Detecting and managing common child and adult mental health problems in HIV care

Facilitators' Guide
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The **Detecting and managing common child and adult mental health problems in HIV care** training package was first prepared by Dr. Teketel Tegegn, Neuropsychiatrist, Amanuel Specialized Mental Hospital (ASMH) and Dr. Larry Wissow (psychiatrist, Johns Hopkins School of Public Health) and with input from Dr. Degu Jerene (clinical director, JHU TSEHAI) and Henok Legesse (palliative care advisor, JHU TSEHAI)

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1. Dr. Abebaw Fekadu, Psychiatrist, AAU /ASMH
2. Dr. Abraham Endesha, FMOH
3. Dr Aschalew Endale, FMOH
4. Dr. Desalegn Bekele, Psychiatrist, ASMH
5. Dr. Elizabeth Berhanu, Psychiatrist, ASMH
6. Dr. Ginbaru G/Mariam, Psychiatrist, Defense Health
7. Dr. Haddis Solomon, Psychiatrist, ASMH
8. Dr. Kunuz Abdella, WHO Ethiopia
9. Ato Lelisa Ammanuel, JHU TSEHAI
10. Dr. Mesfin Araya, Psychiatrist, AAU
11. Dr. Solomon Tefera, Psychiatrist, AAU
12. Dr. Tedla W/Giorgis, Psychologist, FMOH
13. Dr Yonas Baheretibeb, Psychiatrist, AAU

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COURSE DESIGN

This training course is designed to enable non-mental health providers (doctors, health officers and nurses) to recognize and deliver brief, first-line interventions for people with mental health problems encountered in the course of comprehensive HIV care, treatment and support. Every setting that provides care for HIV infected individuals, be it at outpatient or an inpatient setting, can maximize the effectiveness of its programs by involving staff in specialized training and encouraging other healthcare workers to expand their existing knowledge regarding mental illnesses.

The training course consists of three components:

- Knowledge and skill update on the most frequently encountered mental health problems, including characteristic clinical features and management in HIV infected individuals.
- Communication skills which help elicit signs and symptoms of mental health problems as well helping to deliver supportive advice and counseling.
- Transfer of knowledge and skills to the job situation: soon after completing the course, the participants will be followed up by the supervisor or a facilitator to ensure that the knowledge and skills learnt are transferred to the job.

There is tentative course **schedule** provided in this Guide.

During the morning of the first day of the course a written test (Pre-test Questionnaire) will be given. Progress in knowledge base is measured at the end of the course using a practical clinical skills evaluation and a standardized written test (Post-test Questionnaire). Successful completion of the course is based on mastery of the content of the course. The participants will also complete a course evaluation form for overall evaluation of the course.

COURSE SYLLABUS

Course title: Detecting and managing common child and adult mental illness in HIV care

Course description: This 5- course is designed to update the knowledge and the skills of service providers who work in the area of prevention and treatment of HIV infection. It consists of the following nine modules and clinical practice. For TOT participants the CTS (clinical training skills) training will also be given.

The course modules are:

Introduction to mental health and HIV care
Module 1 Communication skills and assessment
Module 2 Thought, perception, and memory problems
Module 3 Depression
Module 4 Anxiety and psychotrauma
Module 5 Substance abuse
Module 6 Epilepsy
Module 7 Behavior and developmental issues in children and adolescents
Module 8 Mental health aspects of living with HIV
Module 9 Implementation issues
Clinical practice

Course participants: This course is designed for non-mental health worker health providers (doctors, health officers and nurses) that work in or intend to work in healthcare settings that provide care and treatment for HIV/AIDS. Trainers may need to adapt some of the material to best fit the background of particular trainees.

Course structure and training methods: This course is designed to last 5 days. Small-group exercises, role plays, case studies, clinical practice, and discussions are used as a teaching method.

The following table gives one suggestion for organizing the materials. Adequate breaks are needed to keep up energy and to allow for informal teaching and sharing among the trainers and participants.

	AM	**PM**
Day 1	Administrative issues, pre course assessment, Introduction	Module 1
Day 2	High lights of the previous day Module 2	Module 3
Day 3	High lights of the previous day Module 4 and 5	Module 6
Day 4	High lights of the previous day Modules 7 and 8	Module 8 and orientations about the clinical practice
Day 5	High lights of the previous day and clinical practice	Feedback of clinical practice, Module 9, post course assessment, and administrative issues

You may chose to follow the facilitators' guide closely using the method outlines (the participants read aloud or silently and then you discuss) or you may wish to make some summary points using slides and move directly to the exercizes. In any group there are likely to be learners who prefer one or the other method.

Whatever your methods it is essential to do as many of the small group case studies and role plays as possible. This is the way that participants will be able to become familiar with the way to approach mental health cases, and it will help them identify what aspects of the material they need to review. This active case work is also essential to their getting the most from the clincial practice session on Day 5.

Course materials: The training package for this course consists of the following components,

1. **The participants' manual, "Detecting and managing common child and adult mental health problems in HIV care"** is the core text for trainees. It also contains exercises for use during the training.
2. **The facilitator's guide** describes the facilitator's role in course planning and offers the facilitator directions to conduct each session. It contains introduction and course information, course schedule, general suggestions for teaching the course, specific suggestions for teaching each module, and activities including exercises, role-plays, and case studies by individual module.
3. **The pocket guide** which contains clinical logic models, some basic diagnostic and treatment outlines, and medication guides; it is meant to be a support for day-to-day implementation of the training materials.

4. A small number of "slides" are provided for easy group reference to key tables and diagrams.

Objectives

The overall goals of this training are:

1. To enable non-specialist health providers to work together in teams to recognize mental health problems among individuals receiving HIV care, and to deliver brief, first-line interventions.
2. To enable non-specialist health providers to collaborate with mental health specialists (nurses, psychologists, social workers and psychiatrists) in the evaluation and treatment of mental health problems among individuals receiving HIV care.
3. To be familiar with the many different ways in which people with mental health problems can be helped, and to be familiar with "stepped" approaches based on response to initial treatment and follow-up

What the training is meant to do:

1. Provide practical information about recognition of mental health problems, how to recognize and manage emergencies, how to give brief advice, and how to use basic medications
2. Enable the non-specialist to be an effective partner with mental health specialists, pharmacists, adherence supporters, and site supporters in providing care for mental health problems among individuals receiving HIV care.

What the training does not do:

1. Focus much on precise psychiatric diagnosis, but rather to help providers develop a broad differential diagnosis and identify emergencies.
2. Expect that providers will be functioning as professional psychotherapists or providing extended-length visits for psychotherapy

How to use this set of materials

This set of materials is designed to serve as a template for translation/adaptation in the particular setting where it will be used. It is possible that trainers will decide to change the order of modules, or even omit some in an initial training, depending on the priorities, audience, and time available at their particular site.

How to prepare for being a trainer

Ideally, trainers will have experienced the training itself. This may be as participants in a prior round of training or by going through the material in detail with each other. If this is not possible, trainers should at the very least read in detail the material that they will present, and skim the rest of the material so that they will be familiar with other things the participants are learning.

Whatever one's method of preparation, it is helpful to keep in mind that they purpose of the training is to provide participants with very practical information about common problems.

Most importantly, trainers should be prepared for their sessions: read through with an eye toward what materials will be needed (blank paper, handouts, flip charts, slides) and make sure that these are in hand prior to beginning.

Running a training session

Of course, the most important step in running a training session is preparation. Before you present, read the material in the participants' manual, review the corresponding section in the facilitator's guide, and think through the exercises making notes about the points you most want to teach. Make sure that you have whatever materials at hand that you need – flip charts, markers. The facilitator's guide is written so that the only equipment needed is a flip chart or blackboard, but a projector capable of showing "slides" from a laptop is suggested. For each module, you will want to know where, in the reference manual and pocket guide, are the appropriate flow charts, instruments, or tables that go along with that module's lessons. This will help participants become familiar with the reference material available so that they can use it in their actual clinical practice.

For the first session you need to factor in time for introductions – the participants probably all know each other but they may not know you or your background. Take time for people to talk about their individual goals and motivation for being in the course.

In general you need to be prepared to start and finish on time, but you also need to show how well you can roll with the needs of the group. It's likely that there will be stragglers, those who must leave in the middle, and those who say they have to leave early. Try to stay aware of the time – it's critical to respect the schedule – even if people are enthusiastic – they will still get restless if the training goes on too long or if it gets too passive or unfocused. If discussions are wandering, use some of the techniques from the training to get them back on track and move things along to the next activity. *Do not hesitate to appoint members of the group to take on the roles of timekeeper and "energizer."*

Remember that your training style will usually have to make up for many deficiencies in the training environment. Trainings often take place in conference rooms that have bad acoustics, lighting, and ventilation. Speak up, be energetic, postive, and engaging. Be prepared for power outages that will interrupt slide presentations.

Responding to questions about the training: In general, if someone asks a question that is critical of the training or for which you don't know the answer, consider techniques from the training!

1. "That sounds interesting/ important." Ask for other people's comments. What have others thought?

2. Don't feel compelled to be the expert or have an answer if you don't feel you have a good one. But if you can, try to remember the question and find the answer so that we can get it back to the participants.

Avoid saying (though it may be true) that you don't know why the authors of the training included this or that. Similarly, try not to make remarks that imply that you would have done the training differently had you written it. These sorts of statements undermine your credibility and make it harder to finish teaching the material. But please, DO let the authors know how the training could be improved, or if you found it necessary to make important adaptations for your set of participants, a particular site, or a particular patient group.

Supervising a role play: Adult learning is best accomplished in relatively brief, active sessions. Role plays – brief opportunities to act out a situation or skill – can be powerful ways to help

learners realize what they can and can't do, to motivate further learning, and to give confidence that the skills can be tried out in a real clinical assessment. If your participants are not familiar with role plays, or even if they are, you can remind them of the following thoughts:

1. This is just practice among friends and peers – no one is evaluating you
2. Don't worry a lot about the actual facts of the case – you will be given just a couple of details and you are free to use them or elaborate on them as you'd like
3. The whole role play itself should just take 3-4 minutes – it doesn't have to represent an entire visit
4. If you are taking on the role of a patient, take it easy! – don't try to be the most difficult patient you have ever experienced

Usually role plays are done in groups of three or four. Initially, two participants take on the roles, and the other two are observers. The participants then rotate so that everyone in the group has had a chance to be the "clinician" once. In many of the role plays in this training, though, there is a role for a family member as well as for the patient, so you may only have one observer.

The first time there is a role play in the training, you may want to demonstrate with two volunteers, and then let the groups work by themselves. This is a key place for you to set up an atmosphere of collaboration and support, and even fun. For the demonstration:

1. Ask for two volunteers. Have one of them read the role play instructions out loud. Then let them choose who will be the clinician and who the patient. Ask them to start; telling them they can stop at any time to ask you a question but that you will stop them at the end of about 3-4 minutes.
2. Let the role play go for about 3-4 minutes if it does not end by itself.
3. First, say something nice – tell the participants that they did a good job.
4. Next, ask the person playing the clinician for comments: What went well? What problems were faced? Do they have any questions for the person who was playing the patient and for those who were observing?
5. Do the same for the person playing the patient: What went well? What did they like about what the clinician did? What feelings were they having? Do they have any questions for the observers?
6. Each role play has some learning points attached to it – go over them and ask if there are any other questions.

Self-evaluation and feedback

You are likely to be very tired, but after each training session that you lead, fill out a copy of the trainer evaluation form (in the attachments to this guide) and assign someone from the participants to summarize the day's findings and present it on the next day. These comments will help us improve the training over time.

When you ask a participant to summarize material from a prior lesson, ask them to use the following guidelines

- the summary should not take more than 5 minutes to present
- they should not attempt to summarize all that was presented – but rather, make the points that they felt were the most important
- they are free to raise questions that remain unanswered or to ask about points that seemed unclear as they made their summary

- they should avoid reading the summary but rather try to present it from notes.

At the end of the training participants should also fill out the overall course evaluation form.

Introduction: HIV and Mental health

AIM: The aim of this unit is to give overall picture of the training and understand the correlation of HIV/AIDS and mental health

<table>
<tr><td rowspan="6">Total Duration:
105 minutes

Materials:
LCD projector
Blank flipchart/ marker pens,
Preparation:
Exercises
Case studies</td><td colspan="3">Learning Objectives: By the end of this section, participants will be able to:
• Understand the purpose of the training
• Understand the overall course content, methodology, and course materials
• Be able to understand relationships between mental health and HIV/AIDS
• Outline the framework and flow chart for mental health treatment</td></tr>
<tr><td>Content</td><td>Methods</td><td>Duration</td></tr>
<tr><td>Over all training goals , overall course content, methodology, and course materials</td><td>Reading, discussions</td><td>15 minutes</td></tr>
<tr><td>HIV and Mental illness</td><td>Reading, Discussions and exercises</td><td>60 minutes</td></tr>
<tr><td>Framework and flow chart for mental health treatment</td><td>Reading, Discussions</td><td>15mintes</td></tr>
<tr><td>Key points, Case stories</td><td>Case presentation, Group discussions,</td><td>15 minutes</td></tr>
</table>

Materials: ask if everyone has copies of the following two booklets, and describe their contents:

1. **The participants' reference manual** contains the background, diagnostic, and treatment information plus exercises for use during the training.
2. **The pocket guide** contains basic diagnostic and treatment outlines, diagnostic tools, summaries of advice for patients, and medication guides.

Participants' goals: go around the group asking people to say their name, their role in ART care, and what they hope to get from attending the training. Write down their goals on a flip chart and post them.

Some participants may speak quietly or very briefly, especially if it is a mixed group at several professional levels. Gently encourage everyone to speak up; tell them how much you value the chance to be working together as a team.

Goals of the training
Ask everyone to turn to page 3 of the participant's manual. Ask someone to read aloud the goals of the training and what the training is meant to do:

The overall goals of this training are:

1. To enable generalist providers to work together in teams to recognize mental health problems among individuals receiving HIV care, to deliver brief, first-line interventions.
2. To enable generalist health providers to collaborate with mental health specialists (psychiatrist nurses, clinical psychologists, social workers and psychiatrists) in the evaluation and treatment of mental health problems among individuals receiving HIV care.
3. To be familiar with the many different ways in which mental health problems can be helped, and to be familiar with "stepped" approaches based on response to initial treatment and follow-up

What the training is meant to do:

1. Provide practical information about recognition of mental health problems, how to recognize and manage emergencies, how to give brief advice, and how to use basic medications
2. Enable the non-specialist to be an effective partner with mental health specialists, pharmacists, adherence supporters, and site supporters in providing care for mental health problems among individuals receiving HIV care.

Compare the training goals with the participants' own goals and expectations.

If it comes up, you can reassure the participants that we don't expect them to become psychiatrists or psychologists, or to be conducting lengthy therapy, after only a few days of training. We do want them to be able to recognize when people may be having mental health problems and to start providing help while figuring out whether more specialized care is needed.

Go over the outline of the course *[Slide with table showing activities by day, or just describe it]*

Talk about commitments of trainers and participants
- Acknowledge that everyone is here because they care about making life better for people living with HIV/AIDS
- Trainers commit to staying on time, creating an atmosphere of respectful learning, helping everyone have an opportunity to participate
- Participants commit to coming on time, preparing when necessary, respecting each other's knowledge and needs to understand, and to engaging actively in the training.

What do we mean by mental health
Ask participants to go around the room reading paragraphs aloud from this section of the manual (pages 3-4).

Make two lists on a flip chart:

- What are some other that participants feel are signs that someone has good mental health?

  Discuss this list with the group: how do they know these things about the people around them? About their patients?

- What are some of the ideas that are commonly held about the causes of mental health problems, or the reasons why someone might not have good mental health?

  Discuss this list with the group: without getting into which ideas are correct or not, talk about how they might influence someone's willingness to get care.

HIV and mental health

Ask the participants to read quietly for a few minutes the section titled, "**Why is mental health important to caring for people with HIV/AIDS?"** (pages 4, up to the section on mental health treatment). Then do Exercise 1.

Exercise 1

Purpose: Generate ideas about the relationship between HIV and mental illness.

Ask the participants to listen to the following two cases. While they are listening, they should think about what they know about HIV and mental health from their own clinical experiences.

Ask one volunteer to read the first introductory case story [Exercise 1 of the introductory module – page 8]; then go through the questions and write responses on a flip chart.

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 psychiatric 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 pains, 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 seropositive.

1. What are the similarities and differences between HIV and schizophrenia treatment?

2. Can you think of any ways to try to protect people like Tsehay from exposure to HIV both when her mental illness is in control and when she relapses?

- Issues in common among chronic illnesses
  - Need for good adherence to long-term medication and monitoring
  - Side effects of medications discourage adherence
  - Stigma creates discouragement and adds to burden of illness
- Possible preventive measures
  - Help her family learn early signs of relapse so they can bring her to care

- Help her functioning in general so that she is less likely to be taken advantage of.

Ask another volunteer to read the second case:

Case 2
Ato Tollosa 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 doctor recommended that he start ART. Since then his behavior has changed. He says that he can not concentrate on his business. He has isolated himself from any social interaction, and felt so sad that he has contemplated killing himself.

1. What do you think Tollosa is experiencing and why do think it is happening now?

2. Can you think of any way that Tollosa's doctor could have prevented his response to the fall in his CD4 count, or perhaps made it less severe?

- List specific milestones of HIV disease which are more likely to predispose to psychiatric problems.
  - At discovery of seroconversion
  - At onset of physical symptoms
  - At HIV-related bereavement
  - At advance in HIV stage – due to awareness of neurocognitive decline, etc.
- Relationship of acute stress and mood changes
  - Hopelessness, inability to gain perspective beyond immediate situation
  - Intrusive thoughts, difficulty concentrating
  - Social withdrawal compounds problems
- Possible prevention steps
  - Educate ahead of time about inevitable changes in CD4 count and effectiveness of medications in reversing this
  - Tell Tollosa that he's likely to feel badly at this time, and many people do, but that it's just a phase of the treatment and that you will help him take good care of himself

Mental health treatment
Ask participants to read to themselves the paragraphs about mental health treatment (page 5).

Ask participants in what ways they are already helping people with mental health needs; ask them about mental health resources that they feel are already in place in the communities they serve.

- Encourage participants to think broadly about the kinds of interventions and supports that promote mental health or encourage treatment
  - Community groups
  - Religious groups
  - Traditional healers
  - Natural helpers, within communities, families, and the clinic
  - Help with day-to-day needs

Mental health decision-making process
Ask participants to turn to Figure 0.1 in their manual (page 7).

Explain to the participants about mental health work flow
- show the slide of Figure 0.1 if you are using the LCD projector
- explain the flow from engaging the patient, asking some mental health questions, getting a concern, using the brief mental status exam, and then picking one of the modules as a likely place to start

Summing up
Exercise 2: Interrelationship of mental illness and HIV/AIDS
Purpose:
a) To summarize and memorize the reasons for high risk of mental illness in HIV infected individuals and vice versa.
b) To know the common causes of psychiatric disturbances in HIV

Instruction
1. **While you write on a flip chart, ask** participants to list factors increasing the risk of mental illness in HIV infected individuals.

1. Primary – due to direct effect of HIV virus or immune reaction to it
   — Mild neurocognitive Disorder; Dementia; Psychosis etc.
2. Secondary to compromised immunity
   Infections and neoplasms
   — Toxoplasmosis, cryptococcal meningitis, cytomegalovirus encephalitis
   — Progressive Multifocal Leukoencephalitis (PML); lymphoma
3. Due to psychosocial factors
   Primary stressors leading to break down in coping capacity which occurs
   — At discovery of seroconversion, at onset of physical symptoms
   — At HIV-related bereavement, at advance in HIV stage – due to awareness of neurocognitive decline
   Secondary stressors
   — Stigmatization, loss of employment or inability to work – financially disadvantaged
4. Treatment related
   — Medications used to treat - HIV (ART), opportunistic infections, co-morbid medical illnesses
   — Drug-drug interactions

Summarize the module
- Ask participants for what they think are the main points made in the module
- Write each briefly on a flip chart
- Note that this is the format you'd like for the daily summaries that volunteers will be doing for each module

- The summary should not take more than 5 minutes to present
- They should not attempt to summarize all that was presented – but rather, make the points that they feel were the most important
- They are free to raise questions that remain unanswered or to ask about points that seemed unclear as they made their summary
- They should avoid reading the summary but rather try to present it from notes.

Module 1. Communication skills and assessment

Read the module objectives aloud to the participants [page 9]

Module objectives

1. To be able to use core communication skills to:
   - Build a therapeutic connection with families
   - Help families disclose concerns in actionable and efficient ways
   - Give advice that is likely to be accepted

2. To know a few screening questions that can be asked of every patient at intake and periodically during follow-up to open discussion of mental health issues

3. To be able to do a focused "mental status" interview that helps decide which assessment/treatment module to use first when it is not obvious

This module is divided into two main parts. The first covers basic communication skills that are themselves therapeutic and make it more likely patients will disclose mental health-related concerns. The second section covers mental health assessment in two ways: first, questions that can be asked of any patient to detect or monitor mental health problems, and second, a brief but more detailed list of questions that can be asked if a mental health problem is suspected.

Section 1. -Communication Skills

AIM: The aim of this first section is to understand the basics of communications

Overview of section 1 of the module

<table>
<tr><td rowspan="6">Total Duration:
50 minutes

Materials:
LCD projector
Blank flipchart/ marker pens,
Preparation:
Exercises
Case studies
Role plays</td><td colspan="3"><u>Learning Objectives</u>: By the end of this unit, participants will be able to:
• understand the basics of communications
• Build a therapeutic connection with patients and families
• Help patients and families disclose concerns in actionable and efficient ways
• Give advice that is likely to be accepted</td></tr>
<tr><td>Content</td><td>Methods</td><td>Duration</td></tr>
<tr><td>Objective</td><td>Reading</td><td>5 minutes</td></tr>
<tr><td>Interviewing and communications skills</td><td>Discussions exercises and role plays</td><td>20 minutes</td></tr>
<tr><td>Practice with communication skills</td><td>Discussions, role plays and exercises</td><td>20 minutes</td></tr>
<tr><td>Key points,
Case stories</td><td>Discussions and exercise</td><td>5 minutes</td></tr>
</table>

Ask participants to read Section 1, "Basic interviewing technique," individually (pages 9-10 of the participants' manual)

Ask the group to help you:

Define the difference between open and closed-ended questions

- Ask for some examples of both
- Ask why open may be preferable and why

Define reflective listening

- Ask for some examples of ways to listen reflectively
- Ask for a list of the goals of reflective listening

Define an empathetic comment

- Ask for some examples
- Ask for the goals of empathetic comments

Open-ended questions are questions that tend to draw information from the client and allow the client a great deal of scope in determining how to respond**.**

A close-ended, or directive, question - for specific information - absence of certain symptoms, assessing such factors as frequency, severity, and duration of symptoms; too many close-ended questions can be restrictive

Reflective listening comments focus the client's attention on the thoughts or feelings he or she is having in response to certain events or issues that are being discussed

It's possible that a participant will suggest that they sometimes make empathetic comments because they don't agree with what the patient did or they think that the patient deserves the difficulty they are experiencing. If so, you can note that it's possible to empathize with the feelings or dilemma without having to agree. For example, "I know that once you've said something hurtful like that to someone you wish you could have said something else."

Another issue that may come up when talking about empathy is how to provide reassurance. Truthful reassurance, or reassurance based on information the clinician knows, increases trust and adherence and can be experienced as an empathic response. False reassurance- essentially lying to a patient - can badly impair the patient's trust.

Talking about reassurance could also trigger a discussion of whether patients should always be told the truth about their prognosis; in many cultures it is believed to be humane not to tell people that they have a condition that may not respond to treatment. Ask for the group's views on this, and try to clarify what they think is considered the right thing to do where they practice.

Ask the participants to read individually Section 2, "Starting off a visit," (pages 11-12) of the reference manual.

Ask the group to help you (you can write on the flip chart) make a list of things that can help to get full list of concerns from a patient or family member.

Using open-ended questions Not assuming you know the reason for the visit Not interrupting the patient's first statements about their concerns Being alert for hints about problems Setting an agenda Paying attention to everyone present

Ask the group to read individually Section 3, "When people seem to be asking for advice" (page 11).

Ask them to give you some ideas about how to offer advice, and what to do if people seem reluctant to accept it. Ask what ideas they have had themselves Ask if anything might get in the way of carrying out the advice Ask for permission to give other information or to respond to concerns Be aware of hints that the patient is concerned about the advice you are giving

Communication skills role plays (page 17)
Purpose: To review and apply communication skills

Instructions for scenario 1: For this first role play, select two volunteers, one who acts as mother, and another as a HCW. Read the following scenario to the group before the role play. Ask the selected participants to act out the role play. Thank the participants for the role play

After the role play, ask the group to comment on how well the interview demonstrated the points discussed so far in the module. Make sure that the group starts off with praise or things that they thought were good about the participants' acting or interviewing skills.

Scenario 1
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

Now for Scenario 2, ask the group to break up into groups of 3 (the factory worker, the health care worker, and an observer). Ask them to go through the role play three times, so that each person gets to be the health care worker. Then ask for a report from at least one of the groups. Ask them to tell you which skills were easy to use, and which presented more difficulty.

Scenario 2

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 frequently 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.

Summarize your presentation by emphasizing on the following key points (you can ask the participants for their list first, and then if the following points are not covered you can add them)

- Through a skilled interview physicians can gather data necessary to understand and treat patients, and in the process, increase the patients' understanding of, compliance with the clinicians' advise

- There are specific techniques that make the information exchange between the health worker 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

Section 2. Routine questions and targeted assessment

Overview

AIM: The aims of this part of the module are

1. To help participants learn screening questions that can be asked of every patient at intake, and periodically during follow-up, to open discussion of mental health issues.

2. To be able to do a targeted assessment (a "mental status" interview) that helps decide which assessment/treatment module to use to try to better understand possible mental health problems.

<table>
<tr><td rowspan="5">Total Duration:
105 minutes

Materials:
LCD projector
Blank flipchart/ marker pens,
Preparation:
Exercises
Case studies
Role plays</td><td colspan="3">Learning Objectives: To learn screening questions that can be asked of every patient; To be able to do a brief mental status assessment to better understand possible mental health problems</td></tr>
<tr><td>Content</td><td>Methods</td><td>Duration</td></tr>
<tr><td>Objective</td><td>Reading</td><td>5 minutes</td></tr>
<tr><td>Routine questions and Mental Status Examination</td><td>Discussions exercises and role plays</td><td>80 minutes</td></tr>
<tr><td>Key points,
Case stories</td><td>Discussions and role plays</td><td>20 minutes</td></tr>
</table>

Read the aims aloud.

Ask a participant to read aloud the first two paragraphs under "C. Routine Questions" on page 12 of the reference guide. After they have read the paragraphs, ask the group:

- what other questions or questionnaires they use routinely at intakes or periodically in follow-up care (they might mention asking about TB symptoms, for example)
- ask the group why these other questions are asked routinely (answers might include that it serves as a reminder to that these are important issues; that the issues might otherwise be missed; that asking about it routinely makes it clear to patients that these are important issues)

Ask the participants to pair up and ask each other the adult and child routine questions. Tell them that they don't have to use the exact words, but can use similar questions that come more naturally to them (and they can practice with each other in whatever language they chose).

When everyone has had a chance to try out the questions, discuss how they think they can incorporate asking these questions at intakes and periodically during follow-up.

Tell the participants that you are now going to move on to Section D, assessment. You can explain to them that they are now going to learn a short version of what psychiatrists and psychologists call a "mental status exam," a comprehensive assessment of possible mental health problems. In many ways it is similar to the format used by generalists, but includes some different elements and places extra emphasis on others. This assessment will be useful when someone's initial concerns do not immediately suggest what kind of mental health problem they may have. This is often the case. Ideally, if there is time, the assessment can be useful even when the concerns seem clear – many conditions result in similar-appearing symptoms.

Ask the participants to read to themselves the first two paragraphs after "D. Assessment" on page 12. When they have finished, go around the group:

Exercise: Ask a participant to read one of the sections of the mental status exam, starting with "1. History and Background," on page 13. For each section, ask for suggestions on how to ask about the issues that have been covered, or what they might observe about the patient, or observe in a physical examination. Reproduce the outline on the flip chart as the participants give you the contents of each section. *This is a very important exercise to help the participants start to become familiar with this routine. Encourage them to refer to this list here or in the pocket guide whenever they are thinking about a case.*

1. History/background
2. How does the patient look
3. How is the patient interacting with you?
4. How do they describe their mood?
5. What is their thinking like?
6. Perceptions
7. Alertness and awareness
8. The neurologic exam
9. Functioning

Exercise 2: Practicing the mental status interview (page 17)
Ask participants to form groups of three (health care worker, patient, family member). They should read the case, and then refer to the outline of the brief mental status evaluation in their manual or in the pocket manual. Referring to the evaluation outline, the participant playing the health care provider should formulate questions they might ask each patient or their family, and think of observations to make in order to decide what sort of treatment is needed. They should not worry that they cannot yet do this in a lot of detail. They will learn more about each category as they go through the other modules. When they get to the end of each evaluation, they should take out Figure 0.1, the flow chart of all the modules, and talk about which module they think would be the best place to start for each patient.

When the groups have finished, ask for volunteers to tell you what sorts of problems they identified in each case and what aspects of the history stood out for them. Check to see if any other groups have come to different conclusions; if so, discuss the differences. If you want, use

the LCD projector to put up Figure 0.1, the overview of the modules, to help guide the discussion.

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, pains 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 seropositive. Now her family has brought her to see you because neighbors found her wandering late and night, and though they were old friends she did not seem to recognize them.

Case 2
Ato Tollosa 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 doctor recommended that he start ART. Since then his behavior has changed. He says that he can not 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.

Closing discussion of the module:
Summarize your discussion by focusing on the following key points

- The psychiatric interview is different from history taking in other medical conditions
- There are different interview techniques which are helpful to get the necessary information and to build a trustful therapeutic relationship with the patient.
- In psychiatric history taking one strives to get comprehensive picture of the patients life, not only the symptoms
- Through a skilled interview physicians can gather data necessary to understand and treat patients, and in the process, increase the patients' understanding of, compliance with the clinicians' advise
- There are specific techniques that make the information exchange between the health worker and the patient easy, open and constructive. The major ones include:
    - Open-ended vs. close-ended questions
    - Reflective listening comments
    - Empathic comments,
    - Giving advice
    - Reassurance
- The mental status examination is the description of the patient's appearance, speech, actions, and thoughts during the interview

Module 2: Thought, memory, and perceptual disturbances

Aim: The aim of this unit is to identify and treat a group of problems that are overall characterized by problems with thinking, perception and memory.

Overview

Total Duration:

240 minutes

Materials:

LCD projector

Blank flipchart/ marker pens,

Preparation:

Exercises

Case studies

Role Plays

Learning Objectives: By the end of this unit, participants :

1. Will be able to recognize individuals who have:
   a) Hallucinations and delusions
   b) Dementia
   c) Delerium
2. Will be able to assess and manage safety issues (for patient, staff, family members, and other clinic patients)
3. Will be able to recognize when a treatable acute medical illness may be the cause and either initiate treatment or refer the patient for treatment
4. Will be able to recognize dementia associated with HIV and initiate appropriate treatment
5. Will be able to initiate antipsychotic treatment for individuals with abnormal thought symptoms in the absence of medical illness or when symptom control is needed
6. Will be able to provide basic education to the patient and family members about the nature of the symptoms and how to cope with them
7. Will be able to refer to mental health specialists for additional diagnostic or treatment advice

Content	**Methods**	**Duration**
Objective, introduction and Introductory Case	Reading, Discussion on the case	5 minutes
Types of thought problems and How these patients are noticed in ART care?	Presentation, reading, exercises and role plays	80 minutes
Approach to treatment for thought, perception and memory disorder in primary care/HIV care and Follow-up care	Presentation, reading, exercises and role plays	80 minutes
Key points, Exercises and Case story 2	Case presentation, Group discussion,	30 minutes
Role play 1, 2	Group discussion,	15 minutes

Read the objectives aloud

1. To be able to recognize individuals who have:
   a) Hallucinations and delusions
   b) Dementia
   c) Delerium
2. To be able to assess and manage safety issues (for patient, staff, family members, and other clinic patients)
3. To be able to recognize when a treatable medical illness may be the cause of the patient's problems and either initiate treatment or refer the patient for treatment
4. To be able to recognize dementia associated with HIV and initiate appropriate treatment
5. To be able to initiate antipsychotic treatment for individuals with abnormal thought symptoms in the absence of medical illness or when symptom control is needed
6. To be able to provide basic education to the patient and family members about the nature of thought symptoms and how to cope with them
7. To know when to refer to mental health specialists for additional diagnostic or treatment advice

Read and discuss the following introduction [page 19 of reference manual]
This module addresses a group of problems that are overall characterized by problems with thinking, perception and memory. These problems go beyond simple confusion, being indecisive, or forgetful. They include hearing voices not heard by others or seeing things that are not seen by others. They involve truly not being able to tell what is real from what is not real, not knowing where one is or even who one is, or not being able to remember even the most basic things e.g. fasting days or holidays.

These 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.

Ask a volunteer participant to read the first introductory case (page 19 of the reference manual). The purpose of this exercise is to help the participants get an idea of how familiar they are with severe mental illness and what their attitudes and biases might be. You can introduce the exercise by saying that you will come back to the case later in more detail, but that right now you just want to see how familiar people are with this sort of problem. You can also note that in Ethiopia (and many other places) talking about someone like this, or saying you know someone like this, can be very sensitive, so talking about this case is also somewhat of an "ice breaker."

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 this sort 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?

Ask participants to read to themselves about the types of thought problems (sections A and B, pages 19-21 of the participants' manual). This reviews and goes into some more depth from the material in Module 1.

Distribute the following list (or write it on a flip chart) and ask participants to fill in or give you examples.

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

Exercise 1 (page XX in the reference manual):

Purpose: To identify and understand the terminology of signs and symptoms of mental disorders

Instructions:
Ask volunteer participants to read the following cases (one case per participant). After each case story is read, ask the participants to identify the psychiatric terminology for the sign or symptom in each case.

1. Thought problem terminology

Instructions: for each of these cases, give the mental health/psychiatric term that best corresponds.

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. (Paranoid delusions, ideas of reference)

2. 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. (An illusion, likely from anxiety, not likely to be delerium)

3. 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, and he does know where he is. (This is probably dementia)

4. For the past 2 months, a 22-year-old college student has been increasingly convinced that a well-known music star, Dawit Melese, 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. (This could be a delusion)

5. A patient's family reports that he frequently seems to change what he is doing in the middle of it. In your interview with him, he tells you that he hears the voice of a man telling him that he is a sinful person. (These are auditory hallucinations)

Before moving on, ask the participants to look back at the case of Bogale (the introductory case). How would they describe his symptoms using the terms that they have just learned?

Ask the participants to read the *first paragraph* of Section C, urgent needs for treatment under "Approach to treatment for thought, perception and memory disorder in primary care/HIV care" (page 22).

Ask them to look forward to Case 2 in the exercises for this module (Taye, who is brought to the clinic after hearing voices and attempting to stab a co-worker – bottom of page 33).

Taye is a 23 year old factory worker, single, who is taking ART for about a month. Last week he started to show behavioral changes. He claimed that, two weeks ago, one of the co-workers has put something in his food during lunch. Since then he has not been his old self. He believes he is under the control of some spirit. This thing forces him to do things he does not like. For example, the thing tells him he may not wear red colored cloth. His sleep is disturbed with interruptions and nightmares. This morning he heard the voice of his co-worker, even though he was alone in the toilet. It said "Koy gena minun ayteh". He is brought to the clinic by friends who caught him trying to stab his co-worker with a dagger. He has no fever, cough, or chest pain. He is fully conscious and his speech is coherent.

Discuss safety issues. Don't worry about diagnosis at this point. What about Taye's story would make the participants worried? What would they want to observe when they first meet Taye? What precautions would they take? How would they interact with him?

Ask the participants to read to themselves the next section (2) of Section C, covering delerium and opportunistic infections.

Ask participants the following questions (you can put up the table of opportunistic infections during this discussion):

What can cause psychosis in people living with HIV?
What presentations might lead you to believe that the thought or memory problem is being caused by a medical illness?
What drug-drug interactions, and drug side effects should one consider?

Summarize the discussion using the information in the following table

- Psychosis is usually a later stage complications of HIV/AIDS
- Caused mainly due to medical illness, opportunistic infections, and medication side effects
- Hallucinations tend to include **visual, olfactory and tactile** elements more often than in primary psychotic disorders.
- Delusions of all types may occur in HIV disease. **Persecutory delusions** are probably the most common.
- **Cognitive disturbances**, disturbance of level of consciousness could be present
- **Delerium** is a disorder of alertness and thought that usually is a sign of a serious underlying medical problem

Ask the participants to read the next section (3) of Section C, covering primary mental disorders.

Ask a volunteer participant to read the following case (it is Case 3 in the exercises at the end of the module).

Ato Ketema is a 42 year old government employee with a 2-month history of behavioral changes. His wife stated that he has become suspicious of her. He checks her frequently; makes a phone call to her office many times a day, spies on her, and comes to her workplace unsuspected. She once found him checking her pants for signs that she had been having sex. Lately he has become restless, talkative, sometimes carrying on conversations with himself. During your interview he is agitated and his speech is pressured. He is conscious and fully oriented.

Ask participants the following questions

1. What additional information would you like to know to feel more comfortable that Ketema's behavior is not related to a medical illness?
2. What investigations might you perform?
3. What kind of psychiatric disorder might Ketema have?

Summarize the discussion using the information in the following table

Ask for the presence or absence of signs and symptoms of medical illnesses or substance abuse

Ask about a history of seizures or changes in alertness

Ask what medications he may be taking

With a normal physical examination there may not be any specific lab tests, but if this is the first time this has happened it is worrisome given Ketema's age (42; most primary mental health problems start earlier).

Possible primary mental health problems include mania/bipolar disorder, schizophrenia, delusional disorder

Ask the participants to read part 4 of Section C (covering psychoeducation).

Using the flip chart to record answers, ask the participants to tell you what they think are the most important aspects of psychoeducation for a patient who is experiencing a thought disorder, and for their family.

- make sure to ask them for any other things they think are important that may not be in the manual
- ask them what questions they think families are most likely to ask, and how they would answer them (especially about other explanations for the person's behavior, such as that the patient is possessed)

Ask the participants to read parts 5-6 of Section C (covering medications and their side effects)

Using the flip chart to record answers, ask the participants to suggest a medication for someone who they think has a primary mental health problem with psychotic symptoms (they should refer to Table 2.2 while they are answering – you can put up the slide of this table for this discussion).

- Ask them to suggest an initial dose
- Ask them to list the kinds of side effects they might expect

Make sure that they know the signs of acute dystonia – grimacing, difficulty swallowing – and how to treat it.

Ask the participants to read the section 7 of Section C (describing dementia)

Exercise to differentiate between the clinical manifestations and treatment of delirium and dementia

Instruction: distribute a paper for each participant, or using the flip chart, ask participants to complete the following table. If you have the participants do it individually, summarize the discussion on a flip chart to make sure that all have grasped the key differences.

Feature	Dementia	Delirium
Onset	Slow	Rapid
Duration	Months to years	Hours to weeks
Level of consciousness	Preserved	Fluctuates

Memory	Impaired remote memory	Impaired recent and immediate memory
Speech	Word-finding difficulty	Incoherent (slow or rapid)
Main aspects of treatment	Treat with ART if HIV dementia suspected; educate family; provide help with daily function; ensure adequate supervision	Treat underlying cause; provide orientation and support, treat symptoms if necessary

Ask one volunteer to read the following case (in the Exercises section of this module in the reference manual – "Cases to think about to differentiate dementia and delerium.") (page 33).

Ato Tollossa Gemechu, a 27 years old merchant, is brought to a hospital by his wife. Two years ago he found out that he is 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 hallucination. Such periods alternate with periods of relative normalcy during which time Ato Tollossa becomes calm, coherent with no memory impairment, hallucination or delusion. Physical examination showed no abnormality except low grade fever.

Ask the participants the following questions

a. What is the most likely psychiatric diagnosis? – Likely delerium
b. What will you check in physical examination? – Look for signs of a medical illness.
c. What are the possible causative factors? -- See the table below.
d. List out the most important components of treatment in this case? – Treat the medical illness, provide support when he is disoriented and avoid situations that provoke disorientation, stop medications that may be causing delerium, consider an antipsychotic to control symptoms (but not a continuous dose).

Summarize the discussion using the information in the following table:

Causes of delirium in HIV infected individuals:

- Opportunistic infections -
- Delirium causing drugs in HIV Treatment
  - ✓ Amphotericin B
  - ✓ Ketoconazole
  - ✓ Opiates
  - ✓ Quinolone antibiotics
  - ✓ Rifampicine
  - ✓ Gancyclovir
  - ✓ Didanosine
  - ✓ Zidovudine
- Tumors

Ask one volunteer to read the following case (page 33, the second case under "Differentiating delerium and dementia"

A 61-year old male Ethiopian high school teacher, who was a well-experienced and enthusiastic teacher, appeared to lose interest in his usual work, 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.

This is a case suggestive of dementia. Ask the participants the following questions

a. When you interview the relatives, what information would you check? -- Timing of onset, symptoms of medical illness, history of substance use, medications he is taking.
b. In what components of the mental state examination you would expect to find abnormality? – mostly problems with memory and orientation; if HIV related might expect some motor problems (you can refer to the HIV dementia scale)
c. If this patient is HIV positive, would you consider ART treatment? – Yes, in the hope that some of the symptoms would be reversible.
d. Which of his symptoms respond to psychotropic drug administration? – None of the symptoms named here would likely respond to antipsychotics.

Ask the participants to read sections D and E about follow-up and referral, and then turn to the exercises at the end of the module.

Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions (page 33)

These might be best done in groups or two or three, with some groups doing Cases 1 and 2 and others doing Cases 3 and 4. Give the participants time to work on the cases (about 10 minutes) and then ask for volunteers to present their reasoning, one group for each of the two cases. During the presentations you can, if you wish, put up the slide of the thought problem flow diagram.

Instructions to students: For each case, go through the categories of the brief mental status exam 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 and the reference and pocket guide materials to reach a decision about what you might need to do for the patient.

Case 1

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. Prior to this he was normal, and though he is HIV positive, his most recent laboratory tests show a moderate viral load and high CD4 count. He is not taking any medications.

- Bogale is in the high risk age range for developing a primary psychiatric problem which could be schizophrenia or bipolar disorder, but could also be experiencing problems from substance use.

Case 2

Taye is a 23 year old factory worker, single, who is taking ART for about a month. Last week he started to show behavioral changes. He claimed that, two weeks ago, one of the co-workers has put something in his food during lunch. Since then he has not been his old self. He believes he is

under the control of some spirit. This thing forces him to do things he does not like. For example, the thing tells him he may not wear red colored cloth. His sleep is disturbed with interruptions and nightmares. This morning he heard the voice of his co-worker, even though he was alone in the toilet. It said "Koy gena minun ayteh". He is brought to the clinic by friends who caught him trying to stab his co-worker with a dagger. He has no fever, cough, or chest pain. He is fully conscious and his speech is coherent.

- you previously went over this case for concerns for safety. Now the focus is on what to do for him initially. Make sure that the participants consider medical issues, medication interactions, and a primary mental health problem as possible concerns.
- part of the discussion could be about whether he should get an antipsychotic medication or not. Make sure that medication interactions are considered if the group wants to use a medication, and that any dose should likely be very low.

Case 3

Ato Ketema is a 42 year old government employee with a 2-month history of behavioral changes. His wife stated that he has become suspicious of her. He checks her frequently; makes a phone call to her office many times a day, spies on her, and comes to her workplace unsuspected. She once found him checking her pants for signs that she had been having sex. Lately he has become restless, talkative, sometimes carrying on conversations with himself. During your interview he is agitated and his speech is pressured. He is conscious and fully oriented.

- the agitation and pressured speech could be clues that this is mania, but at least acutely it could be substance abuse or some forms of intoxication. This is another good place to discuss whether medication might be appropriate.

Case 4

Senayt is a 35 year old woman who has had HIV for several years. She was put out by her family when she revealed the diagnosis, and has lived with various friends and worked low-paying and difficult jobs. She will come for ART treatment and start but then vanish for months at a time; when she comes back she says she has run out of her medicine or had to leave it behind at a place she could no longer stay. Recently she has getting confused about how to take the minibus from work to where she is now staying. She has had trouble remembering some of the things she needs to buy to cook, and also has had trouble sewing.

- this case is should make participants think about HIV dementia, but you can also, in your discussion, suggest that in the next module they will learn more about depression and that sometimes severe depression can have cognitive symptoms that might be mistaken for mild dementia – people have trouble with memory or even simple reasoning

3. Role plays to practice interviewing, differential diagnosis, and psychoeducation (page 34)

Instructions: Take turns being the patient, clinician, or accompanying family member. The clinician should use the brief mental status guide to 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. The clinician should then explain the diagnosis and plan to the patient and accompanying family member. Participants can use materials from the reference guide – for example, the HIV Dementia Scale or questions about orientation and memory.

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 hasn't 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 attempt 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 may be the interviewer is evil.

- In this case focus on how well the interviewer covers questions that would relate to the range of thought symptoms that can occur.

Case 2

You are the spouse of Ato Mehari, a young man in his late 20's who has been treated in the ART clinic for two years and has been adherent to his treatment. You've brought him in because in the course of a few weeks he started to act strangely. He has begun to talk in ways that don't 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 don't do anything. His sleep is disturbed; seems to see things no one is seeing. 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.

- This case may provoke more practice asking about history and symptoms consistent with a medical problem or medication interaction.

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 same question again and again. He once gets 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 become so confused 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 nor does some unexpected things. Her life has become miserable.

- This case should provoke questions and counseling about dementia

Summarize your presentation by emphasizing on the following key points (also in the participants' reference manual on page 31).

Thought problems

- In cases of psychosis you will find disturbances of thought, perception, and changes in speech, mood, or behavior. Psychotic individuals do not recognize that they are ill.
- Schizophrenia, mania, psychotic depression, and delusional disorder are primary psychotic disorders
- Psychotic states can also be caused by clearly identifiable medical illnesses or in association with use of drugs – medications or abuse drugs
- Psychosis is highly prevalent in HIV/AIDS cases.
- While drug treatment of psychosis with typical and atypical antipsychotic drugs is the mainstay of treatment, behavioral handling of agitated psychotic patient and giving psychoeducation to patient and family are important components of treatment.

- In those HIV cases who are taking ART, the administration of antipsychotic drugs could lead to unwanted effects and interactions and therefore precautions should be taken.
- In those with persistent psychosis, like ART management, adherence to treatment should always be emphasized.

Memory problems

- Cognition includes memory, language, orientation, judgment, conducting interpersonal relationships, performing actions (praxis), and problem solving, and could be caused by general medical condition, substances or multiple factors.
- Delirium is characterized by its acute onset of fluctuating cognitive impairment with disturbance of consciousness, and is more prominent at night.
- Delirium is highly prevalent HIV. It is caused by opportunistic infections, tumors and different medications used in HIV treatment
- Dementia is a condition in which there is a progressive impairment of cognitive functions occurring in clear consciousness. It mainly affects memory, attention, thinking, and comprehension which leads to behavioral changes and impairment in social or occupational functioning
- In HIV dementia there is motor abnormality like slowed rapid movements, abnormal gait, incoordination, hyperreflexia, hypertonia, or muscle weakness.
- HIV dementia is more common in the late stage of HIV illness or with anemia, low CD4 cell count, and high plasma viral.
- Treatment in both delirium and dementia includes:
    - Identifying and treating the primary cause (though in non-HIV dementia there may be no treatment).

Module 3: Depression

AIM: The aim of this unit is to identify and treat depression and prevent suicide in HIV

Total Duration: 195 minutes **Materials**: LCD projector Blank flipchart/ marker pens, **Preparation**: Exercises Case studies Role plays	**Learning Objectives**: By the end of this unit, participants will be able : - To be able to identify, evaluate, and respond to emergencies (in particular suicidal ideation and psychotic symptoms) - To identify medical conditions that may be contributing to low mood - To be able to assess overall severity of mood problems and decide on the level of intervention required - To use good advice-giving skills to be an empathetic and therapeutic listener - To be able to give psychoeducation about low mood - To use good advice-giving skills to give brief advice about depression self-management, including behavioral activation, stress management, and problem solving. - To know when medication for low mood may be warranted, and to know how to chose and prescribe initial medications - To be able identify, assess, and provide initial advice to mothers of young children who may be depressed		
	Content	**Methods**	**Duration**
	Objective Introductory Case story 1	Reading ,discussions	20 minutes
	Etiology, Clinical Manifestations of depression and suicide in HIV	Presentation, reading ,discussions	60 minutes
	Treatment and follow up	Presentation, reading ,discussions	70 minutes
	Referral criteria Case story 2	Presentation, reading ,discussions	40 minutes
	Role play 1, 2	Reading ,discussions, role play	35 minutes

infected individuals.

Read the objectives aloud

1. To be able to identify, evaluate, and respond to emergencies (in particular suicidal ideation and psychotic symptoms) related to low mood
2. To identify medical conditions that may be contributing to low mood
3. To be able to assess overall severity of mood problems and decide on the level of intervention required

4. To be able to give psychoeducation about low mood
5. To use good advice-giving skills to give brief advice about depression self-management, including behavioral activation, stress management, and problem solving.
6. To know when medication for low mood may be warranted, and to know how to chose and prescribe initial medications
7. To be able identify, assess, and provide initial advice to mothers of young children who may be depressed

Read and discuss the following introduction
This module introduces detection and treatment of problems associated with low mood. These are 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. WHO predicts that major depression will become second only to ischemic heart disease as a cause of disability among adults.

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.

Present the following introductory cases (pages 37-38). As in the prior module, the purpose of reviewing these cases is to assess the participants' familiarity with this type of mental health problem. *It is also a good opportunity to assess stigma associated with this type of case.* What are the participants' attitudes toward the causes and treatment? You may want to bring out some gender differences in assumptions about the causes of depression, or feelings that people bring on their low mood through their actions. Another point to bring out from the second case is that depression can occur in children, too, and that is it often hidden because the symptoms are taken as only bad behavior, or because 'children should have no reason to be depressed.'

Ask one volunteer to read the following case:

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.

Questions to ask to prompt discussion:

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

Case 2

Etenesh is a 12-year old girl who recently was forced to move to a new neighborhood because her grandmother died and the family's economic situation changed. Before, 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 in this time when the family must adapt to new surroundings that Etenseh is not being helpful. Etenesh's mother does not understand the change in her daughter and thinks it might be because she is becoming an adolescent.

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

Ask the participants to read Section A and Section B of the module up to *but not including the section on "assessing suicidality."*

Start the first exercise for this module, major symptoms of depression and suicidality (page 49)

Purpose: review major psychological and somatic symptoms, review questions to ask to elicit them.

Instruction: While you or a participant writes on the flip chart, individually list as many possible symptoms as you can in the two main categories (psychological and somatic). Highlight or put a mark next to the ones you think are the most common or most important to ask about. Put another set of marks next to things that might be different in children compared to adults. Then, go around the group each proposing a way to ask patients about each of the symptoms.

Ask the group for suggestions about other somatic symptoms, or for stories about patients they have seen who had unexplained somatic symptoms that could have been indications of low mood or worry.

Ask the group to now read the section on assessing suicidality. Then continue with the exercise: What are some initial questions to ask everyone you are evaluating for possible depression? What additional questions would you ask if the person said they had some suicidal thoughts? Which responses would make you think that the person is at high risk of self harm?

- help the participants think of this as a two-stage process with some initial

questions that ask about suicidal feelings and then a second set that follows up on specifics if the first are positive:

- first stage questions:
    - 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? *Tesfa mokuret* – do you have periods of hopelessness?
    - Have you ever thought of harming yourself

- Second stage questions
    - 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)

Ask the group to tell you some of the other things a patient might tell them that would make them think about an elevated risk of suicide.

Ask the group to read part 1 of section D about treatment of depression (this part focuses on identifying emergencies) (page 42). Suggest to them that it could be helpful to look at the flow chart for this module (at the end of the module in the reference manual, and also in the pocket guide) while reading this and the following sections).

Exercise: While you or a volunteer writes on a flip chart, list situations in which someone who may have depression might need emergency treatment. Make sure that the group mentions:

- depression accompanied by severe thought problems
- people who say that they are actively suicidal (you can refer to the discussion you just had about suicidal symptoms)
- people who are depressed and acutely intoxicated
- worry about having taken insecticide or some other poisonous substance, including medication (make sure to ask the group what some of the more common things might be where they practice)

Make another flip chart list of stages of HIV illness that could be related to suicidal thoughts (this is partially a review from the introductory module)

- recent medical bad news
- recent shaming, disclosure, or rejection
- death of someone else from HIV, especially someone close (partner, parent)

Ask the group to read part 2 of section D about treatment (this part focuses on causes and treatment of less severe depression)

Exercise: Make another flip chart list of medical conditions or medications that can provoke depressive symptoms or make depression worse. You can direct the participants to the table in the Pocket Guide that give mental health side effects of medications commonly used in HIV care.

Ask the group for the key points of depression psychoeducation they could try to communicate to patients and their families:

- 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. 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.

Ask the group for some brief advice they could suggest to someone with mild depression.

- 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).

Ask the group to remember some of the communication techniques that could be helpful for people with depression:

- Give the patient time to explain their feelings
- Empathize with their difficulties
- Find something positive to say – at least, complement them on their willingness to talk and to seek help

Ask the group to read part 3 of section D about treatment (this part focuses on medication treatment)

Ask the group how they might decide if someone should be recommended medication for depression, and which medications they would consider for someone not on any other medications, and for someone who might be taking ART. You can put up the slide of Table 3.1 to guide this discussion.

Ask the group to read sections E and F about follow-up and referral criteria. This is now preparation for working on the case materials and role plays. You can introduce this section by pointing out some important issues about depression and its treatment:

- While some people will feel better quickly, for many others improvement is very gradual
- It is quite common for people to feel discouraged with lack of progress and stop treatment within the first days or weeks
- Relapses are common, especially for those who stop treatment as soon as they start to feel better

Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions (page 49).

Instructions: For each case, go through the categories of the brief mental status exam 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 and the reference and pocket guide materials to reach a decision about what you might need to do for the patient.

As in Module 2, you might want to have participants work in groups of two or three, each group taking two of the cases and working on them for about five minutes. You can put up the slide of the low mood flow diagram while they are working. Then one of the groups will report on their management of each case. As you hear them present their plans, think about how they are assessing severity, and how completely they are thinking about treatment (psychoeducation, advice, medication, use of community resources).

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 not 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.

[In the discussion, make sure that the participants recognize all of the symptoms of depression. You could also make sure that the participants think about chronic illnesses, poor nutrition, and chronic psychosocial stressors as contributors. You will want to make sure that they have ideas about how to follow-up on Almaz's statement that she prefers to die rather than live. What risk factors for suicide might they assess? If they were to offer ambulatory treatment, what precautions might they advise for her family? How do they approach the question of using medication or not?]

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.

[What other questions would you want the participants to ask about his medical and mental status before they made a decision about diagnosis and treatment? We don't really know his health status from this description, nor if he is suicidal.]

Case 3

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's come 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 she has not felt much purpose in life; she says that her motto is just to life for today, because life can be so uncertain. Her physical examination is normal.

[For the discussion of this case:

- Look for presence or absence of overt suicidal thoughts
- Check for the presence or absence of medical illnesses – what conditions might be present in the absence of findings on the physical exam?
- Have they considered substance use as something that could be contributing?]

Case 4

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.

[For the discussion of this case:

- What prompted her to make a suicide attempt
- Whether she has depressed mood; Whether Hirut is still suicidal- don not regret what she did, check whether she has psychotic symptoms as well
- Drug treatment – based on severity of depression
    a. in severe depression – antidepressants
    b. choice of antidepressant – based on clinical symptom e.g. TCA (amitriptyline for those with diarrhea), for suspected suicidal patient SSRI preferable
    c. if additional psychotic symptoms – antipsychotics
- Areas of counseling
    a. Self-blame, self-esteem, guilt, negative thoughts
    b. Issues regarding death
    c. Practical themes: career plans, relationships with families and friends; identifying and managing stressors, etc.]

Case 5

Etenesh is a 12-year old girl who recently was forced to move to a new neighborhood because her grandmother died and the family's economic situation changed. Before, 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 in this time when the family must adapt to new surroundings that Etenseh is not being helpful. Etenesh's mother does not understand the change in her daughter and thinks it might be because she is becoming an adolescent.

[For discussion of this case:
- Are there any medications that might be of help (not likely)?
- Is there other information to be obtained (think about nutrition, bullying or other violence)
- Focus on advice to the family]

Case 6
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.

[For discussion of this case:
- What other information would you want the participants to get?
- How would you assess risk of suicide?
- If you were to start a medication, what would you have to consider?]

Case 7
Abdella is is 35 year old, single, an accountant who is 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 girl friend, he started to show behavioral changes. He stopped going to work. He is slow, spends most of his time in his bed, cry a lot and his sleep was full of nightmare.

[For discussion of this case"
- Death of his girl friend- loss as a precipitating crisis that could be focus for counseling and support]
- Being started on HAART – what is the meaning of this to Abdella; what is his overall adjustment to having HIV?
- Drug side effects ; drug-drug interaction – which of the commonly used HIV or anti-TB medications could be contributing?
- Drug treatment- antidepressants – considerations for the total number of medications being used, contributing to problems with adherence]

Role plays to practice interviewing, differential diagnosis, and psychoeducation (page 50)

As in the first module, the participants should break up into groups of 3-4 (the three "actors" and an observer) and rotate roles at least once so that all members of the group get to have an active part at least once. Each group should do only one of the scenarios. When the groups have finished their work, lead a discussion about the decisions that they made about the nature of the patient's problem and the treatment on which they decided.

Instructions: Participants should take turns being the patient, clinician, and an accompanying family member. The clinician should use the brief mental status guide to 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. The clinician should then explain the diagnosis and plan to the patient and accompanying family member.

Scenario 1

Senait, and is 31. She is 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 seem 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.

[Additional questions could be raised to rule out possible causative factors, and to select treatment approaches

- Focus on psychotic symptoms- delusion and hallucination
- Focus on suicidality – assess suicidal risk;
- Focus on medical causes/illnesses and substance use/drugs
- Inpatient vs. outpatient management
- Counsel her on treatment plan]

Scenario 2

Teklu is a 16 year old a 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 has been imprisoned for a long time and his grandmother, who raised him, is very ill.

[The discussion could focus on:

- What additional questions might be asked of the patient or family to help the practitioner feel more certain of the diagnosis
- What would the practitioner tell the patient or family about the condition and the forms of treatment that might be appropriate
- What medication/medical treatment could be offered, if any
- What advice/counseling could be offered?
- What follow-up plan would be best?]

At the end of the role plays, you can summarize the module with the following points:

- 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 symptomatology should always be identified and managed accordingly.

Module 4. Anxiety and psychotrauma

AIM: The aim of this unit is to identify and treat various types of anxiety disorders in HIV infected individuals.

Overview

Total Duration:

110 minutes

Materials:

LCD projector

Blank flipchart/ marker pens,

Preparation:

Exercises

Case studies

Role plays

Learning Objectives: By the end of this unit, participants will be able :

- To describe of the range of symptoms that could indicate an underlying problem with anxiety, including manifestations related to psychotrauma
- To know basic screening questions for anxiety, including the possibility of exposure to psychotrauma.To respond to possible emergency situations associated with anxiety symptoms
- To identify possible medical and developmental causes of anxiety
- To give patients and families psychoeducation about anxiety problems
- To give brief counseling for anxiety including stress reduction, active coping, and relaxation
- To be able to identify panic attacks and to provide psychoeducation and suggest treatment
- To know when medication for anxiety may be warranted, and to know how to chose and prescribe initial medications
- To make plans for reassessment and referral if needed

Content	Methods	Duration
Objectives Introductory Case 1	Reading, Discussion	10 minutes
Clinical Manifestations of anxiety disorders	Presentation, Reading, Discussion	30 minutes
Treatment and follow up of anxiety disorders	Presentation, Reading, Discussion	30 minutes
Key points, Exercises and Case story 2	Case presentation, Group discussion	30 minutes
Role play 1, 2	Reading, Discussion, scenarios	10 minutes

Read the objectives aloud

1. To be able to describe of the range of symptoms that could indicate an underlying problem with anxiety, including manifestations related to psychotrauma
2. To know basic screening questions for anxiety, including the possibility of exposure to psychotrauma.
3. To be able to respond to possible emergency situations associated with anxiety symptoms

4. To identify possible medical and developmental causes of anxiety
5. To be able to give patients and families psychoeducation about anxiety problems
6. To give brief counseling for anxiety including stress reduction, active coping, and relaxation
7. To be able to identify panic attacks, and to provide psychoeducation and suggest treatment
8. To know when medication for anxiety may be warranted, and to know how to chose and prescribe initial medications
9. To make plans for reassessment and referral if needed

Ask the participants to read aloud the following introduction (page 53).

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.

The mental health literature recognizes many distinct types of anxiety 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 in 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?

The following introductory case gives some idea about the level of knowledge of the participants and the problems associated with handling such kind of cases. *Perhaps the main point to draw out of the discussion of this case is how common and disabling anxiety can be, especially anxiety after traumatic experiences.* It is likely that the participants will volunteer similar stories from acquaintances or from their own lives. At the same time, anxiety is often hidden – it causes changes in behavior that often go unexplained, even when the consequences are great. You can invite the participants to speculate about why people do not talk about their anxieties.

Ask one of the participants to read the case; then discuss the questions.

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, having been dismissed for poor attendance. He says that this has caused him many stresses, and he sometimes now 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 mini-bus he was riding in was hit by a speeding truck. He was thrown free and was shaken but 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.

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

Ask the participants to read to themselves Section B, "Presentations and detection in primary care and ART" (page 54), up through the paragraph on "Questions to ask" (page 55). (Stop before reading the discussion about psychotrauma).

Exercise 1: identifying the major symptom groups of anxiety disorder

Using a flip chart or individual handouts, ask participants to write the list of signs and symptoms and symptoms of anxiety in each heading, as in the table below. Ask the participants which are the ones they most commonly see, and how they would ask patients whether they experience these symptoms.

Anxiety symptoms are divided into three major groups		
a. Mental symptoms	b. Physical symptoms	c. Behaviors
• Inability to relax • Nervousness, irritability • Excessive worry • Disturbance of concentration • Panic • Feelings of unreality • Fear of losing control • Fear of going crazy • Fear of dying • Intrusive thoughts	• Chest pain • Choking sensation • Diarrhea • Diaphoresis • Dyspnea • Fatigue • Flushing • Headache • Hyperventilation • Muscle tension • Nausea • Palpitations • Parasthesias • Tachycardia • Vertigo • Vomiting	• Unwilling to leave home • Difficulty separating from parent • Avoidance of feared situation • Evasive answers about injuries • Oppositional behavior

Exercise 2: Major triggers of anxiety. Ask the participants to list as many as possible sources of anxiety and situations that might trigger anxiety symptoms. Again, focus on how you would ask patients about these situations and triggers.

Exercise 3. Identify anxiety predisposing conditions and situations in HIV infected individuals. Ask the participants to list as many HIV-related conditions and situations as you can think of, then share ways of either asking about these situations or trying to bring them up in advance so that the patient will not become so anxious or avoidant.

- This is a good time to point out that some anxiety can be prevented or reduced by telling people in advance about procedures or things to expect. Participants may say that they often do not want to talk about side effects of medications and similar things that may be unpleasant; get ideas from the group of the pros and cons of informing patients about the process of care.

Milestones of HIV disease leading to anxiety	
• HIV testing • News of HIV positive status • Disclosure of HIV status • Appearance of first illness symptoms • Declining CD 4 counts • Increasing viral load	• Onset of AIDS-defining illness • Initiation of multi-drug regimen • Bereavement • Onset of functional disabilities • Onset of cognitive disorders

Ask the participants to read the remainder of Section B (paragraphs about psychotrauma, page 55). Note that this can be difficult to discuss – it is likely that at least one of the participants has been a victim of trauma, witnessed trauma, or had a close friend or relative who was a victim.

Discuss the points in the "box" in the text:
- How would you ask about trauma in the patients that you see?
- Which patients would you think of asking?

Ask the participants to start reading Section C, "Approach to treatment" (page 56), through part 1a (up to but not including "1b. Impact on function"). This section focuses on assessing if someone is involved in ongoing violence.

Exercise 4: initial assessment of ongoing violence. Read the following short case to the participants and ask what they would do next.

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.
- Find a private place to talk
- Consider finding a same-gender interviewer
- Listen empathetically
- Resist immediate advice and ask the patient what she has been thinking
- Offer ongoing support and visits
- Refer to any community organization that may be available

Ask the participants to read to themselves sections 1b and 2 (pages 56 and 57). These cover thinking about a) how much anxiety is having an impact on function, and b) possible medical causes of anxiety.
You can point out that assessing the impact on function is something important to do for all mental health problems. People often minimize the impact, but are also often grateful that you realize how much of a burden they bear.

Lead a discussion of medical causes of anxiety. You can ask if anyone has any additions to the list of medical problems and medications that are listed in the reference manual.

Ask the participants to read to themselves section 3 about panic attacks. When they have finished, ask one of the participants to pretend you are patient who may have panic attacks. Ask them to ask you about possible symptoms of panic attacks. When they are finished, ask the group if there are other symptoms they would add. To sum up this section, you can emphasize that panic attacks are a reflex response to a feared situation. Lead a brief discussion on how panic attacks might be differentiated from other conditions that could cause similar symptoms (shortness of breath, sweating, fainting).

- panic attacks often resolve on their own
- patients may (but not always) be able to tell you what fears triggered the attack
- while there is shortness of breath there will not usually be wheezing, retractions, or other signs of impaired air flow

In the section titled "General treatment for anxiety problems," ask participants, one at a time, to read aloud parts 1-3 (psychoeducation, skills to reduce the effects of stress, and active coping). After each section, is read aloud, ask someone to rephrase it as if they were talking to a patient. You can invite others to comment on how they might phrase the information.

Ask the participants to read to themselves the section on anxiety related to traumatic stress (page 58). Then ask for comments on what they think are the most important elements of responding. You can provide your own opinion. Many would say that the most important points include:

- being able to listen attentively without interrupting
- being quick to offer empathy but cautious about giving advice
- assessing if there is ongoing danger and, if so, working with the patient to try to find a path to safety.

If you have time, you can do something similar for the section on obsessions and compulsions. If not, go directly to the section on medications for anxiety.

Show the slide (or if not available, ask everyone to make sure they have turned to Table 4.1 in the reference manual. Ask the group which of these medications are available where they work. Walk through those medications pointing out the side effects and interactions.

The remainder of the module is taught via case discussions and role plays. There are 5 cases (starting on page 64). Ask the participants to work in small groups using the brief mental status exam outline from Module 1 (page 13) and the flow chart for this module to guide them in their

evaluation of the case. If you would like, you can put up the flow chart slide using the LCD projector. For each case, they should ultimately be able to discuss:

- the patient's most likely problem (and how they arrived at that conclusion)
- possibilities for medical causes
- treatment options, including possible medications (with attention to medication interactions)
- follow-up plans and thoughts about when they would refer to mental health care

Give the small groups 5-10 minutes to talk about the cases, and then ask for volunteers to present each case and lead the discussion.

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 since 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 had a negative effect on her marriage and her relationship with her two children.

- This is likely a case of generalized anxiety – there are worries about many things and many somatic, mental, and behavioral symptoms that have persisted over many years.
- You would want to ask if she also had panic attacks
- It would be important to assess for stresses or violence
- Treatment could include relaxation, active coping, and suggestions to change patterns of behavior that increase stress.
- Medication could be helpful – probably an SSRI since long-term treatment would be required.

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 the pupils are mildly dilated. She is on no medications.

- This woman is probably experiencing panic attacks.
- Medical conditions should be ruled out first before diagnosing primary psychiatric conditions. There are several that could be considered, but the most common might be hyperthyroidism, migraine headaches, alcohol withdrawal, hypoglycemic episodes.
- Non-pharmacologic treatment of panic attacks can include:
    - Identify the early warning signs of an impending panic attack
    - Stay where you are until the panic passes
    - Start slow, relaxed breathing, counting up to four on each breath in and each breath out
    - Do something to focus your thinking on something visible and non-threatening (e.g. look at the books in the supermarket)
    - Concentrate on controlling anxiety and not on the physical symptoms
- Pharmacologic treatment could be with an SSRI starting at a low dose and working up slowly
- One would expect that there are other sources of anxiety, and that the panic attacks may come and go.

Case 3

A23-year-old schoolteacher 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.

- this individual likely has a specific phobia – fear of heights.
- non-pharmacologic treatment would involve gradually greater and greater exposure to the fear, with support to tolerate it. A brave role model could also be helpful.
- an SSRI might be helpful; a benzodiazepine would not be a good choice because this is a situation where prolonged treatment is likely to be needed.

Case 4

Habtamu is 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 can not wash his hands immediately, he will develop anxiety symptoms. Lately he stopped shaking people, and has stopped going to operating theatre due to the fear the air in the operation room 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.

- Habtamu has symptoms that suggest obsessive-compulsive disorder. The key feature to point out that separates this from delusions is that Habtamu knows that his worry is unwarranted but he can't control it.
- psychoeducation can be helpful as well as general relaxation.
- the "gradual exposure" approach for specific phobias can help – this time with encouraging the person to resist the temptation (here, washing) for longer and longer
- often working on general relaxation and stress reduction helps since the symptoms come and go
- an SSRI might help but about half of patients don't benefit or only benefit a little

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.

- Abeba has symptoms of post-traumatic stress disorder – emotional numbing, avoidance, hyper-arousal.
- the treatment starts with the clinician's willingness to hear the story since it seems that

Abeba has not told anyone. This is a terrible story for many reasons – the event itself, the shame, and the fear that telling her family would make things even worse. The clinician will have difficulty listening, and feel at a loss for what to say. It is important to remind the participants that they need say very little other than that they understand how difficult this is and recognize the pain Abeba must be experiencing. At the same time they can say that she is a strong person to have sought help and they can assure her that they will try to help as best they can.

- psychoeducation is the first treatment to give: explain the symptoms, talk about how common they are after such an ordeal, reassure that they will gradually get better.
- ask Abeba about additional concerns for physical health – is she worried about pregnancy, infection, or physical injury. Offer to investigate these concerns.
- assess for suicidal thoughts and depression.
- ask to see her again now that she has had a chance to tell you the story – at the next visit you will start thinking about what else to do.

Role plays (page 66)

Instructions: Ask the participants, in groups of three or four, to take turns being the patient, clinician, and an accompanying family member (if four, one person is the observer). The clinician should use the brief mental status guide to 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. The clinician should then explain the diagnosis and plan to the patient and accompanying family member.

Scenario 1

Mengistu is a thirty two 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 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 bar lady. Since then he is worrying about HIV.

- this role play illustrates the need to think about mental health and physical health symptoms at the same time. All of his symptoms could be caused by anxiety, but perhaps they could be signs of HIV or another illness, too.

Scenario 2

A teenager has headaches and stomach aches many mornings and does not want to go to school. She worries a lot about her school work, 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 is a "scene" before she is ready to go to school.

- this is a version of "school avoidance"
- the goal of the role play is to find out if there are particular things at the school or associated with it that are creating anxiety
- it will be important to think about whether there are symptoms of depression, too.
- if no serious threat at school is identified, the family might be counseled to be sympathetic but firm about the need to go to school.

Summarize this module by focusing on the following key points

- The main characteristic of anxiety disorders is **excessive** fear and/ or inappropriate feelings of nervousness; fear that something bad or dangerous will happen
- 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.
- In those with HIV/AIDS helping the patient in anticipating milestones often associated with anxiety is crucial to prevent anxiety.
- SSRIs, tricyclic antidepressants, and benzodiazepines are the drugs used in anxiety; in those with HIV/AIDS interaction between ART and these anxiolytics determines the choice and dosage of the drugs.
- Anxiety problems tend to be chronic and therefore long term follow-up and monitoring should be instituted.

Module 5: Substance use

AIM: The aim of this unit is to identify and treat substance related disorders in HIV care settings.

Overview

<table>
<tr><td rowspan="8">Total Duration:
100 minutes

Materials:
LCD projector
Blank flipchart/ marker pens,
Preparation:
Exercises
Case studies
Role plays</td><td colspan="3">Learning Objectives: By the end of this unit, participants will be able to:
• Ask screening questions about substance use when indicated
• Recognize medical and mental health symptoms associated with substances that require urgent treatment (especially mild to moderate alcohol withdrawal)
• Assess relative level of use/risk
• Give brief counseling, including recommendation to quit or cut back, strategies to quit or cut back</td></tr>
<tr><td>Content</td><td>Methods</td><td>Duration</td></tr>
<tr><td>Objectives, introduction and
Introductory Case story 1</td><td>Reading and discussions</td><td>10 minutes</td></tr>
<tr><td>Background on the four substances</td><td>Reading and discussions</td><td>20 minutes</td></tr>
<tr><td>Treatment, follow up ,referral criteria’s</td><td>Presentation, reading and discussions</td><td>40 minutes</td></tr>
<tr><td>Exercises, case story</td><td>Discussions</td><td>15 minutes</td></tr>
<tr><td>Key points, Exercises and Case story 2, 3</td><td>Reading, scenarios and discussions</td><td>15 minutes</td></tr>
</table>

Read the objectives aloud

1. To be able to ask screening questions about substance use when indicated
2. To recognize medical and mental health symptoms associated with substances that require urgent treatment (especially mild to moderate alcohol withdrawal)
3. To assess relative level of use/risk
4. To give brief counseling, including recommendation to quit or cut back, strategies to quit or cut back

Ask participants to read aloud the introduction (page 68)

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.

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").

The nicotine in cigarettes is strongly addictive and that is one of the reasons that it is difficult to stop smoking once one decides to try. However, people can feel strong urges to keep using substances even when they are not addicted. For example, in some societies, having a drink, or chewing khat, is an important part of socializing and the urge and pressure to use those substances can be strong. Substance use can be harmful even if someone does not become addicted. It can have an impact on physical health, change behaviours (including promoting risky sexual behaviour and HIV acquisition or transmission), and harm families financially and legally.

Ask one volunteer participant to read the following introductory case.

Demisse is a 40 year-old man who works driving a delivery truck. 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 beers 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.

Ask participants the following questions. In the discussion, try to get a feeling for whether the participants see caring for Demisse's alcohol problem as something that is part of their responsibility. You can also ask about how the use of alcohol, and attitudes toward people who drink, might vary among Ethiopia's many communities.

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

Ask participants to read to themselves the background on the five substances (pages 69—71) of the reference manual – alcohol, tobacco, khat, marijuana, and inhalents.

After they have read those pages, ask the participants if there are any other substances that seem to be problems among the patients that they care for. Ask which substances seem to be the most common among their patients.

Ask the participants to read Section C, "Presentations in ART/primary care" (pages 72-3).

Exercise 1. Major symptoms of substance problems

Purpose: review major indicators of harmful substance use and of substance dependence.

Instruction: You can do this on a flip chart asking for input, or first ask participants to take a piece of paper, make the two columns, and fill in as much as they can based on what they have just read. Then, go around the group each proposing a way to ask about each of the symptoms. You can tell them that the main reason for trying to identify dependence, in addition to abuse, is that dependence will more likely need specialized treatment if it is available. Dependence on alcohol or benzodiazepenes can be very dangerous because of severe reactions to suddenly stopping intake.

Substance abuse	**Substance dependence** - additional to what is present in substance abuse
• Significant impairment or distress • Failure to fulfill major role obligations because of substance use • Substance use in physically hazardous situations • Substance-related legal problems • Social, physical, economic, legal consequences	• Tolerance (need higher amounts) • Withdrawal symptoms • Abstinence attempts - unsuccessful efforts • A great deal of time - in substance related activities • Give up other activities - social, occupational, or recreational

Exercise 2. Asking patients about substance abuse

Purpose: to get some practice with the "CAGE" and other ways of systematically asking about substance use

Instruction: In pairs, write down the "CAGE" questions for alcohol; ask them to a partner 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 or use khat.

Ask volunteers to report on their experience – what did they ask as follow-up questions, what did they ask for the patient they had just met and for the patient they knew was an ongoing user. You can ask at least one group to report how they phrased the CAGE questions in Amharic or another language.

Exercise 3. Substance use and HIV

Purpose: To summarize the relationship of substance abuse/dependence and HIV

Instruction: Discuss how substance abuse can influence acquisition of HIV and adherence to treatment.

Summarize the discussion using the information in the following table

a. High co-morbidity of substance use and HIV b. High risk of acquiring HIV in substance users   a. when under the influence of psychoactive substances, they engage in unsafe sex practices c. Substance use can also complicate the course of HIV disease – medical illnesses d. ARV Adherence is affected in those with substance abuse or dependence e. Substance abuse can worsen other mental health problems and create additional stresses

Ask the participants to read to themselves Section D1 about substance-related emergencies (page 73). Take a poll of the group: how many work in a clinic where there is emergency medical care available? Ask if anyone in the group has already treated someone with alcohol withdrawal? If so, ask them to explain:

- what are some of the signs of alcohol withdrawal
- why it can be so dangerous to the patients
- what is the most important part of treatment.

If there are participants from sites where there is no other emergency care available, go through the steps of withdrawal treatment on page 73 to make sure it is clear to all.

Ask the participants to read to themselves section D2, a counseling approach to substance use (page 74). To introduce this section, you can say at least in studies in North America and other parts of the world, there is good reason to believe that this sort of brief advice is helpful in reducing substance use. It does not work for everyone, and not immediately, but over time is more effective than doing nothing.

Point out how doing the CAGE and getting other information about abuse or dependency is an important part of the counseling – the first step is to empathetically but clearly outline to the person how the substance use is harmful to them and to their family.

If you have time, you can ask for suggestions from the group about what they would say next to someone after having summed up the harm.

Then review the following cases (page 76) to discuss identification and treatment of several important substance-related situations.

Ask the participants to work in small groups, each group doing one of the three cases. They should use the brief mental status exam and the flow chart for this module as a guide, plus information in the reference manual and pocket guide. Their presentations should describe treatment or counseling, and include thinking about other conditions that can develop along with substance abuse.

Case 1

A 35-year-old taxi driver is brought into clinic by his wife, who 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 drinker daily 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 has not had any alcohol in the last 3 days.

Summarize the discussion using the information in the following table

Sign of alcohol withdrawal	**Management**
Starts within 24-48 hours of stopping drinking • hands shaking, • nausea, sweating, • feelings of anxiety, • increased heart rate and blood Pressure, • visual and tactile hallucinations • Seizures	• Diazepam/librium or Carbamazepine ✓ Diazepam 10 mg po tid ✓ Carbamzepine 800mg per day – 200 mg tid With 5-7 days tapered and discontinued • Thiamine 50-100mg PO, IM or IV

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."

Summarize the discussion using the information s in the following table

a. Substance-related issues
    1. Quantify substance abuse- how much?, how long?, how frequent?
    2. Other substances- alcohol, chat, that might explain the unsteadiness.
b. Co-morbidities
    1. Assess risk behavior for unsafe sex- substance abusers have a higher risk of behavioral acquisition of sexually-transmitted illnesses.
    2. Comorbid mental illness possible
    3. Abdominal pain as a possible concern for pregnancy, sexual violence
c. Short and long-term treatment plans depend on findings about severity and co-morbidity.

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 6 months he has increased his consumption. He now chews every afternoon and evening. He has 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 six months ago was taken by the police because they were notified by his uncle.

Summarize the discussion using the information in the following table

Probable risk factors

- Past history of mental illness
- Family history of mental illness
- Presence of psychosocial stressors

Treatment

- Patient is psychotic – substance induced psychosis
- Haloperidol - prescribed for the first few days
- Advise - against quitting chat or any other substance use

Role plays to practice interviewing, differential diagnosis, and psychoeducation

Instructions: Ask the participants to take turns being the patient, clinician, and an accompanying family member. This can be done by one "team" in front of everyone or in small groups. The clinician should use the brief mental status guide to 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. The clinician should then explain the diagnosis and plan to the patient and accompanying family member.

Scenario 1

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 is working as a steward in a local "Tej bet". When he presented he is shabbily dressed, smells of alcohol, and he has a lot of bruises on his head. He's responded vaguely to your question about whether he ever drinks alcohol, but does say that he's 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.

Summarize the discussion using the information in the following table

CAGE questionnaire

- **Cut down** on your drinking?
- **Annoyed** by other people's criticism?
- Felt **Guilty** about your drinking?
- **"Eye Opener"** - Early morning drinking?

Stepped intervention

- Ask the person to set a goal for cutting back – starting date and goals, etc.
- Identify the settings where someone is at high risk to drink - avoid them
- What kind of rules can the person make to limit their consumption?
- Alternatives to drinking?
- Is there a family member or friend who will help you cut back?

Scenario 2

Demisse is a 40 year-old man who works driving a delivery truck. 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 beers 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. But he also is firm with you that he doesn't have a drinking problem – he says that many of his friends drink more, and his wife and children have everything that they need.

Summarize the discussion using the information in the following table (next page)

Communication skills

- Think about ways to give advice in a non-confrontational way (see Module 1)
- Review with Demisse the "facts" about the areas of his life in which the drinking seems to be having an impact.

Stepped intervention

- Ask Demisse what would have to happen for him to consider that he might need to change his drinking habits?
- Ask Demisse if it would be OK for you to talk with him about this again the next time he comes to the clinic.

. Summary – Substance related disorders

- 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 "abuse", 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 psychostimulant widely used in Ethiopia. Chat is known, in susceptible individuals, to lead to psychotic states: transient psychotic disorders, manic symptoms, or paranoid reactions. It will also exacerbate or cause of relapse of preexisting psychotic disorders.
- Khat causes mainly psychological dependence rather than physical withdrawal symptoms
- There is high comorbidity of substance use and HIV. There is high risk of acquiring HIV in substance users. Substance use can also 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 substance abuse and dependence. There are a range of strategies that the person might use to reduce or cease to use substances.

Module 6: Epilepsy

AIM: The aim of this unit is to identify and treat epilepsy in HIV infected individuals.

Overview

Total Duration:

225 minutes

Materials:

LCD projector

Blank flipchart/ marker pens,

Preparation:

Exercises

Case studies

Role plays

Learning Objectives: By the end of this unit, participants will :

- Be able to identify seizures by history and if directly observed
- Be able to react appropriately when a seizure is witnessed
- Understand situations in which some rapid medical intervention is needed for a seizure
- Be able to prescribe an initial medication for seizure treatment and understand when treatment is appropriate
- Be able to educate patients and families about the causes of seizures, their lack of relationship with mental health problems, their treatment, and prognosis

Content	Methods	Duration
Objective, introduction and Introductory Case story	Reading and Discussion	15 minutes
Etiology, Classification, and Clinical presentations of different types of Epilepsy	Presentation, reading and Discussion	60 minutes
Diagnosis and treatment of epilepsy	Presentation, reading and Discussion	60 minutes
Specific Issues in Epilepsy; Case management-Follow up	Presentation, reading and Discussion	60 minutes
Key points, Exercises and Case story 2, 3	Case presentation, discussions, reading, exercises	30 minutes

Read the objectives aloud

1. Be able to identify seizures by history and if directly observed
2. Be able to react appropriately when a seizure is witnessed
3. Understand situations in which some rapid medical intervention is needed for a seizure
4. Be able to prescribe an initial medication for seizure treatment and understand when treatment is appropriate
5. Be able to educate patients and families about the causes of seizures, their lack of relationship with mental health problems, their treatment, and prognosis

Read and discuss the following introduction

Seizures are very common, affecting up to 1 in 100 people, half of who are thought to have active seizures (had one in the last 2 years). 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 can change behavior, movements, and consciousness. In many countries, seizures are not considered mental health problems (and in fact they are not), 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.

Ask one volunteer participant to read the following introductory case (page 79).

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 Ato Girma?
- What do people think about people with problems like Ato Girma's?
- What do people assume are the causes of this sort of problems?
- If people try to help people like Ato Girma, what do they do or suggest?
- What gets in the way of getting help for people like Ato Girma?

As part of the discussion of the case, lead the participants through Exercise 1: causes of epilepsy. Asks them to list as many causes of epilepsy and traditional beliefs about its cause as possible (see the table below). Then ask someone to try to explain "idiopathic epilepsy." What is a good way to describe it to patients without using difficult technical words? There may be different ways of putting it in different languages.

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

Ask the participants to read to themselves about the classification of seizures (page 80) of the participants' manual) and all of Section B, "Presentation/detection in primary care/ART" (pages 80-82).

Exercise: Review types of seizures. The goal of this exercise is to solidify knowledge of major features in the history that can differentiate partial, grand mal, petit mal, and psychogenic seizures (you can note that there are other types but these are the most common).

Instruction: as a group, while you write on a flip chart, list the distinguishing features of each type and suggest a question to ask the patient or family member. Then, for each group, suggest a medication that might be appropriate, and talk about how you would decide if medication is indicated.

- Generalized seizures: most commonly "grand mal" with prodrome of feeling ill or change in mood, brief aura, tonic-clonic movements (you may need to demonstrate), loss of consciousness, afterwards drowsy and confused with no memory of the seizure itself. May fall an injure themselves; may be incontinent. Medications could be valproate, carbamazepine, phenytoin, phenobarbital.
- Generalized seizures less commonly are "absence" or "petit mal" with no prodrome or aura. Sudden interruption in consciousness for only a few seconds – stare, stop talking, may have some mild movements. Afterwards can remember it happening. Valproate or ethosuxamide.
- Partial seizures: do have an aura, last a few minutes and usually have some odd behavior or movements, often marked by funny affect (odd laughing); followed by sleep, can't remember the seizure. Carbamazepine, phenytoin, or phenobarbital.
- Psychogenic seizures: may look like grand mal seizure but rare to injure self or have incontinence, not drowy or confused afterwards. No medication.

The following tables from the reference manual can help distinguish the different seizure types.

Table 6.2 Differentiating types of seizures

Seizure type	Aura	Activity during seizure	Anmesia	Post-ictal phase
Generalized				
Grand mal	Seconds to minutes, feeling or twitching in part of the body	Tonic-clonic followed by unconscious terminal phase	Yes	Headache, drowsiness, confused
Petit mal	None	Very briefly (only seconds) motionless, stare, stop responding	Variable	No
Partial				
	Can include hallucinations	2-3 minutes of behaviors ranging from small motions of head or face to complex activities	Yes	Headache, deep sleep

Table 6.3 Psychogenic versus generalized seizures

	Psychogenic seizure	**Grand mal epilepsy**
Onset	Gradual	Sudden
Tongue bite	No	Yes
Incontinence	No	Yes
Nocturnal occurrence	No	Yes
Injuries	No	Yes
Eyes	Closed	Open, turn upward, side ward
Postictal state	Alert	Confused
Recollecting events during the attack	Not impaired	Amnestic

Ask the group to read the first part of Section C, starting on page 82 and up until the "treatment" paragraph on page 83. This will cover possible medical causes of seizures and how to help someone who is actively having a seizure.

Lead a discussion by asking the group to imagine that they are in their clinic and are called to the waiting area where an adult is having what appears to be a grand mal seizure. Ask the group the following questions:

- what would they observe about the patient that would suggest that he or she was having a seizure?
- what would they ask family members or others who observed the person? [How long has this seizure been happening? Did the patient hit his or her head during the seizure? To their knowledge, has the patient ever had a seizure before?]
- what would they do for the patient while he or she is seizing?
- assume that the seizure stops and the patient is drowy but appears comfortable. What additional history would they want to get from the family?
- If this is a first seizure, what medical conditions might they suspect?
- what if the seizure is prolonged (more than 5 minutes)? What would they do?

Ask the group to now read the rest of page 83 about treatment. Put up the slide of table 6.3 (medications for seizures) and ask the group which of these medications are available where they work. Walk through the table with them, pointing out the main features of each medication.

As the group to now read the rest of the section on pages 85-86. Then ask them to take the quiz below individually (page 89 of their reference manual).

Exercise: Epilepsy quiz. Once everyone has had a chance to write down their answers, go around the room and ask each person to give an answer. Discuss the reason for the correct answer.

1. ____ Most children with febrile seizure develop epilepsy later. [False – only a minority do, except if the febrile seizure is associated with CNS malaria]
2. ____ Sleep deprivation can precipitate seizure attacks in epileptic individuals. [True]

3. ____You should immediately put a tongue plate into the mouth of a convulsing patient. [False – putting anything in the mouth risks harming the patient's teeth or contributing to aspiration.]
4. _____Phenobarbital is an anticonvulsant and is effective for both grand mal epilepsy and petit mal epilepsy. [False – see Table 6.4 – it is not effective for petit mal]
5. _____Pregnant women with epilepsy should not take any antiepileptic drug because of danger of congenital malformation on the fetus. [False – the risks and benefits should be weighed]
6. _____Grand mal seizure could be the first symptom of HIV infection. [True – you can ask participants to turn back to the table in the thought module to see which CNS infections can present with seizures]
7. _____ A patient with HIV/AIDs developed his first seizure, and is diagnosed to have toxoplasmosis. Long term anticonvulsant medication is indicated in this patient. [True]
8. _____ Never stop medication during labor or breast-feeding. [True]

Ask the participants to read sections E and F on follow-up and referral. When they have finished, as a group work through the following case examples (page 89). You can put up the slide of the flow chart for this module. For each case, go through the categories of the brief mental status exam noting which details are present in the case description and what other questions might be asked of the patient or family. Then use the flow chart and the reference and pocket guide materials to reach a decision about what you might need to do for the patient. Ask the group to describe suggested treatment or counseling. Make sure they think not just about epilepsy but other conditions that can develop along with it or be complications. Note that one case involves status epilepticus, so the mental status exam will be administered via the family (and in a very focused way) while the seizure is being controlled.

Case 1:
Ato Chalachew Yehune, a 51 year old man, is a widow. He works as a and merchant in Addis Ababa. For the last two years he has had episodes of falling down, loss of consciousness and generalized convulsion. Just before the falling down he develops deviation of his head to the right side and when he regains consciousness, he develops severe headache and transient weakness of the right side of the body. In the last 8 months he additionally suffered from persistent headache, marked forgetfulness, and recurrent cough. He has neither diabetes nor hypertension. There is no family history of epilepsy.

Summarize the discussion using the information in the following table:

1. These are grand mal seizures
2. What medical conditions might be suspected?
    a. CNS TB is a possibility with the cough
    b. If he has HIV there could be other possibilities
3. Anticonvulsant medication should be started if the seizures are frequent; the first concern would be to treat what is likely an underlying medical problem

Case 2

Tamiru is 30 and has been coming to the ART clinic for some time. He is taking a three-drug combination antiretroviral drug. Today in the waiting area he had what appeared to be a grand mal seizure. He was unharmed but several of the other patients in the waiting area were frightened. He is now starting to wake up – you've gotten him to an examining table in one of the offices. For this case, think about what you will do and be thinking about as he awakens, then what you will tell him, and then what you will ask him and his wife, who is was with him in the waiting area.

Assume that he has had a few seizures like this before, but has never been treated. How would you talk with him about the possibility of getting treatment?

Summarize the discussion using the information in the following table

1. Discuss the measures one should take if a patient suddenly convulses in front of you.
   - Move patient away from water, fire, traffic,
   - Take away any object that could harm the patient
   - Loosen tight cloths, remove eye-glasses
   - Put something soft under the head
   - Turn patient to his side
   - Remain with the patient until he regains consciousness

2. List of ART drugs and drugs used to treat opportunistic infection which could cause seizures as a side effect
   - ddc
   - d4t
   - Foscarnet
   - Isoniazid
   - Ganciclovir
   - Acyclovir
   - -ddi
   - -Cycloserine
   - -Quinolones
   - - Interferons

Case 3

Ato Wondimu is brought to the emergency OPD due to recurrent grand mal seizures; it appears that he has several during the past night – maybe as many as 10, and most of the time he was not fully conscious. He was found to be HIV positive 5 years ago; a year ago he started taking ART and his CD4 count has been getting higher – a week ago it was 310.

Summarize the discussion using the information in the following table

1. This patient has status epilepticus
2. Epilepsy in HIV/AIDs can be caused by:
   a. the HIV infection itself
   b. related tumors, hemorrhages,
   c. opportunistic infections
   d. drug toxicity.
3. It is a very serious, life threatening medical emergency
   a. general supportive measures for the unconscious - side positioning, institute IV line, control input-output, frequent check-up of vital signs
   b. 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
c. if no response refer to ICU for further management

Case 4

A 25 year-old accountant for a commercial bank began noticing episodes of losing track of conversations and having difficulty with finding words. These episodes lasted 2-3 minutes. This is usually followed by severe headache. A colleague at her work place told her that she sometimes appears totally absent and does not respond when talked to; they have seen her bow down to the floor and to pick something which is not there. There is no one in her close family who has a seizure disorder. She is in her third month of pregnancy.

Summarize the discussion using the information in the following table

1. This is likely a partial seizure (complex partial seizure). You can ask them for the clue in this history that might differentiate this from petit mal/absence (which is a form of grand mal epilepsy). It is the mannerism of reaching to the floor to pick up something.
2. Look for
    a. causative factors for epilepsy
    b. peinatal history; developmental history, past history of febrile seizure, head injuries
    c. family history of epilepsy
    d. presence or absence of medical illness
3. Anticonvulsant medication should be started
    a. Sodium valproate is an absolute contraindication during pregnancy
    b. Carbamazepine is a relative contraindication
    c. Phenobarbital and phenytoin could be given

G. Summary - Epilepsy

- Epilepsy has a higher prevalence rate in HIV/AIDS cases as compared to the general population
- There are different types of epilepsy, each with 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 type 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 case
- Psychoeducation 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: Behavior and developmental issues in children and adolescents

AIM: The aim of this unit is to identify and treat common psychiatric disorders in children and give initial treatment.

Overview

Total Duration:

100 minutes

Materials:

LCD projector

Blank flipchart/ marker pens,

Preparation:

Exercises

Case studies

Role plays

Main objectives for this modules: By the end of this unit, participants will be able :

1. To be able to develop a therapeutic relationship with parents who are stressed or angry because of child behavior
2. To be able to respond to minimize potential harm when parents make harsh or very negative comments about their children
3. To identify treatable underlying problems related to child behavior, including medical conditions, attention problems, developmental and learning problems, substance use, and mood/anxiety problems.
4. To identify emergencies (in particular child maltreatment) that may be related to behavior problems
5. To use good communication skills to identify specific behavioral targets that parents would like to work to achieve
6. To use good advice-giving skills to give parents instruction in basic child behavior strategies
7. To make plans for reassessment and referral if needed

Content	Methods	Duration
Objectives Introductory Case story 1	Reading and discussion	10 minutes
The child who is developing slowly and who has difficulty with studies The child who wets his bed	Presentation, discussions	20 minutes
The child who cannot sit still	Presentation, discussions	20 minutes
Depression and anxiety in childhood and adolescent	Presentation, discussions	30 minutes
Key points, Exercises and Case story 2, 3	Case presentation, discussions,	20 minutes

Read the objectives aloud

1. To identify treatable underlying problems related to child behavior, including medical conditions, attention problems, developmental and learning problems, substance use, and mood/anxiety problems.
2. To identify emergencies (in particular child maltreatment) that may be related to behavior problems
3. To use good communication skills to identify specific behavioral targets that parents

would like to work to achieve
4. To use good advice-giving skills to give parents instruction in basic child behavior strategies

Ask participants to take turns reading aloud the following introduction (page 92):
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 the issues that make it harder for them to be the kind of parents they would like to be.
2. Recognizing when the child's behavior 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 behavior that incorporate the parents' values.
4. Finding ways to reduce parenting stress while the behavior 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.

Ask participants to read out loud and then discuss the following cases (page 93). In the discussion, you can ask about attitudes toward children's behavior: do parents see the participants as someone they would turn to for advice about behavior? Are there differences around the country in how children are expected to behave? When children behave badly, or have developmental problems, how do their families feel about them?

<u>Case 1</u>
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?
- What do people assume are the causes of this sort of problems?
- If people try to help children like Aynalem and her parents, what do they do or suggest?
- What gets in the way of getting help for children like Aynalem?

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 is the matter or to be more respectful, he refuses to talk.

- Have you ever met or heard about a child like Girma?
- What do people think about children with problems like Girma's?
- What do people assume are the causes of this sort of problems?
- If people try to help children like Girma and his parents, what do they do or suggest?
- What gets in the way of getting help for children like Girma?

Ask the participants to read to themselves Section B, "Presentation in primary care/ART treatment" (page 93-94).

Exercise: Asking parents about child behavior. Taking notes on a flip chart, ask the group to suggest to you:

- A few questions they might routinely ask at all child/adolescent visits to get an idea if there are any problems with child behavior (they can think about the questions mentioned in Module 1)
- A few questions they might ask to understand stresses the family may be experiencing
- How they would try to get more details if a parent is upset with a child but can not seem to tell you the exact problem

Ask the participants to read to themselves the first parts (1-3) of Section C, "Treatment in primary care/ART treatment." This section concerns exposure of children to various forms of violence.

This can be a very delicate subject to discuss. Violence directed at children, or witnessed by children in the home, is very common. It is likely that at least one person among the participants has experienced this form of violence, or knows someone who has.

Lead a discussion about the following points:

- How might they come to be aware that a child has been exposed to violence? Answers include that there may be signs of injury (or injuries with odd explanations); the child may seem fearful to talk; the child may have an STD (or have acquired HIV where sexual contact seems to be a possible means of transmission).
- Many times parents will speak openly about the ways in which they punish children. Where do the participants see the boundary between acceptable physical punishment and excessive force (or excessive emotional harm)? If they feel that a parent has exceeded what seems appropriate, what do they feel they can say?
- In what ways can a child be harmed when there is violence between spouses? Answers include being hurt as a bystander or when trying to intervene to stop the violence,

becoming fearful, becoming angry at one of the parents and then being emotionally or physically harmed.
- In the various places the participants work, what kind of help can they get with these situations?

Ask the participants to read to themselves parts 4-6 of Section C, "Treatment in primary care/ART treatment." This section concerns other possible emergencies, including suicidal thoughts, malnutrition, and thought problems.

Lead a brief discussion about psychotic symptoms in childhood. Ask the group what are the leading causes of psychotic symptoms in pre-adolescent children. Hopefully they will tell you:
- if these truly seem to be hallucinations, look for medical causes and toxicities
- consider if the symptoms (seeing the dead, having imaginary friends, for example) are actually normal for young children in many cultures.
- that trauma may be a factor, especially if there seem to be symptoms of anxiety as well. Anxious children may "see" or "hear" things of which they are afraid.

Ask the group to go on reading about non-urgent treatable causes of child behavior problems (page 95, sections 1-5).

Exercise: Causes of behavior problems in children. Review common causes of behavior problems that could be related to the family, to the child's physical health, to child development, and to the child's emotional health.

Instruction: Using the flip chart, make a list of causes in each of the four categories above; write down ways that you could tactfully explore these causes with the parent and child.

Some examples include:

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

Read aloud the following "Ten Questions" for detection of child developmental disability (Table 7.1 on page 96). As each question is read, ask if there are any concerns among the participants about how to ask it and how to interpret the answers. Then ask the group what might prompt them to ask these questions. Reasons to ask might include:
- the parent feels the child is different from others

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 any one 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?

Exercise: Developmental assessment. The goal is to become familiar with simple tests of child development.

Instruction: Ask the participants to pair up and administer to each other the Draw-a-person and Gesell figure drawing tests (in the Pocket Guide). Practice scoring them. Ask the participants to imagine how they would explain to a parent results that were less than the child's age.

Ask the participants to take turns each reading a part (items 1-7) of the "General interventions to suggest to parents" on page 97, and the "Things that help with school behavior problems" on page 98. (Some are short so someone can do two together.) After each section, ask for comments on how easy or hard it would be to give this sort of advice to the families that they usually care for. If it would be difficult, ask for suggestions about how to modify the advice.

Ask the participants to read to themselves the section on page 97 about treating children with disabilities.

- have a discussion about what resources are available to help these families in the area where the participants practice. As them to suggest to each other things that may help in the absence of services such as special schools.

Cases to practice using the brief mental status exam and the flow chart to guide diagnosis and treatment decisions

Instructions: Ask the participants to work in small groups thinking about one or two of the cases that start on page 103 (item 4) (assign the groups different cases). For each case, they should go through the categories of the brief mental status exam noting which details are present in the case description and what other questions they might ask the patient or family. Then they should use the flow chart and the reference and pocket guide materials to reach a decision about what they might need to do for the patient. They may want to refer to the anxiety and depression modules as well You can put up the slide of the flow sheet for child behavior problems.

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.

- Basnael has "separation anxiety."
- The important tasks are to a) see if there are other stresses or problems in the family that may be contributing to his anxiety, b) see what the family has tried, especially if it has been suggested by elders in the family or neighbors.
- Assuming that there are no other major stresses (for example, his mother is not ill and he is afraid that if he leaves the home she will die while he is away), the family can be counseled how to gently but firmly insist that he go, perhaps rewarding him in some small way for going.

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.

- Eyoel has physical and mental delay (with the walking more delayed than his speech)
    - The most important issue would be to look for a treatable problem that might accelerate his development. These might include trouble with vision or hearing, chronic malnutrition, harsh treatment
- There are other things to find out that could have an impact on treatment
    - Additional symptoms- behavioral changes – e.g. any difference or change in playing with other children, aggression or self injurious behavior
    - Perinatal history- complicated pregnancy and delivery – pre/post term delivery, severe infections/trauma, prolonged labor, instrumental/operative delivery
    - Developmental milestones – age at which child sits/stands unsupported, toilet trained
    - Medical problems in the first years of life - infections of brain, prolonged jaundice, severe malnutrition, convulsions, etc.
    - Family history of similar problems.
- Treat - comorbid psychiatric disorders if they were found (most likely behavior, anxiety or attention problems at this age)

- Give psychosocial support and help family understand limitations but potential for growth
- Seek special schooling or tutoring where possible

Case 3

Ato Gemechu complains that his 6 years 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.

- There could be several explanations for Diriba's problems
  - Hearing or speech problems
  - Developmental issues that have not been diagnosed
  - Food insecurity or other challenges in his home
  - Chronic illness
- If none of these seemed to be the case, he could have a problem with attention.

Advice to the parents

- Avoid punishment, "time out", ignore the behavior or leave the room
- Praise or reward when child behaves
- Do not give too many commands; reduce stimulation – one toy at a time
- Regular sport or physical activity, regular routine, avoid crowded places

Advice to the teacher

- seat near the teachers desk-not near window or door
- When giving instruction- look at the student, clear and concise instruction, ask the child to repeat the instruction; avoid multiple commands,
- Monitor the child more frequently,
- Keep a home work book, more time in tests, never insult a child, set of rules on discipline, praise and reward for every successful task

Possible medication treatment

- Though not available in Ethiopia at this time, stimulants such as methylphenidate could be effective if Diriba met criteria for ADD.

Case 4

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.

- Berhanu has symptoms that are consistent with depression in a school-aged child, though one would want more details (for example, whether he had been withdrawing from or equally irritable with friends)
- Factors that may make the symptoms surface now include the anniversary of his father's death, stresses within what may be a crowded household (including economic stress from losing the income the father may have earned)
- His mother may also be depressed (or possibly ill from HIV)
- Treatment might center on four things:
  - Understanding the family situation and using that knowledge to help Berhanu's mother understand his behavior so she can react more effectively
  - Tending to his mother's needs – mental health and somatic health

- Acknowledging the anniversary of the father's death and helping the family mark it in whatever way is appropriate
- Providing whatever concrete support would reduce family stress (housing, food, employment)

Summarize this module by focusing on the following key points

F. Summary of child behavior and development problems

- 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 as well as psychostimulant drugs is important in the management of children with ADHD.

Module 8: Mental health aspects of living with HIV

AIM: The aim of this unit is to identify mental health issues in HIV and recognize the problems of treating mental illness in HIV infected individuals.

Overview

<table>
<tr><td rowspan="8">Total Duration:
110 minutes

Materials:

Blank flipchart/ marker pens,
Preparation:
Exercises
Case studies
Role plays</td><td colspan="3">Learning Objectives: By the end of this unit, participants will be able to:

1. Know how recognize mental health problems associated with medications taken for HIV
2. Know how to identify potential interactions between ART and mental health medications
3. Be able to inquire about and respond to common adjustment problems experienced by people living with HIV infection
4. Know when to consider cognitive effects of HIV (HAND) when assessing individuals for problems or challenges related to everyday functioning.</td></tr>
<tr><td>Content</td><td>Methods</td><td>Duration</td></tr>
<tr><td>objectives
Introductory Case story 1</td><td>Reading , discussions</td><td>10 minutes</td></tr>
<tr><td>Reaction to the diagnosis, Stigma and disclosure;</td><td>Reading, discussions</td><td>20 minutes</td></tr>
<tr><td>Caregiver burdens and close social relationships; . Food and housing insecurity; Need for additional patient education</td><td>Reading, discussions</td><td>20 minutes</td></tr>
<tr><td>Mild impairment of cognitive functioning; Palliative care” and pain management</td><td>Reading, discussions</td><td>20 minutes</td></tr>
<tr><td>Medication side effects and interactions</td><td>Presentations, Reading, discussions</td><td>20 minutes</td></tr>
<tr><td>Role play 1 and key points</td><td>one scenario ,discussions</td><td>10 minutes</td></tr>
</table>

Read the objectives aloud

1. To know how recognize mental health problems associated with medications taken for HIV
2. To know how to identify potential interactions between ART and mental health medications
3. To be able to inquire about and respond to common adjustment problems experienced by people living with HIV infection

4. To now when to consider cognitive effects of HIV (HAND) when assessing individuals for problems or challenges related to everyday functioning.

Read and discuss the following introduction (page 104).
Many of the topics discussed in this module are covered in more depth in other trainings. The goal of repeating them here is to be able to think about them in the context of 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.

Perhaps biggest change in thinking over the past few years has been the realization of how much 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.

The issues discussed here can come up with or without a definable mental health problem that you might identify in one of the other modules. Some of the problems that might make you think of the considerations in this module include:
- Not wanting to or feeling able to return to school or work after a break or illness
- Difficulty sticking with a medication regimen, or coping with the need for a change in treatment
- Long-term feelings of fatigue for which no medical or frank mental health cause can be found

Ask the participants to read Sections B and C (Reaction to the diagnosis, Stigma and disclosure) (pages 104-105).

Next, ask one volunteer participant to read the following case (Case 1 in the exercises for this module, page 109).

Aman is 45 years old and a father of two children who are in their teens. Recently he discovered that he is seropositive. 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 blaming himself a lot. He came to you looking for some advice.

Lead a discussion of the following three questions:
- How would you help Aman cope with his new diagnosis? [possibilities include education about treatment and prognosis, introduction to an "adherence supporter," offering time just to listen to his concerns and empathize with his difficulties]
- What guidance would you give Aman about disclosure to his wife, children, or others? [It is right to be selective about who you tell; telling his wife (or other sexual partners) is most important; offer time to talk through decisions about who to tell and when; give more information to Aman rather than insist that he act in any particular way. The group may to talk about how much to insist that Aman disclose to sexual partners. You can ask for their input or talk about the pros and cons of insisting or not insisting, with a focus on how to retain Aman in treatment.]
- What mental health problems or issues could complicate the situation and how would you ask about them? [depression and in particular suicidal thoughts, substance use either ongoing, accelerating, or new]

Ask a participant to read the following case (Scenario 1 in the role plays for this module, page 109).

Eyoel is a 9 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, presumably 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 didn't 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.

Lead a discussion that includes the following points:

- What do you think that Eyoel really wants to know at this time? [Most likely Eyoel wants to know why he feels badly, and why people are fussing and worrying about him.]
- What would be the risks and benefits of telling Eyoel at this time? [One risk that many families might bring up is that Eyoel still would not really understand the nature of the problem, and might tell others who did not need to know about his diagnosis. It is also possible, though, that Eyoel has figured out that something is the matter with his mother and father; in that case me might be frightened if the explanation somehow suggested that he had the same problem as his parents. It is not certain that telling him would increase his adherence.]
- What else would you want to know about Eyoel and his family so that you could help his mother make a good decision? [How well have his mother and father adjusted to the diagnosis – both his and their own. His coping is likely to follow theirs'.]
- If ultimately you and Eyoel's mother decide that he should be told about his HIV, how might you plan to do it? [Gradually, giving him only a little bit of information at a time, as discussed on page 106.]

Ask the participants to read Section D, "Medication side effects and interactions"

Lead exercise 1. Side effects and interactions of ART medications

Purpose: Describe mental health side effects of ART and psychotropic drugs, and possible drug – drug interactions.

Instruction: Ask the participants to think of the ART and OI medications they most commonly use in their day-to-day work (make this a short list otherwise the exercise will take too long and seem repetitive). They should look in the reference and pocket manuals for information about possible mental health-related side effects; together you will make a reference table on a flip chart. Then make a similar list of mental health medications discussed in this training. Make a new list showing which interact with the ART medications and what the likely interaction might be.

Summarize the discussion using the information in the following table

Psyhotropic drugs	**Interactions**

Carbamazepine	May decrease PI and NNRTI levels; if using IDV or EFV consider other anticonvulsant. Carbamazepine toxicity possible if combined with RTV.
Diazepam	All PI's can increase levels of diazepam, as can delavirdine. 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 and DLV can increase haloperidol level; NNRTI's except DLV can decrease haloperidol levels.
Phenobarbital	Can decrease PI and NNRTI levels but is ok to use with NRTI's. Not recommentded with DLV or LPV/r.
Phenytoin –	Can increase PI and NNRTI levels but is ok to use with NRTI's. Not recommentded with DLV or 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, TPV/r – those medications can raise the TCA level to toxic levels (use fluoxetine instead).
Valproic acid –	No significant interactions

Ask the participants to read Section E, "Mild impairment of cognitive function" (page 107).

Ask a volunteer to read aloud the following case (Scenario 3 in the role plays, page 110).

Abraham is a 35 year old man who was working at an office that prints a local tourist magazine. He wrote short articles for the magazine and solicited advertizing from area businesses and hotels. About a year ago he started feeling poorly, and lost weight. He was diagnosed with HIV and, because his CD4 count was already low, he 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's not ready to go back to work. His former boss knows about his HIV and says that he is welcome to return whenever he wants, but Abraham continues to feel that he is not ready.

Lead a discussion covering some of the following points:

- What are some of the possible causes of Abraham not feeling ready to go back to work [look for mood, cognitive problems, side effects of medications that are uncomfortable or embarrassing, fatigue, stigma]
- What are some questions that you would want to ask Abraham [review brief mental status exam, review brief medical review of systems, ask about functioning that might reveal issues with "HANDS"]
- Assuming that HANDS is a possible cause (but not likely to be the only cause), what would you suggest for Abraham? [Think of ways that he can make reminders for himself; avoid things that would make HANDS worse – poor sleep, low mood, alcohol or other drug use]

Ask a volunteer to read the following case (Case 2 in the exercises, page 109)

Mihret, a 29 year old single woman being treated for HIV, and medically she is doing well. She had a job in private company until recently but 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.

Lead a discussion covering the following points:

- What are some of the possible causes of Mihret's memory problems [depression, substance use; her symptoms seem too severe for HANDS, and she does not seem to be at risk for HIV-related opportunistic infections.]
- How might you try to distinguish some of the possible causes? [conduct a brief mental status exam, ask for other depression symptoms, look for any neurologic symptoms that may have been overlooked]
- What other information might be helpful? [Prior to the diagnosis of HIV, did Mihret ever have problems with depression or substance use?]

Role plays: If there is time, the participants can do all three role plays. If time is short, ask the participants to form small groups and do Scenario 2:

Scenario

W/rt Lidiya, a 21 years old girl, 3rd year university student came to ART clinic. She is nervous, fidgety on her chair, her voices strained and her speech is frequently interrupted. She has known about her seropositivity 12 months ago. Her CD4 count is 450 and she has no medical illness. Last 4 weeks she fell in love with a nice guy, her classmate, and he is head over heels about her. She was not able to concentrate in her study. She stays in her dormitory and cries a lot. She is uncertain what to do next.

Some of the main points to cover:

Additional questions could be raised to rule out possible causative factors, and to select treatment approaches

- focus on depression symptoms and anxiety symptoms
- focus on suicidality and assess suicidal risk;
- focus on substance use/drugs

Summary points for Module 8

- 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 Implementation issues and "putting it all together"

Overview

<table>
<tr><td rowspan="6">Total Duration:
225 minutes
Materials:

Blank flipchart/ marker pens,
Preparation:
Exercises
Case studies</td><td colspan="3"><u>Main objectives for this modules</u>: By the end of this unit, participants will be able to:
• describe the roles of different individuals in the primary care setting with regard to detection and treatment of emotional, behavioral, and mental health problems
• describe the referral/consultation system as it exists or needs to be, and general criteria for referral of cases up and down the system
• communicate information to a consultant
• create a brief record of sample cases for supervision/team discussion
• Describe what Monitoring and evaluation is.
• Develop action plan
• Orientation for clinical practice</td></tr>
<tr><td>Content</td><td>Methods</td><td>Duration</td></tr>
<tr><td>objectives</td><td>Presentation,
Discussion</td><td>20 minutes</td></tr>
<tr><td>M and E, concept suggested indicators</td><td>Presentation,</td><td>35 Minutes</td></tr>
<tr><td>Action plan preparation</td><td>Group work</td><td>90 Minutes</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td>Action plan presentation</td><td>Presentation and discussion of action plan</td><td>70 Minutes</td></tr>
<tr><td></td><td>Orientation for clinical practice</td><td>Discussion</td><td>1o minutes</td></tr>
</table>

Read the objectives aloud

1. To be able to describe the roles of different individuals in the primary care setting with regard to detection and treatment of emotional, behavioral, and mental health problems
2. To be able to describe some of the ethical/privacy issues surrounding mental health care
3. To be able to describe the referral/consultation system as it exists or needs to be, and general criteria for referral of cases up and down the system
4. To be able to communicate information to a consultant
5. To be able to create a brief record of sample cases for supervision/team discussion

Read the following introduction

Introduction

The purpose of this module is to help participants think about how they will be working with each other and within the larger ART care system to provide mental health care to their patients. The main goal of the module is to help participants anticipate barriers and possible changes to how they work that might be needed to provide mental health care – it is a way to wrap up the training with participants thinking about practical next steps.

Ask participants to look at Figure 9.1, "Flow chart for a patient newly thought to have a mental health problem" (page 113).

- If you have a projector, show it on a slide
- If you only have a flip chart and have the time, re-draw the figure on a flip chart

Referring to the text in the reference guide, describe for participants the flow of a patient through the chart. Ask the participants how this would work in their settings – are there variations, and if so, why?

Ask participants to look at Figure 9.2, "Flow chart for returning patients known to have a mental health problem" (page 114).

- If you have a projector, show it on a slide
- If you only have a flip chart and have the time, re-draw the figure on a flip chart

Referring to the text in the reference guide, describe for participants the flow of a patient through the chart. Ask the participants how this would work in their settings – are there variations, and if so, why?

Ask participants to read Section B, "Ethical/procedural issues for mental health."

Lead a discussion about why these policies are important. If participants are not familiar with the policies, get suggestions for who at their site might be responsible for knowing or developing them. The issues suggested in the reading include:

- Privacy
- Sharing information among staff members
- What to document about visits in charts
- When confidentiality can be breached to protect a patient or someone else?
- Whether children are entitled to confidentiality?
- What other family members can be told about a patient's condition or treatment?
- Decisions for people who do not seem capable of making them on their own

[Though all of these issues are important, the first two may be the most important for instituting a mental health program. Patients will be very reluctant to disclose sensitive issues if they do not feel they can do it in private, or if they come to believe that their information is being shared with other staff who are not directly involved in their care.]

Ask a participant to read aloud the paragraph under Section C, "Monitoring and evaluation."

Ask the participants to look at Table 9.1 (or show it on a slide if possible)

A Comprehensive M&E Framework

Types of Monitoring and Evaluation			
Formative assessments and research (concept and design)	Monitoring (monitoring inputs, processes, and outputs; assessing service quality)	Evaluation (assessing outcome and impact)	Cost-effectiveness analysis (including sustainability issues)
Questions Addressed By the Different Types of M&E			
• Is an intervention needed, e.g., palliative care? • Who needs the intervention, e.g., people with HIV/AIDS or cancer? • How should the intervention be carried out, e.g., what model of palliative care delivery best suits the need?	• To what extent are planned activities actually realised, e.g., has the palliative care service been set up? • How well are the palliative care services provided?	• What outcomes are observed, e.g., is there better pain control? • What does the outcome mean (e.g., what does it mean if pain is not controlled)? • Does the programme make a difference?	• Should programme priorities be changed or expanded? • To what extent should resources be reallocated?

Point out the middle two columns as the main reasons why good data about treating mental health in the ART clinics will be important.

- Are the services really being delivered?
- Are the outcomes what had been hoped for?
- Does the program really make a difference for patients and their families?
- To ultimately be able to tailor the mental health emphasis for the patient mix at a given site – which conditions are most important?

Point out the draft mental health registry in the reference manual (page 117) and discuss each item – why is it being collected and how might it be useful for regular patient care and for M&E?

Draft register

Patient ID: _____Patient name: _____
Patient date of birth: _____Gender: _____
Date registry initiated: _____
Treatment site where initiated: _____Provider initiating: _____

Codes to use:
Conditions: 1. Thought problems; 2. Depression; 3. Anxiety/trauma; 4. Epilepsy; 5. Child development or conduct; 6. Substance use; 7. Difficulties living with HIV

Severity: 0. Problems resolved. 1. Mild distress or interference with function; 2. Moderate distress or interference with function; 3. Severe chronic distress and interference with function; 4. Medical or psychiatric emergency.

Means of identification: 1. Patient or family raises concern; 2. Referral by someone in the community (non-medical); 3. Referral by other medical provider (including other ART provider); 4. Discovered in response to clinician question or exam; 5. Follow-up from prior visit.

Date of visit	Conditions identified or treated	Overall severity	Means of identification	Counseling provided (yes or no)	Medications provided or continued (give names and doses)	Other treatment (describe)	Referral – non emergent	Referral – emergent (give location)	Tests ordered or reviewed	Date of next visit	Provider

Ask the participants to work in groups from the same clinical (or if they are all from the same clinical site divide the following task in two parts. *This is one of the most important steps in the training.*

Ask the participants to read Sections D and E of the module, and then work on the following two exercises.

At the end of the time allotted, one of the groups should present its modified charts and their action plan from the second exercise.

Encourage participants to continue this activity when they return to their clinic. This action plan will be used by site support team members, advisors, and others to regularly follow the implementation of the MH program. This action plan is expected to be developed in two copies one copy will be kept by the facility/trainee and the other copy will be submitted to the trainer (training organizer).

1. Creating a patient flow/staff needs chart for your own clinic

Purpose: to help identify staffing needs and gaps at your own work site

Instruction: take the flow charts (Figures 9.1 and 9.2, describing how patients are evaluated)
- Modify them for your clinical site
- Fill in names of staff who might be in the various roles
- Think about what additional training or materials these staff members might need to carry out the roles
- Think about any other changes at the site that might have to be made
- When the site support teams come for a follow-up assessment, what information might they want to see to understand if the training had been effective

2. Creating an action plan for your own clinical site

Purpose: to make it possible to work systematically once you return to your own work site to put in place what is needed to provide mental health care

Instruction: thinking about the flow chart you created in Exercise 1, and going back through the contents of this module, make a table like the one below for your site.

Action Area	Current Gaps	Key Activities or Actions	Person(s) Responsible	Resources Needed	Time frame

Clinical practice (Minimum of 180 minutes)

The trainees are expected to have clinical practice for a half 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 4 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 feed back later on after the discussion

Summary 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)		

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.

Daily Evaluation Form (Day 1)

Fill out this form as each topic is completed.
1 = Good 2 = Average 3 = Poor

Day one (daily evaluation form)

Module	Time allocated	Relevance to your job	Support from facilitator	Contribution to skill development	Suggestions
Introductions, expectations, pretest					
Introduction: HIV and mental heath					
Module 1					

If you have any other suggestions ----------

Your professional background (nurse, doctor, etc.): _____

Thank you for your comments and we look forward to improve!!!

Daily Evaluation for Day 2

Daily Evaluation Form (Day 2)

Fill out this form as each topic is completed.
1 = Good 2 = Average 3 = Poor

Day 2 (daily evaluation form)

Module	Time allocated	Relevance to your job	Support from facilitator	Contribution to skill development	suggestions
Module 2					
Module 3					

If you have any other suggestions ----------

Your professional background (nurse, doctor, etc.): _____

Thank you for your comments and we look forward to improve!!!

Daily Evaluation for Day 3

Daily Evaluation Form (Day 3)
Fill out this form as each topic is completed.
1 = Good 2 = Average 3 = Poor

Day 3 (daily evaluation form)

Module	Time allocated	Relevance to your job	Support from facilitator	Contribution to skill development	suggestions
Module 4					
Module 5					
Module 6					

If you have any other suggestions ----------

Your professional background (nurse, doctor, etc.): _____

Thank you for your comments and we look forward to improve!!!

Daily Evaluation Form (Day 4)
Fill out this form as each topic is completed.
1 = Good 2 = Average 3 = Poor

Day 4 (daily evaluation form)

Module	Time allocated	Relevance to your job	Support from facilitator	Contribution to skill development	suggestions
Module 7					
Module 8					
Module 9					

If you have any other suggestions ----------

Your professional background (nurse, doctor, etc.): _____

Thank you for your comments and we look forward to improve!!!

Daily Evaluation Form (Day 5)
Fill out this form as each topic is completed.
1 = Good 2 = Average 3 = Poor

Day 5 (daily evaluation form)

Module	Time allocated	Relevance to your job	Support from facilitator	Contribution to skill development	suggestions
Clinical practice					

If you have any other suggestions ----------

Your professional background (nurse, doctor, etc.): _____

Thank you for your comments and we look forward to improve!!!

Overall Course Evaluation Form

1= Excellent 2= Very good 3= Average 4= Poor 5= Very poor

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		
Meals		

If you have any additional comment: ----------

Your professional background (nurse, doctor, etc.): _____

Thanks for your comments and we will look forward for improvement.

Pre /post questions for the Detecting and managing common child and adult mental illness in HIV training – answer key

There are two types questions: true or false and multiple choice. Please write you answers in the space provided. For the true/false questions write either true or false. For the multiple choice questions write the letter /s of your choice/s on the space provided.

Each question counts five points.

The **Bold Face** answers are the correct ones.

Module 1

1. The proportion of people living with HIV/AIDS who have a mental health problem is twice that of people in the general population. (**True** /False)_____

2. Mental health problems are a major reason for decisions to decline or stop taking ART. (**True** /False)_____

3. Which one of the following does **not** have mental health problem?_____

   A. A person was normal, but now is restless and hears voices
   B. A person is overly cheerful for weeks, excited, and never finishes things
   C. For weeks or months a person is sad and miserable, unable to cope
   D. A person has for a long time been strange, wandering, unkempt
   E. A person has a lot of aches and pains, worries a lot, and has trouble falling asleep
   F. None of the above

4. Which one of communication skills may **not necessarily** be important while we communicate with our clients?_____

   A. Use gestures that shows interest
   B. Paraphrase what the client said as deemed necessary
   C. Respect the client's ideas and opinions
   D. Touch
   E. Giving adequate time for the discussion

Module 2

5. Medications are very effective for many people with primary thought problems (schizophrenia, bipolar disorder, etc.) and it may take 6 months to see a full response.(**True**/False) _____

6. Which one of the following is **not** true about the management of dementia?_____

   A. Help the person stay oriented by reminding them of the day and time
   B. Having family routines and simple, familiar tasks that the person can do or assist with
   C. If the person uses glasses, remind them to use them and try to keep them from being lost

D. Provide additional supervision, though this may have to be gentle if the patient comes to resent being watched or accompanied all the time

E. None of the above

7. All patients with any condition that has caused persistent psychotic symptoms should be treated at least for six months. (**True**/False)_____

Module 3

8. 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.(**True**/False)_____

9. In which of the following cases should one **not** consider medication for depression management_____

   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
   E. none of the above

10. In the management of depression, there is **no** evidence for effectiveness of TCAs (tricyclic antidepressants) in children or adolescents (**True**/False)

    _____

11. Suppose you have patient with depression and you diagnosed him correctly and start him with one of the TCAs. After 4 days there is no response? What will be your reaction? _____

A, switch him to another TCA
B. switch him to another class of antidepressants
C. **wait for a couple of weeks (4 weeks minimum)**
D. A or B
E. none of the above

Module 4

12. Anxiety is known to affect all people regardless of culture, race, age, religion, gender, level of education or economic background(**True**/False)_____

13. Which one of the following is **not** part of general management for most of anxiety problems?_____

A. Psychoeducation.
B. Learning skills to reduce the effects of stress
C. "Active coping"
D. Medication if the symptoms seem severe

E. None of the above

14. SSRI's (fluoxetine, sertraline) are the first choice and thought to be effective for general anxiety, obsessions/compulsions, symptoms related to trauma, and panic attacks in children, adolescents, and adults.(**True**/False)_____

Module 5

15. Substance use problems are among the most prevalent of mental health problems. (**True**/False)_____

Module 6

16. Seizures are very common, affecting up to 10 in 100 people (True/**False**)_____

17. In the management of seizures it possible to use more than one drug initially in selected cases. (True/**False**)_____

18. In the management of seizures, the first choice for managing absence/petit mal is _____

    A. Sodium valproate
    B. Carmabazepine,
    C. Phenytoin,
    D. Phenobarbital
    E. All are correct

Module 7

19. When a parent has a child with behavior problems and needs to punish, all of the following are true regarding punishment **except**_____
    A. It should avoid long-standing consequences
    B. It should come quickly after the problem occurs
    C. **It should be as frequent as possible**
    D. It should be mild

Module 8

20. Neuropsychological testing is the best way to diagnose HAND (HIV-associated neurocognitive dysfunction) (**True**/False)_____

Presenter 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? _____

Did the participants seem prepared?

1	2	3	4	5
not at all	a little	OK	very good	excellent

Did the participants seem energetic and engaged?

1	2	3	4	5
not at all	a little	OK	very good	excellent

Were there interruptions or distractions?

1	2	3	4	5
not at all	a little	OK	very good	excellent

How thoroughly do you think you covered the material in the module?

1	2	3	4	5
hardly any	some	half	most	all

How well do you think the participants understood the material?

1	2	3	4	5
not at all	a little	OK	very good	excellent

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?