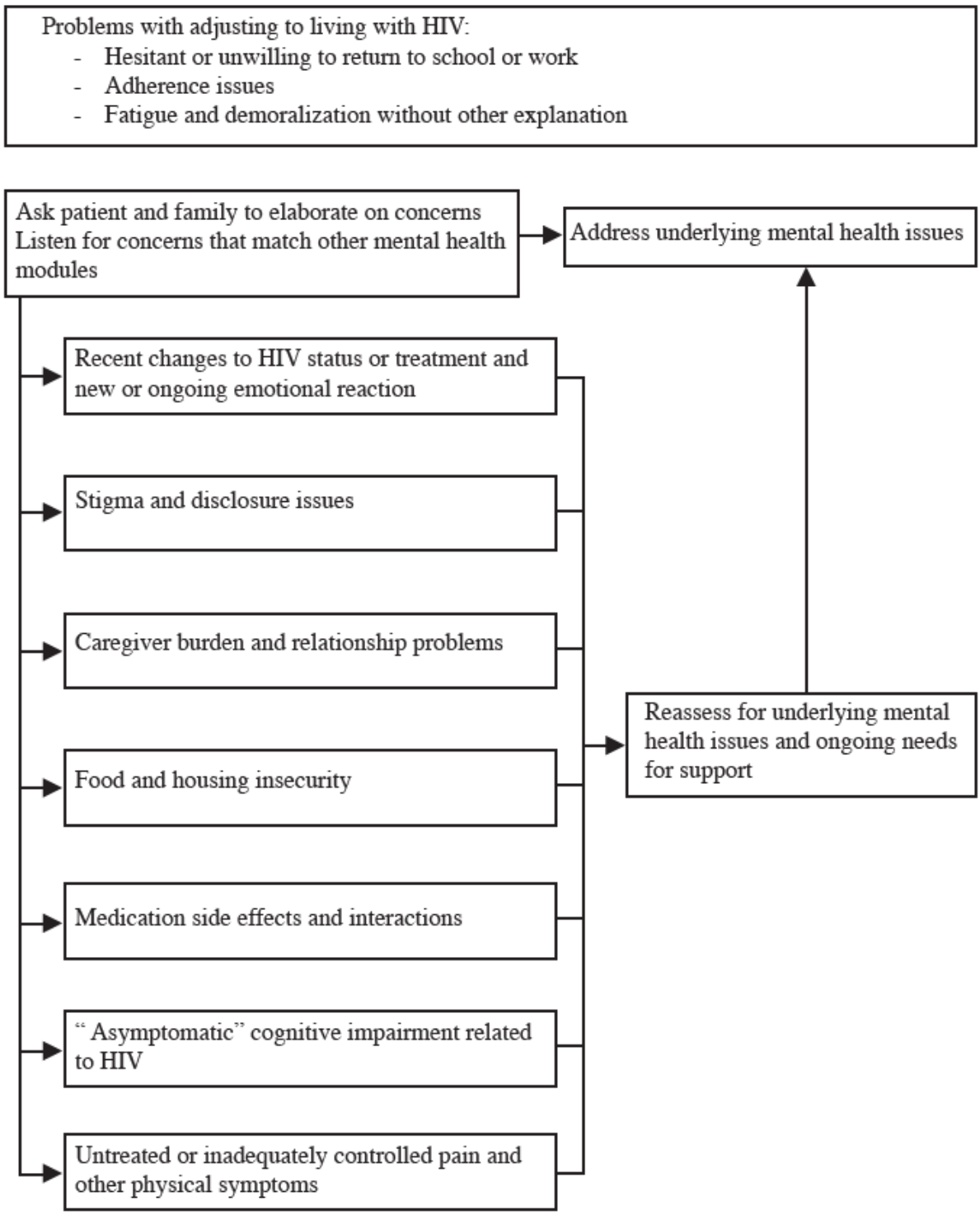
Module 8 Activity10: *Group discussion*

Purpose: practicing about the flow chart

Instruction: In your groups, read and discuss about the flow chart given in figure 8.1 for 5 minutes. Then select one person to give a 5-minute presentation.

Time: 10 minutes

Figure 8.1: Living with HIV flow chart



Module 8 Activity 11: *Reflections*

Instruction: Raise any questions or comments about the module

Have you answered the questions raised at activity 1?

8.6. Module summary

- Reactions to HIV diagnosis can resemble, precipitate, or exacerbate mental health problems.
- Decisions about disclosure of HIV status can be major sources of stress.
- Medication side effects and interactions should always be suspected as contributing to mental health problems among people living with HIV.
- Mild forms of cognitive problems can occur even among people who are doing well with HIV treatment and can cause a lot of functional problems
- Mental health problems can look like cognitive problems.

Module 9: Monitoring and evaluation

Duration: 120 minutes

Module description: The module focuses on monitoring and evaluation, implementation process of MHI activities, roles and responsibilities HCWs as well as documentation and reporting mechanisms including action planning. It uses different teaching methodologies, illustrated lecture, group work and group discussions.

Primary objective: By the end of the module participants will be able to explain monitoring and evaluation, as well as implementation process of mental health integration (MHI) activities including the monitoring and evaluation.

Enabling objectives: by the end of the module, participants will be able to:

- Describe monitoring and evaluation
- Describe the client flow in MHI activities
- Describe roles and responsibilities of HCWs and HF management on MHI activities
- Document and , report MHI activities
- Analyze, and discuss data on MHI activities
- Prepare action plan on MHI activities

Outline

9.1: Introduction to the module
9.2. What is monitoring and evaluation?
9.3: Roles and responsibilities of HCWs and HF management on MHI activities
9.4: Documentation and reporting of MHI activities
9.5: Analysis , and discussion on MHI activities
9.6: Prepare action plan on MHI activities
9.7: Module summary

9.1. **Introduction to the module**

Module 9 Activity 1: *Think-pair-share*

Purpose: to stimulate participants
What are MHI tools?
Have you ever had experience with any tools in your previous practice?
If 'yes', please share what you experienced.

MHI for PLHIV has been implemented in Ethiopia since 2010. During the initial phase,

health care providers (HCPs) were expected to screen all ART clients using screening tool and manage clients accordingly. After two years in 2012 the concept of task sharing of MHI screening to adherence case managers (ACMs) was introduced in the Ethiopian setting. Accordingly, client flow, roles and responsibilities of HCWs and PST tools were revised. These tools have been in use since 2012. However to address implementation gaps and to make the follow up of MHI activities more simple, it was considered necessary to revise the client flow, SOPs and documentation tools. Those tools are revised by FMOH TWG based on the gaps identified on FMOH-led JSS conducted in Jan 2020.

In this module we will discuss on MHI client flow, roles and responsibilities of HCWs and HF management on MHI activities.

9.2. **What is monitoring and evaluation?**

Monitoring

Monitoring is the regular collection of information about all project activities. It shows whether things are going according to plan, and helps project managers to identify and solve problems quickly. It keeps track of project inputs and outputs such as:

- Activities;
- Reporting and documentation;
- Finances and budgets;
- Supplies and equipment.

Monitoring is an ongoing activity that should be incorporated into everyday service/ program activities.

Evaluation

An evaluation asks whether a project is achieving what it set out to do, and whether it is making a difference. Evaluations keep track of key outcomes and impacts related to the different project components, assessing whether the objectives, aims and goals are being achieved. Evaluations take place at specific times during interventions (WHO).

In general, monitoring and evaluation helps the management team to:
Determine the extent to which the program is meeting the stated goals, objectives, targets and make corrections accordingly

- Make informed decisions regarding program management and service delivery.
- Ensure the most effective and efficient use of resources.
- Evaluate the extent to which the National Cervical Cancer Prevention and Control
- Program is achieving desired outcomes and impact.

9.3. **Roles and responsibilities of HCWs and HF management**

Module 9 Activity 2: ***Group discussion***

Purpose: to study roles and responsibilities of HCWs and HF management
Instruction: Based on section 9.3 (9.3.1-9.3.4), read in your groups on the roles and responsibilities of HCWs and HF management in the context of implementing MHI activities for 10 minutes.
Then, you will be assigned to one of the 4 roles and responsibilities on which to prepare presentation. Select one person to give a 5-minute presentation to the class on the topics from those listed 'a'-'d' assigned to the group.

a. Roles and responsibilities of MHI trained ACM/s
b. MHI trained ART clinicians
c. Roles and responsibilities of ACM coordinator, ART focal person, and HF management ensures:
d. Roles and responsibilities Psychiatry unit

Duration: 15 minutes

9.3.1. Roles and responsibilities of MHI trained ACM/s

- Provide routine health education on mental health conditions based on the HE schedule at ART waiting areas
- Identify all eligible clients linked to him/her for MHI screening
- Use MHI screening tool to conduct screening
- Document all clients screened for MHI screening on MHl CM log book
- Link those identified to have MH conditions to ART clinicians trained on MHI
- Based on the decision of MHI trained link to MHI trained ART clinician/ psychiatry unit
- Update the confirmed MH diagnosis section of MHI CM log book
- For those with confirmed for mental health diagnosis continue to provide continues counseling and support as appropriate

9.3.2. MHI trained ART clinicians

- Ensure HE on MHI is included as part of the routine daily HE schedule at ART waiting areas
- Ensure all MHI screening priority clients are channeled to ACM/s trained on MHI
- Ensure continues availability and appropriate use of MHI screening tools and other PSTs by ACMs and ART clinicians
- Ensure ACM/s give enough time in screening MHI screening priority clients using MHI screening tools
- Assess all clients identified to have MH conditions and manage accordingly; for clients with MH conditions which could not be treated at the ART clinic refer to psychiatry units by escorting them with ACM/ AS

- Ensure MHI performance is reviewed on the monthly HF level or ART clinic level PRMs & PIPs are developed to improve performance
- Ensure MHI performance data reported to the HF and RHB

9.3.3. **Roles and responsibilities of ART focal person, and HF management ensure:**

- Coordinate and lead the overall MHI activates in a HF
- HE on MHI is included as part of the routine daily HE schedule at ART clinics
- MHI screening & management of MHI priority clients is done as per the client flow
- Availability & appropriate use of MHI M&E tools and other PSTs
- ACM/s give enough time in screening MHI priority clients using MHI screening tools
- Appropriate convenient room is allocated for MHI screening service
- Escorted linkage is done by AS and fast tracking of service at each MHI SDP across the client flow
- Availability & utilization of directory of community level organizations who would support clients with mental health conditions
- Functional referral mechanism to community level organization with feedback mechanisms for clients who need support
- MHI performance is reported, included in regular PRMs, PIP are developed for performance gaps and followed

9.3.4. **Roles and responsibilities psychiatry unit**

- Availability of psychotropic drugs as per the HF standard
- Participate in case discussions and MHI performance reviews conducted in the HF
- Ensure HIV testing is provided using HIV risk screening tool for all clients seen in psychiatry OPDs & IPD
- Consolidate lessons learnt and best practices on HIV MHI to tap the experience in the expansion of MHI services to other chronic illness

9.4. **Documentation and reporting of MHI activities**

Module 9 Activity 3: ***Group discussion***

Purpose: to exercise on MHI tools and the current practice

Instruction: In your groups, hold a discussion based on the questions given below for 10 minutes. Discus about how the documentation practice of MHI activities is going in your respective HFs. Comment whether there is a practice of appropriate documentation in your respective HFs with respect to those listed below.

1. MHD screening and documentation
2. MHI documentation tools
3. MHI reporting tools, including data source to complete the information needed

on each tool

4. Reporting flow and reporting practice of MHI activates

Then, select one person to give a 5-minute presentation on behalf of the group.

Time: 15 minutes

9.4.1. MHI documentation and reporting tools

Module 9 Activity 4: *Group discussion*

Purpose: to make participants familiar with the MHI tools
Instruction: In your groups, look critically into the tools provided under this session (Fig 9.1 to Fig 9.7) one by one. At the end of reviewing each tool, fill them with hypothetical data for those tools, which are meant to be used for data recording and reporting.

Time: 20 minutes.

Most of these tools would be completed by ACMs.

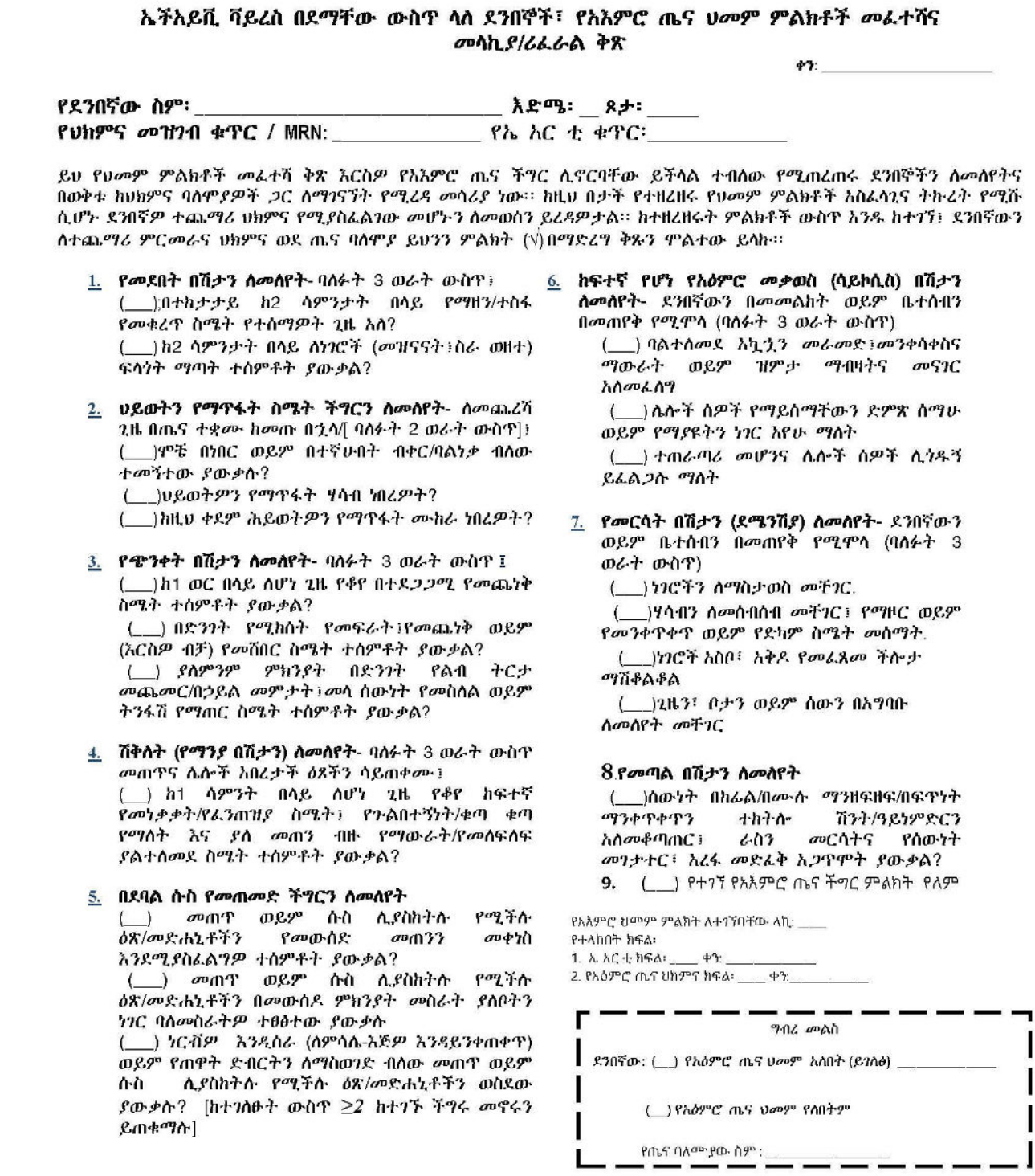
Fig 9.1: ART clinic waiting area ACMs HE documentation format

የጤና ትምህርት መመዝገቢያ ቅፅ

የኬዝ ማናጀር ስም:_____ጤና ድርጅት:_____ወር:_____

ቀን	የጤና ትምህርት የተሰጡባቸው ርዕሶች	የተሳታፊዎች ቁጥር			
		የክፍለ ጊዜ ብዛት	ወንድ	ሴት	ድምር
አጠቃላይ ድምር					

Fig 9.2: MHD screening tool Amharic version



ኤችአይቪ ቫይረስ በደማቸው ውስጥ ላለ ደንበኞች፣ የአእምሮ ጤና ህመም ምልክቶች መፈተሻና መላኪያ/ሪፈራል ቅጽ

ቀን: _____

የደንበኛው ስም፡ _____ **እድሜ፡** __ **ጾታ፡** _____
የህክምና መዝገብ ቁጥር / MRN: _____ **የኤ አር ቲ ቁጥር፡**_____

ይህ የህመም ምልክቶች መፈተሻ ቅጽ አርስዎ የአእምሮ ጤና ችግር ሊኖርባቸው ይችላል ተብለው የሚጠረጠሩ ደንበኞችን ለመለየትና በወቅቱ ከህክምና ባለሞያዎች ጋር ለማገናኘት የሚረዳ መሳሪያ ነው። ከዚህ በታች የተዘረዘሩ የህመም ምልክቶች አስፈላጊና ትኩረት የሚሹ ሲሆኑ ደንበኛዎ ተጨማሪ ህክምና የሚያስፈልገው መሆኑን ለመወሰን ይረዳዎታል። ከተዘረዘሩት ምልክቶች ውስጥ አንዱ ከተገኘ፣ ደንበኛውን ለተጨማሪ ምርመራና ህክምና ወደ ጤና ባለሞያ ይህንን ምልክት (√) በማድረግ ቅጹን ሞልተው ይላኩ።

1. **የመደበት በሽታን ለመለየት-** ባለፉት 3 ወራት ውስጥ፣
(___)በተከታታይ ከ2 ሳምንታት በላይ የማዘን/ተስፋ የመቁረጥ ስሜት የተሰማዎት ጊዜ አለ?
(___) ከ2 ሳምንታት በላይ ለነገሮች (መዝናናት፣ስራ ወዘተ) ፍላጎት ማጣት ተሰምቶት ያውቃል?

2. **ህይወትን የማጥፋት ስሜት ችግርን ለመለየት-** ለመጨረሻ ጊዜ በጤና ተቋሙ ከመጡ በኋላ/[ባለፉት 2 ወራት ውስጥ]፣
(___)ሞቼ በነበር ወይም በተኛሁበት ብቀር/ባልነቃ ብለው ተመኝተው ያውቃሉ?
(___)ህይወትዎን የማጥፋት ሃሳብ ነበረዎት?
(___)ከዚህ ቀደም ሕይወትዎን የማጥፋት ሙከራ ነበረዎት?

3. **የጭንቀት በሽታን ለመለየት-** ባለፉት 3 ወራት ውስጥ ፤
(___)ከ1 ወር በላይ ለሆነ ጊዜ የቆየ በተደጋጋሚ የመጨነቅ ስሜት ተሰምቶት ያውቃል?
(___) በድንገት የሚከሰት የመፍራት፣የመጨነቅ ወይም (አርስዎ ብቻ) የመሸበር ስሜት ተሰምቶት ያውቃል?
(___) ያለምንም ምክንያት በድንገት የልብ ትርታ መጨመር/በኃይል መምታት፣መላ ሰውነት የመስለል ወይም ትንፋሽ የማጠር ስሜት ተሰምቶት ያውቃል?

4. **ሽቅለት (የማንያ በሽታን) ለመለየት-** ባለፉት 3 ወራት ውስጥ መጠጥና ሌሎች አበረታች ዕጾችን ሳይጠቀሙ፣
(___) ከ1 ሳምንት በላይ ለሆነ ጊዜ የቆየ ከፍተኛ የመነቃቃት/የፈንጠዚያ ስሜት፣ የጉልበተኝነት/ቁጣ ቁጣ የማለት እና ያለ መጠን ብዙ የማውራት/የመሰፍሰፍ ያልተለመደ ስሜት ተሰምቶት ያውቃል?

5. **በደባል ሱስ የመጠመድ ችግርን ለመለየት**
(___) መጠጥ ወይም ሱስ ሊያስከትሉ የሚችሉ ዕጽ/መድሐኒቶችን የመውሰድ መጠንን መቀነስ እንደሚያስፈልግዎ ተሰምቶት ያውቃል?
(___) መጠጥ ወይም ሱስ ሊያስከትሉ የሚችሉ ዕጽ/መድሐኒቶችን በመውሰዶ ምክንያት መስራት ያለቦትን ነገር ባለመስራትዎ ተፀፅተው ያውቃሉ
(___) ነርቭዎ እንዲሰራ (ለምሳሌ-ኢጆዎ እንዲይንቀጠቀጥ) ወይም የጠዋት ድብርትን ለማስወገድ ብለው መጠጥ ወይም ሱስ ሊያስከትሉ የሚችሉ ዕጽ/መድሐኒቶችን ወስደው ያውቃሉ? [ከተገለፁት ውስጥ ≥2 ከተገኙ ችግሩ መኖሩን ይጠቁማሉ]

6. **ከፍተኛ የሆነ የአዕምሮ መቃወስ (ሳይኮሲስ) በሽታን ለመለየት-** ደንበኛውን በመመልከት ወይም ቤተሰብን በመጠየቅ የሚሞላ (ባለፉት 3 ወራት ውስጥ)
(___) ባልተለመደ አኳኋን መራመድ፣መንቀሳቀስና ማውራት ወይም ዝምታ ማብዛትና መናገር አለመፈለግ
(___) ሌሎች ሰዎች የማይሰማቸውን ድምጽ ሰማሁ ወይም የማያዩትን ነገር አየሁ ማለት
(___) ተጠራጣሪ መሆንና ሌሎች ሰዎች ሊጎዱኝ ይፈልጋሉ ማለት

7. **የመርሳት በሽታን (ደሜንሽያ) ለመለየት-** ደንበኛውን ወይም ቤተሰብን በመጠየቅ የሚሞላ (ባለፉት 3 ወራት ውስጥ)
(___) ነገሮችን ለማስታወስ መቸገር.
(___)ሃሳብን ለመሰብሰብ መቸገር፣ የማዞር ወይም የመንቀጥቀጥ ወይም የድካም ስሜት መሰማት.
(___)ነገሮች አስቦ፣ አቅዶ የመፈጸመ ችሎታ ማሽቆልቆል
(___)ጊዜን፣ ቦታን ወይም ሰውን በአግባቡ ለመለየት መቸገር

8.**የመጣል በሽታን ለመለየት**
(___)ሰውነት በከፊል/በሙሉ ማንዘፍዘፍ/በፍጥነት ማንቀጥቀጥን ተከትሎ ሽንት/ዓይነምድርን አለመቆጣጠር፣ ራስን መርሳትና የሰውነት መገታተር፣ አረፋ መድፈቅ አጋጥሞት ያውቃል?

9. (___) የተገኘ የአእምሮ ጤና ችግር ምልክት የለም

የአእምሮ ህመም ምልክት ለተገኘበት ላኪ: ____
የተላከበት ክፍል፡
1. ኤ አር ቲ ክፍል፡ ____ ቀን: _____
2. የአዕምሮ ጤና ህክምና ክፍል፡ ____ ቀን:_____

ማብረ መልስ
ደንበኛው: (__) የአዕምሮ ጤና ህመም አለበት (ይገለፅ) _____
(__) የአዕምሮ ጤና ህመም የለበትም
የጤና ባለሙያው ስም : _____

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

Fig 9.3: MHD screening tool English version

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 ***c***ut down on your use of alcohol or drugs?
   (___) Has anyone ***a***nnoyed you by criticizing your use of alcohol or drugs?
   (___)Have you ever felt ***g***uilty 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)

Fig 9.4: MHI ACMs log book with instructions on how to complete it

የ አዕምሮ ጠፍ ኬዝ ማኔጅመንት አገ ልግሎት መመዝገ ቢያ ማዝገ ብ												
ተ.ቁ	ቀ ን	የ ህክምና ማዘገ ብ ቁጥር	ስም	ጾ ታ	እድሜ	የ ደንበኛውአይነ ት		የ ተፈተሸ የ ተገ ኘ የ አእምሮ ጠፍ ማውጪ ምልክት (1-10)	ተፈተሸውየ አእምሮ ጠፍ ማውጪ ምልክቶች ለተገ ኘባቸው ብቻ			አስተያየት
		የ ኤአር ቲቁጥር	የ አባት ስም			ፀረ ኤች አይ ቪ ህክምና የ ጀመሩ (1-5)	ፀረ ኤች አይ ቪ ህክምና ያልጀመሩ (1-4)		የ ተላ ኩበት ክፍል/ቦታ (1-3)	የ ጠፍ ባ ለ ሞያ ውጭ ሚ ውጤት (1-10)	ህክምና እና የ ምክክር አገ ልግሎት ያገ ኙ? (1/2)	
1	2	3	4	5	6	7	8	9	10	11	12	13

ፀረ ኤች አይ ቪ ህክምና የ ጀመሩ (1-4)
1. አዲስ ኤአ ር ቲ የ ጀመሩ
2. ከፍተኛ የ ቫይረስ ጫንን ያላቸው
3. ህክምና አቁሙየ ተማሉ
4. ሞድሃ ኒ ት በአ ግባቡ የ ሚውሰ ድ ችግር ያለ ባቸው
5. ሌሎች ምክ ን ያ ቶች (ይገ ለፅ)

ፀረ ኤች አይ ቪ ህክምና ያልጀመሩ (1-4)
1. ህክምና ለ ሚጀመር ፈቃደኛ ያልሆኑ
2. ህክምና ለ ሚጀመር >ከ2 ሳምን ት በላይ የ ወሰ ደባቸው
3. የ ጡና ህ ሙምመልክት የ ሚታይባቸው
4. ሌሎች ምክ ን ያ ቶች (ይገ ለፅ)

የ ተፈተሸ የ ተገ ኘ የ አእምሮ ጠፍ ማውጪ ምልክት (1-10)
1. ሚ ደበ ት
2. ጭ ቀ ት
3. ሽ ቅለ ት (ማን ያ)
4. በ ደባል ሱስ ማ ኮ ሚድ
5 . ሕይወትን የ ማ ኮፋ ት ስ ሜ ት
6. ከ ፍተኛ የ ሆነ የ አ ዕ ምሮ ማ ቃወስ (ሳ ይኮ ሲስ)
7. ሚ ሳ ት (ደ ሜ ሽ ያ)
8. የ ማ ኅል በ ሽ ታ
9. ሌሎች የ አ ዕ ምሮ ህ ሚሞ ች
10. የ አ ዕ ምሮ ጠፍ ች ግር አ ል ተገ ኘ በ ት ም

የ ተላ ኩበት ክ ፍል/ቦ ታ (1-3)
1. ኤ አ ር ቲ ክ ፍ ል
2. ሳ ይ ካ ትሪ ክ ፍ ል
3. የ ሚህ በ ረ ሰ ብ ድ ጋ ፍ ድ ር ጅ ቶ ች

የ ጠፍ ባ ለ ሞያ ውጭ ሚ ውጤት (1-10)
1. ሚ ደበ ት
2. ጭ ቀ ት
3. ሽ ቅለ ት (ማን ያ)
4. በ ደባል ሱስ ማ ኮ ሚድ
5. ሕይወትን የ ማ ኮፋ ት ስ ሜ ት
6. ከ ፍተኛ የ ሆነ የ አ ዕ ምሮ ማ ቃወስ (ሳ ይኮ ሲስ)
7. ሚ ሳ ት (ደ ሜ ሽ ያ)
8. የ ማ ኅል በ ሽ ታ
9. ሌሎች የ አ ዕ ምሮ በ ሽ ታ ዎች
10. የ አ ዕ ምሮ ጠፍ ች ግር አ ል ተገ ኘ በ ት ም

Fig 9.5: MHI service reporting template and instruction (To be completed by ACMs)

ሥነ - አእምሮ እና የፀረኤችአይቪህክምና ቅንጅታዊ አገልግሎት ሪፖርት			
1. በሥነ - አእምሮ እና የፀረኤችአይቪህክምና ቅንጅታዊ አገልግሎት ላይ ያተኮረ የጤና ትምህርት			
የጤና ትምህርት	**ወንድ**	**ሴት**	**አጠቃላይ**
በተቋሙውስጥበሥነ - አእምሮ እና የፀረኤችአይቪህክምና ቅንጅታዊ አገልግሎት ላይ ያተኮረ የጤና ትምህርት ያገኙ			

2. ሥነ - አእምሮ እና የፀረ ኤችአይቪ ህክምና ቅንጅታዊ አገልግሎት ሪፖርት ማድረጊያ																		
	የፀረኤችአይቪመድሃኒት የጀመሩ										የፀረኤችአይቪመድሃኒት ያልጀመሩ							
ሥነ - አእምሮ እና የፀረ ኤችአይቪ ህክምና ቅንጅታዊ አገልግሎት አማካኝ	አዲስመድሃኒት የጀመሩ		ከፍተኛየቫይረስማከንያላቸው		መድሃኒትአቋርጦየጀመሩ		የፀረኤችአይቪመድሃኒትአወሳሰድችግር የለበት		ሌሎች*		መድሃኒቱንለመውሰድፍቃደኛያልሆኑ		ከሁለትሳምንትበላይበዝግጅትላይያለ		የጤና ህመም ምልክት የሚታይባቸው		ሌሎች	አጠቃላይ
	ወ	ሴ	ወ	ሴ	ወ	ሴ	ወ	ሴ	ወ	ሴ	ወ	ሴ	ወ	ሴ	ወ	ሴ	ወ	ወ
በኬዝማናጀሮችለአይምሮህማሚ ተፈተሹብዛት																		
በኬዝማናጀሮችየአይምሮህሙምችግሮች የተለዩ ብዛት																		
በኬዝማናጀሮችከኤአርቲባለሞያጋርትስሰርየተደረገላቸውደንበኞችብዛት																		
ኤአርቲ ከጤና ባለሞያወደኬዝማናጀሮችየተደረገ ግብረሜልስ																		
ኤአርቲ ከጤና ባለሞያየአይምሮሕመማማ ኘቱየተረጋገጠ																		
በኤአርቲ ከጤና ባለሞያ ከስነ አይምሮባለሞያጋርትስሰርየተደረገላቸውደንበኞችብዛት																		
ሌሎች*ለምሳሌ፡ በጤና ባለሞያ ወይምኬዝ ማናጀር የስነ አይምሮ ሁኔታዎች ይኖሩባቸዋል ተብለውየታሰቡ ወይምበራሳቸውየስነ -አይምሮ ፍተሻ እንዲደረግላቸውየጠየቁ፣ እንዲሁምወጡትን ይፋ ከማድረግ አንፃር ከነባራዊ ሁኔታውበተለየ እጅግየተጋነነ ስጋት/ጭንቀት ያለባቸውሰዎች																		

የአዕምሮ ጤና ኬዝ ማናጅመንት ሪፖርት ቅፅ አሞላል መመሪያ			
1. **አላማ፡** ይህ የሪፖርት ቅፅ በጤና አገልግሎት ተቋሙውስጥየሚሰጠውን የአዕምሮ ጤና ኬዝ ማናጅመንት አገልግሎት ሪፖርተ ለማድረግ እንጠቀምበታለን			
2. **የሪፖረት ቅፁን የሚሞላውማን ነው?** በአማርኛየተዘጋጀውየሪፖርትቅፅየሚሞላውየአዕምሮጤና ኬዝማናጅመንትስልጠና በወሰደኬዝማናጀር ነው ፡			
3. **የሪፖረት ቅፁ የሚሞላውመቼ ነው?** የአዕምሮ ጤና ኬዝ ማናጅመንት ስልጠና ለወሰደው ኬዝ ማናጀር ሪፖረቱን በየወሩ ያዘጋጃል			
4. **.ማ ሻሰነዶች/የመረጃ ምንጮች፡** ኤአርቲ ክሊኒክ የጤና ትምህርት መመዝገቢያ ቅፅ፣ ኤአርቲ መዝገብ፣ ከፍተኛ የቫይረስ ማከን ያላቸውማታተያ ቅፅ፣ ህክምና አቋርጠው የጀመሩ፣ የኬር ማናጀሮች የለትሁኔታ መዝገብ፣ ህክምና ያልጀመሩ መዝገብ			
5..**ሪፖርት የማድረጊያ ማስመር፡** የአዕምሮ ጤና ኬዝ ማናጅመንት ስልጠና በወሰደ ኬዝ ማናጀር በየሳምንቱ የአዕምሮ ጤና ኬዝ ማናጅመንት ስልጠና ለወሰደው ኤአርቲ ባለሞያ ሪፖረት ያደርጋል፤ በተጨማሪምበየወሩ ለክልሉ ኤችአይቪ ፖዘቲቭ ማህበራት ጥምረት ሪፖቱን ያስገባል			
ተራ ቁጥር	**የረድፍ ርእስ**	**መመሪያ**	**ማ ሻሰነዶች/የመረጃ ምንጮች**
1	**የታዩ ደንበኞችቁጥር**	ለአእምሮ ጤና ህመምምልክቶች ፍተሻ	ኤአርቲ ክሊኒክ የጤና

		ለሚገረግ ትኩረት የ ሚሥጥሯውደንበኞችን በፆታ ለይቶ ቆጥሮ ቁጥሩን በየረድፋቸው ሚከቀሚጥ	ትምህርት መመዘገቢያ ቅፅ፣ ኤ አር ቲ መዘገብ፣ ከፍተኛ የቫይረስ ሚጠን ያላቸው ሚከታተያ ቅፅ፣ ህክምና አቋርጡውየጀሙ፣ የኬር ሚጀሮች የለት ሁኔታ መዘገብ፣ ህክምና ያልጀመሩ መዘገብ
2	በኬዝሚጀሮችለአይሚህ ሚሞየ ተፈተሹብዛት	ለአእምሮ ጤፍ ህሚምሚልክቶች ፍተሻ ለሚገረግ ትኩረት ከሚሥጥሯውደንበኞች ውስጥ የአእምሮ ጤፍ ህሚምሚልክቶች ፍተሻ የተደረገላቸውን በፆታ ለይቶ ቆጥሮ ቁጥሩን በየረድፋቸው ሚከቀሚጥ	የአዕምሮ ጤፍ ኬዝ ሚጅመንት አገልግሎት መዘገብ
3	በኬዝሚጀሮችየ አይሚህ ሚምችግሮች የ ተለዩ ብዛት	የአእምሮ ጤፍ ህሚምሚልክቶች ፍተሻ ከተደረገላቸውውስጥ የአእምሮ ጤፍ ሚታወክ ሚልክቶች ያለባቸውን በፆታ ለይቶ ቆጥሮ ቁጥሩን በየረድፋቸው ሚከቀሚጥ	
	በኬዝሚጀሮችከኤአርቲባለሚያጋርትስሰርየ ተደረገላቸውደንበኞችብዛት	የአእምሮ ጤፍ ሚታወክ ሚልክቶች ካለባቸው ውስጥ ወደ የአዕምሮ ጤፍ ኬዝ ሚጅመንት ስልጠና የ ወሰደው ኤአር ቲ ባለሚያ ተወስደው አገልግሎት ያገኙትን በፆታ ለይቶ ቆጥሮ ቁጥሩን በየረድፋቸው ሚከቀሚጥ	
4	ኤ አር ቲ ከጤፍ ባለሚያ ወደኬዝሚጀሮችየ ተደረገ ግብረ ሚልስ	የአእምሮ ጤፍ ሚታወክ ሚልክቶች ካለባቸው ውስጥ ወደ ሳይካትሪ/የአእምሮ ጤፍ ክፍል ተወስደው አገልግሎት ያገኙትን በፆታ ለይቶ ቆጥሮ ቁጥሩን በየረድፋቸው ሚከቀሚጥ	
5	ኤ አር ቲ ከጤፍ ባለሚያየ አይሚህሚምመጣ ኘቱየ ተረገ ጋገ ጠ	ወደ የአዕምሮ ጤፍ ኬዝ ሚጅመንት ስልጠና የ ወሰደው ኤአር ቲ ባለሚያ ተወስደው/ወይም ወደ ሳይካትሪ ክፍል ተወስደው አገልግሎት አግኝተውግብረ ሚልስ የ ሚጓላቸውን በፆታ ለይቶ ቆጥሮ ቁጥሩን በየረድፋቸው ሚከቀሚጥ	
6	በኤ አር ቲ ከጤፍ ባለሚያ ከስነ አይሚባለሚያጋርትስሰርየ ተደረገላቸውደንበኞችብዛት	ወደ የአዕምሮ ጤፍ ኬዝ ሚጅመንት ስልጠና የ ወሰደው ኤአር ቲ ባለሚያ ተወስደው/ወይም ወደ ሳይካትሪ ክፍል ተወስደው አገልግሎት አግኝተውግብረ ሚልስ ከሚጓላቸውን ውስጥ የተረጋገጠየአእምሮ ህሚም የተገኘባቸውን ቆጥሮ ቁጥሩን በፆታ ለይቶ በየረድፋቸው ሚከቀሚጥ	

Fig 9.6: MHI service reporting template (To be completed by ART clinicians)

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**		
	M	**F**	**M**	**F**	**Total**
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					

Instructions on how to complete MHI service reporting template
1. Purpose: This tools helps to report the MHI service activities in the HF **2. Who completes the reporting form** This form will be completed by MHI trained ART clinician, The ART clinician will review the MHI report/s submitted by ACMs using the Amharic version, make data verification &compile the reports using the English version MHI reporting tool

3. when is the time to complete MHI reporting form?
English version of MHI reporting tool should be completed by MHI trained ART clinician on monthly basis **4. Data sources**
CM activity log and treatment non initiated register, MHI CM monthly report
5. Reporting line
ARTclinician reports to ART focal person & HF HIS unit and the HF HIS unit report the woreda/town Health office who would in turn report to RHB

SN	Row title	Instruction	Data sources
1	**Screened by ACMs for MHD**	Count the number of MHI priority clients identified in the HF screened for MH conditions by sex disaggregation	ACMs MH log book
2	**Identified for MHD by ACMs**	Count the number of MHI priority clients screened for MH conditions and identified to have MH conditions by sex disaggregation	
3	**Linked to MHI trained provider**	Count the number of MHI priority clients identified to have MH conditions and are linked to MHI trained ART clinician with sex disaggregation	
4	**Feedback received from ART clinicians**	Count the number of MHI priority clients linked to psychiatry clinic and feedback received with by sex disaggregation	
5	**Confirmed diagnosis for MH conditions from ART clinic**	Count the number of MHI priority clients with confirmed diagnosis for MH conditions from ART clinic by sex disaggregation	
6	**Referred to psychiatry unit from ART clinic**	Count the number of MHI priority clients whose MH diagnosis is confirmed by ART clinicians and referred to psychiatry clinic for further management by sex disaggregation	

NB: If the MHI service cascade form is appropriately completed by ACM/s & data verification is done; ART clinician can transcribe the ACMS report for the specific reporting period from the Amaric version of MHI reporting tool in to the English version.

Fig 9.7: MHI activities report flow

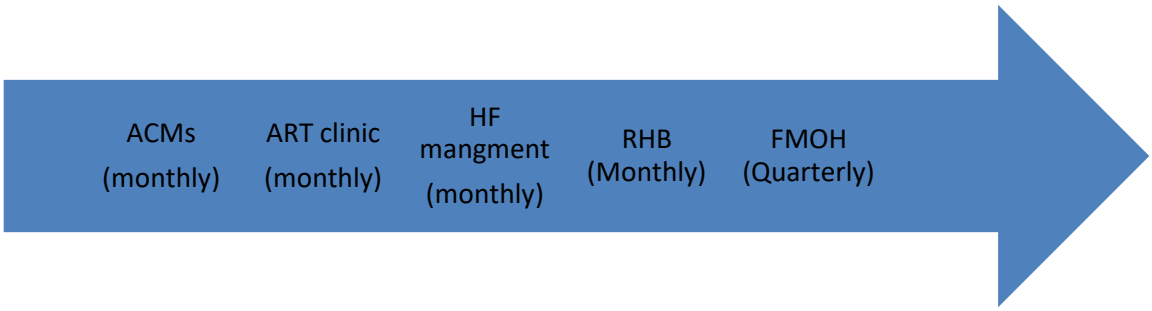


Figure 9.7: Data Analysis and discussions on MHI activities preparations PIPs on identified performance gaps

9.5. **Analysis, and discussion on MHI activities**

Module 9 Activity 5: ***Group discussion***

Purpose: to practice preparing PIP
Instruction: Individually complete previous quarter/month MHI performance data of your respective HFs on the MHI reporting tool within 10 minutes. If you do not have the data at hand, you can call your respective HFs or can use available recent data from other HFs.
Then, working in your groups and supporting each other, analyze MHI performance cascade, identify implementation gaps and prepare PIPs within another 10 minutes.
Discuss how relevant the PIPs you prepared is, as a startup document to prepare comprehensive HF level action plan for 5 minutes.
Then select one person from each group to give a 5-minute presentation of your methods and procedures, using one HF data as example.

Time: 30 minutes.

9.5.1. Important considerations for the future

- Present and discuss MHI performance activities in ART clinic MDT meetings on regular basis
- Present and discuss MHI performance activities in HF PMT meetings in regular basis
- Analyze MHI performance data by critically looking in to performance cascades of MHI activities, prepared PIPs for gaps identified and follow up implementation of PIPs developed
- Ensure MHI performance data is also discussed on the regional and national HIV review meetings.

9.6. Health facility level action plan on the implementation of MHI

Module 9 Activity 6: ***Group discussion***

Purpose: to practice preparing comprehensive HF level action plan for MHI
Instruction: Within your groups, and using the PIP presented earlier as an input, prepare a compressive HF level action plan to strengthen MHI activities in the HF. In addition, each group lists all possible challenges anticipated. Put your plan using the format shown on table 9.1. Finally, select one person from the group to present for 5 minutes.

Time: 30 minutes.

Table 9.1 Planning format for preparing comprehensive HF level plan for MHI activities

Action Area	Current Gaps	Key Activities or Actions	Person(s) Responsible	Resources Needed	Time frame

Module 9 Activity 8: *Reflections*

Purpose: to address participant concerns
Instruction: Raise any questions or comments about the module
Have you answered the questions raised at the beginning of the module?

Time; 5 minutes

9.7. Module summary

- MHI can not be successful without use of the flow chart and the other MHI tools
- Reporting helps HF officials follow and support the MHI process
- Reporting helps HF officials allocate the necessary resources for the success of MHI
- Reporting helps HF officials own the MHI
- Reporting helps health policy makers routinely get the necessary information which helps the passing of correct and appropriate policy decisions for the success of MHI

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Annexes

Annex 1: Clinical practice (Minimum of 6 -8 hours)

The trainees are expected to have clinical practice for a full day. The clinical training set up should be the same as their working environment, that is, not necessarily in mental hospitals. They can bring their reference manual and pocket guides to use during the interviews if they would like.

Groups of participants will be formed and they will be allowed to attend/practice what they have been taught regarding mental health and HIV in a minimum of one adult and one child/adolescent cases (cases will be selected ahead of time by a trainer who is a mental health specialist). Later the trainees will summarize the practice using the following table and present their cases for the larger group and group discussions will be done. The facilitator will give over all feedback later on after the discussion

1.1Summary Sheet for Clinical Practice

Assesses	Client 1	Client 2
Age		
Sex		
Pertinent Hx		
Results of mental status exam and other questions		
Decision/Classification		

Plan/Treatment (immediate and follow-up)		

1.2 Clinical practice assessment checklist

S. No.	Competency assessment items	Needs work	Achieved	NA
1	**Promote respect and dignity**			
	Treat all persons with MNS conditions with respect and dignity in a culturally appropriate manner			
	Promote inclusion and collaborative care of people with MNS conditions and their careers			
	Protect the confidentiality and consent of people with MNS conditions			
2	**Use effective communication skills**			
	Create an environment that facilitates open communication in priority MNS conditions Involve the person, and their career when appropriate, in all aspects of assessment and management of priority MNS conditions			
	Actively listen to the person with an MNS condition			
	Is friendly, respectful and non-judgmental at all times in interactions with a person with an MNS condition			
	Use good verbal communication skills in interactions with a person with an MNS condition			
	Respond with sensitivity when people with MNS condition disclose difficult experiences			
3	**Assessing and managing MNS conditions**			
	Perform an MNS assessment using history-taking, including: presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history			

	Assess and manage physical conditions			
	Assess and manage emergency presentations			
	Provide psychosocial interventions			
	Deliver pharmacological interventions as needed and appropriate			
	Overall			
Areas of strength				
Areas of improvement				

Adapted from the mhGAP.

Annex 2: Daily and over all course evaluation forms

No names should be put on the forms – they can be left face-down on the table in the training room at the end of each day, or put in a box or envelope provided by the trainers.

Annex 2.1 Daily Evaluation Form

Fill out this form as each topic is completed.
Please indicate on a 1–5 scale your opinion of the following course components:
1= Strongly disagree 2= Disagree 3= Neutral 4= Agree 5= Strongly agree

Day ------- (daily evaluation form)

COURSE COMPONENT	RATING
The modules covered were well addressed	
The time allocated for each activity was adequate throughout the module	
The topics covered were relevant to your work	
The Case studies, role plays and other group work activities are were relevant	
The support from the facilitator was satisfactory	
The topics covered had adequate contribution to your skill development	
You feel now confident to handle cases based on topics covered	
Clinical attachment sessions were facilitated well	

If you have any other suggestions ----------

Your professional background (nurse, doctor, etc.): _____

Thank you for your comments and we look forward to improve!!!

Annex 2.2:Overall Course Evaluation Form

For each of the items mentioned in the table, comment on your level of agreement to the adequacy of the items.

1= Strongly disagree 2= Disagree 3= Neutral 4= Agree 5= Strongly agree

Issue to be Evaluated	Score (1-5)	Comments/suggestions
Timeliness of invitation letters		
Ease of travel to the training venue		
Conduciveness of the training venue to learning and skills practice		
Adequacy and importance of clinical practice		
Usefulness and ease of use of handouts		
Daily starting time		
Daily ending time		
Preparedness of facilitators/trainers		
Duration of the course		
Refreshment		

If you have any additional comment: ----------

Your professional background (nurse, doctor, etc.): _____

Thanks for your comments and we will look forward for improvement.

Facilitator rating sheet for training sessions (to be completed after each module)

Date of training:_____ Name of trainer: _____

Training site: _____ Module number/title: _____

Number of participants: _____

Did the training start on time? _____

Did the training end on time? _____

The participants seem prepared.

Issue to be Evaluated	Score (1-5)	Comments/suggestions
The participants are prepared		
The participants are energetic and engaged		
There were no interruptions or distractions.		
You covered the material in the module thoroughly.		
The participants understood the material.		

Please write down:

If you had to skip some material, what did you skip?

_____
_____
_____

If you had to change some of the material for these participants, what did you change?

_____
_____
_____

Do you have any suggestions for revisions of this module, or for how best to teach it?

_____
_____
_____