STANDARD OPERATING PROCEDURES

FOR INTEGRATION OF MENTAL HEALTH AND HIV SERVICES IN ZIMBABWE

"THERE IS NO HEALTH WITHOUT MENTAL HEALTH"

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

JANUARY 2014

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ACRONYMS

CBO	community-based organization
MH	mental health
MOHCW	Ministry of Health and Child Welfare
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
SOP	standard operating procedure
SSQ	Shona Symptom Questionnaire
TMP	traditional medical practitioner
USG	U.S. Government
WHO	World Health Organization
WRAP	Wellness Recovery Action Plan

EXECUTIVE SUMMARY

AIDSTAR-One is USAID's global HIV and AIDS project providing technical assistance services to the Office of HIV/AIDS and U.S. Government (USG) country teams in U.S. President's Emergency Plan for AIDS Relief (PEPFAR) supported countries in knowledge management, technical leadership, program sustainability, strategic planning, and program implementation support. In collaboration with USAID's Care and Support and Treatment Technical Working Groups, AIDSTAR-One conducted an activity to integrate mental health (MH) services into HIV care and treatment programs in Zimbabwe.

Screening and provision of basic counseling interventions and referring for MH services can improve the quality of life, treatment adherence, and retention in care and support programs for people living with HIV (PLHIV) in Zimbabwe (Gutmann and Fullem 2009). MH is a critical component of care necessary for PLHIV, and services are often limited in resource-poor settings. The World Health Organization (WHO) reports that seroprevalence of HIV among people with MH problems is significantly greater than that of the general population. In addition, approximately 75 percent of the burden of neuropsychiatric disorders is estimated to be found in persons living in low- and middle-income countries (WHO 2008). Those suffering from MH problems and harmful alcohol and substance use are more likely to contract HIV. This is largely due to the inherent vulnerability of those living with MH problems as well as the great psychological burden that living with HIV places on the HIV-positive person. Harmful alcohol and substance use may develop as a coping mechanism to deal with this psychological burden of being HIV positive (WHO 2008). In addition, persons suffering from MH problems are more vulnerable to exploitation, have greater difficulties advocating for safer sexual practices, and may be less likely to remain in long-term, monogamous relationships (Tegegn, Wissow, Jerene et al. 2010). Those with harmful alcohol and substance use habits are less likely to take precautions to protect themselves during sexual activity and also experience an increased risk of HIV infection when sharing needles. Self-care, such as adherence to antiretroviral therapy and other medications, optimal nutrition, sleep, exercise, and making and following through with clinic appointments, are also more difficult in the presence of MH problems (WHO 2008).

This standard operating procedure (SOP) was informed by two separate pilot studies that took place in collaboration with the Ministry of Health and Child Welfare (MOCHW) in Zimbabwe in 2012 and 2013. It is accompanied by a **training manual** that utilizes a training-of-trainers approach, such that participants are able to train colleagues at health facilities and community-based organizations (CBOs). The SOP outlines actions that should take place during three stages of integration: 1) program planning, 2) program implementation, and 3) evaluation. MH and HIV integration tools are listed within the SOP and hyperlinked to bring the user directly to the annexed tool. Through using the model set forth within this SOP, this guide may be used as the first step to engage HIV and MH stakeholders and train health facility workers, CBO staff, and traditional medical practitioners (TMPs) to screen for MH problems and harmful alcohol and substance use. This SOP facilitates and plans for strong linkages between community- and facility-level organizations to provide simple interventions and identify clear referral pathways to address the MH needs of the client, resulting in improved health and quality-of-life outcomes for PLHIV.

STANDARD OPERATING PROCEDURES

PROGRAM PLANNING

Program Managers should carry out the following tasks to prepare for integration activities:

1. Identify a coordinating body that will oversee integration efforts and develop a workplan for planning and oversight of integration efforts. Wherever possible, integration efforts on the ground should be led at the highest level possible in order to provide a means to establish the scope of the MH/HIV integration program and to oversee implementation, referral networks, monitoring, and reporting.
2. Carry out community sensitization with community leaders. Explain the objective and scope of mental health and HIV integration efforts within the community and at health facilities; seek support for the program to disseminate information and support for availability and uptake of services to the HIV community.
3. Refer to the Ministry of Health and Child Welfare (MOHCW) guidelines and standards for MH and alcohol and substance use. See **Annex E** on page 17 for the MOHCW Guidelines for Suicidal Ideation. See **Annex F** on page 19 for the MOHCW Guidelines for Acute Alcohol Withdrawal.
4. Build a referral network within the community and at health facilities. Identify a referral point person to oversee the referral network. Identify clinical health workers, CBOs, and TMPs within the community who may provide mental health screenings and interventions and psychosocial services, while keeping in mind that the referral network should also include organizations that meet the social and spiritual needs of clients. Identify a referral hospital that can provide more intensive mental health services as needed. Meet with representatives from facilities and organizations to agree on referral procedures. Wherever feasible, seek out already existing MH/HIV referral directories. See **Annex G** on page 21 of this document to complete the MH/HIV Integration Referral Directory.
5. Create a bi-directional referral system between health facilities and CBOs. Ensure that a solid referral system is in place such that when a referral is made, organizations are acquainted with the referral protocols. If referring to private institutions that have no relationships with the public institutions, be sure to make certain the client is well informed. Identify barriers to completing referrals, including transportation and costs, and brainstorm mechanisms to overcome them with CBOs and family members where appropriate. When completing the Client Referral Form, the top half should be completed by the provider making the referral. The provider should give the Client Referral Form to the client to bring to the appointment for which he or she has been referred. The provider at that organization should complete the bottom half of the form and give the entire form back to the client, who brings it back to his or her next appointment where the original referral was made from. This allows for communication

between providers and agencies regarding a client. Record all referrals made and received in the Referral Log. See **Annex H** (page 23) for a Client Referral Form, **Annex I** (page 25) for the Register of Referrals – OUT Form, and **Annex J** (page 27) for the Register of Referrals – IN Form.

6. Review Screening Tools. Screening tools used at the health facility level are the Shona Symptom Questionnaire (**Annex K**, page 29), which screens for MH problems, and the CAGE-AID Screening Tool (**Annex L**, page 31), which screens for alcohol and substance use problems. The Abbreviated Community Screen (**Annex M**, page 33) is used by CBOs and TMPs. See **Annex N** on page 35 of this document for a list of additional screening tools.
7. Review the Mental Health and HIV Integration Protocol on page 11 (**Annex B**).

At the ***health facility***, all adult clients should receive the SSQ and CAGE-AID screens during each visit.

- Clients who have a positive SSQ (8 or greater) or CAGE-AID (yes to one or more questions) screen or who have negative screens but are still suspected of having mental health problems should receive:
    a. A brief counseling intervention
    b. A referral to the most qualified health professional for diagnosis and management, including counseling and medication as necessary
    c. A referral for relevant community support services.

Clients who have an SSQ of 10 or greater, suicidal ideation, or acute alcohol withdrawal should receive an immediate same-day referral for further evaluation according to the Emergency Action Template. The provider should explore transportation options as needed with the client, including receiving assistance by a trusted friend or family member, to ensure that he or she receives care that day.

At the **CBO or with the TMP**, all adult clients should receive the Abbreviated Community Screen during each visit.

- Clients who have a positive Abbreviated Community Screen (7 or greater to the sad or worry questions or a positive response to the alcohol and substance use question) or who are suspected of having mental health problems despite a negative screen should receive:
    a. A brief counseling intervention
    b. A referral to a health facility for a full SSQ and CAGE-AID screen
    c. Continue to receive services from the CBO.

Clients with suicidal ideation or acute alcohol withdrawal should receive an immediate same-day referral for further evaluation according to the Emergency Action Template. The provider should explore transportation options as needed with the client, including receiving assistance by a trusted friend or family member, to ensure that he or she receives care that day.

8. **Review the Stepped-Care Model.** Identify who will be responsible for (at each site and within the community):
    a. Carrying out screening tools and basic counseling interventions

b. Providing more intensive counseling therapy

c. Providing medication therapy. See the Stepped-Care Model (**Annex A**, page 9).

9. **Review the basic mental health interventions for positive screens**. See **Annex O** (page 37) for the Wellness Recovery Action Plan (WRAP), which is used as a basic intervention tool for a positive SSQ or a positive response to the first two questions on the Abbreviated Community Screen. See **Annex L** on page 31 for the Readiness to Change Rulers, which is used as a basic intervention tool for a positive CAGE-AID or a positive response to the third question on the Abbreviated Community Screen. *Keep in mind that it may be helpful to allow trusted family members and friends to be present to support the client if he or she chooses during counseling sessions. Mental health counseling interventions do not replace HIV post-test counseling.*

10. **Complete the Emergency Action Template.** This identifies where to provide same-day referrals when a client presents with suicidal ideation or acute alcohol withdrawal. The Emergency Action Template should be made available to all staff carrying out screening and be placed in a central location. See **Annex Q** (page 41) for the Emergency Action Template.

11. **Identify and complete any necessary infrastructure changes that are needed to carry out integrated activities.** Identify the required space and materials related to infrastructure that are needed to carry out the integrated services, including adequate space, to ensure that privacy is maintained.

12. **Identify any new supply chain needs as a result of the integrated program.** Ensure that there is a reliable supply of medications for mental health needs per the national guidelines for medication management of mental health and alcohol and substance use, such as amitriptyline, chlorpromazine, diazepam, fluoxetine, haloperidol, imipramine, sulpiride, thioridazine, or trifluoperazine.

13. **Identify Integration Leaders from health facilities, CBOs, and TMPs.** Integration Leaders should be identified based on their interest and commitment to participate and lead MH and HIV integration efforts at their facility, provide supportive supervision to their colleagues, ensure that protocol is followed, and provide additional guidance at the community level where needed. Integration Leaders will also work with management teams to ensure that an uninterrupted supply of integration materials (Data Collection Sheets, Referral Forms, and screening tools) are available. See **Annex R** (page 43) for the Integration Leader's Checklist.

Determine how data will be captured and integrated into the existing system. Each screen that is completed should be placed in the client record. In addition, data captured from each screen should be recorded in the Data Collection Sheet by the individual who carried out the screen. A summary of data collected should be provided to the Data Capturer where appropriate. See **Annex S** (page 45) for a sample Data Collection Sheet for Health Facilities. See **Annex T** (page 47) for a sample Data Collection Sheet at the Community and Traditional Practitioner Levels.

14. **Use a training-of-trainers approach.** Train Integration Leaders on MH/HIV integration and responsibilities. It is recommended that within one to two weeks of this training Integration Leaders should train colleagues at their site on MH/HIV integration. The **training manual** is available at:

PROGRAM IMPLEMENTATION

Integration Leaders should provide the following services to their site during program implementation:

1. **Provide routine supportive supervision.** Following the training, supportive supervision should be provided to each staff person carrying out mental health and HIV integrated service provision and should occur within one month of beginning integration activities and then routinely thereafter. Identify opportunities for ongoing mentoring based on results of supportive supervision visits.
2. **Monitor the referral system routinely.** Referrals should be routinely monitored by the established community referral point person at all organizations within the network to ensure that patients are completing referrals and that the correct referral procedures are being followed. Consider creating a community forum to identify and solve issues surrounding retention and other ongoing problems within the referral system.
3. **Ensure continual availability of integration materials.** Identify and correct any issues surrounding availability of screening tools and referral forms.
4. **Provide continuous training opportunities to increase the number of staff trained and to train new staff.** Carry out training needs assessments every six months to identify training needs and provide as necessary follow-up training and mentoring to ensure that the information was correctly understood and is effectively implemented during service delivery.
5. **Provide and ensure availability of updated job aids.** Integration Leaders should make necessary arrangements with facility heads to ensure these job aids are available and submit formal requests for the materials when they are not available. Job aids should be visible in areas where integration services are offered. See **Annex C** (page 13) for the Health Facility Job Aid. See **Annex D** (page 15) for the CBO and TMP Job Aid. See **Annex B** (page 11) for the Mental Health and HIV Integration Protocol.
6. **Employ motivational strategies for staff.** Provision of integrated services may offer additional challenges to staff; identify motivators such as ongoing training opportunities or staff recognition to keep staff engaged to follow the protocols for the integrated program and to continually provide high-quality care.
7. **Ensure ongoing functionality and quality of supply chain management.** Carry out routine monitoring to ensure that sufficient supplies of medications are available for integrated services.

PROGRAM MONITORING AND EVALUATION

Integration Leaders should provide the following services for integrated monitoring and evaluation:

1. **Routinely monitor the accuracy of data collection and reporting forms.** Ensure that integrated data are correctly reported and routinely utilized.
2. **Carry out quality improvement practices.** Quality improvement activities can help identify and correct any gaps in integrated service provision.

3. **Identify any monitoring and evaluation training needs due to the integrated program.** Training needs may be identified through data monitoring, quality improvement activities, and speaking with staff.
4. **Utilize the data for planning purposes.** This will serve to further inform integration efforts and increase collaboration, particularly at the community and district levels.
5. **Share data, promising practices and lessons learned with community partners.** Advocate for strengthening MH services for PLHIV to ensure that a strong support system is available when required.
6. **Conduct health outcome assessments.** Health outcome assessments can measure the effect of integrating MH and HIV services.

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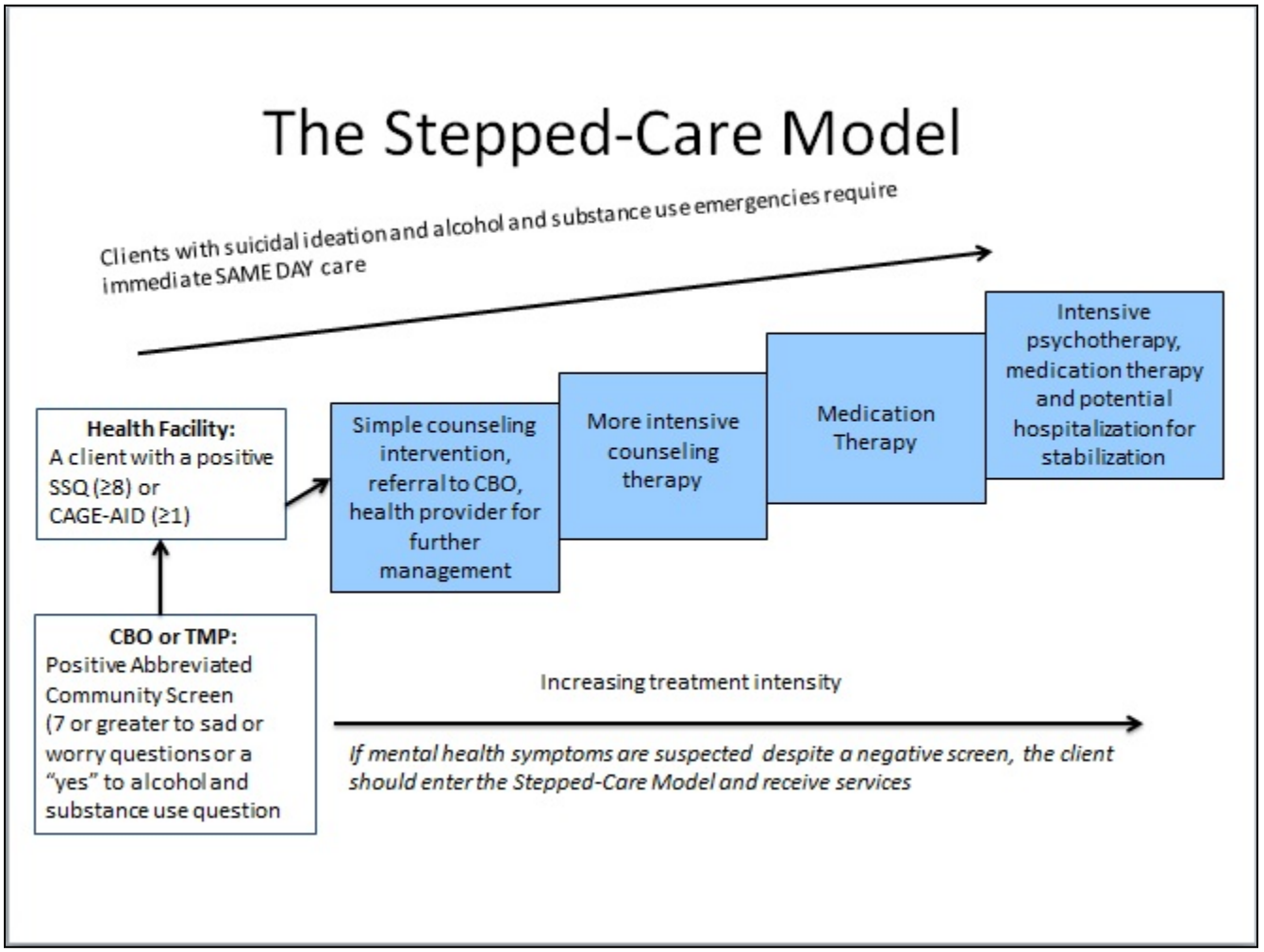
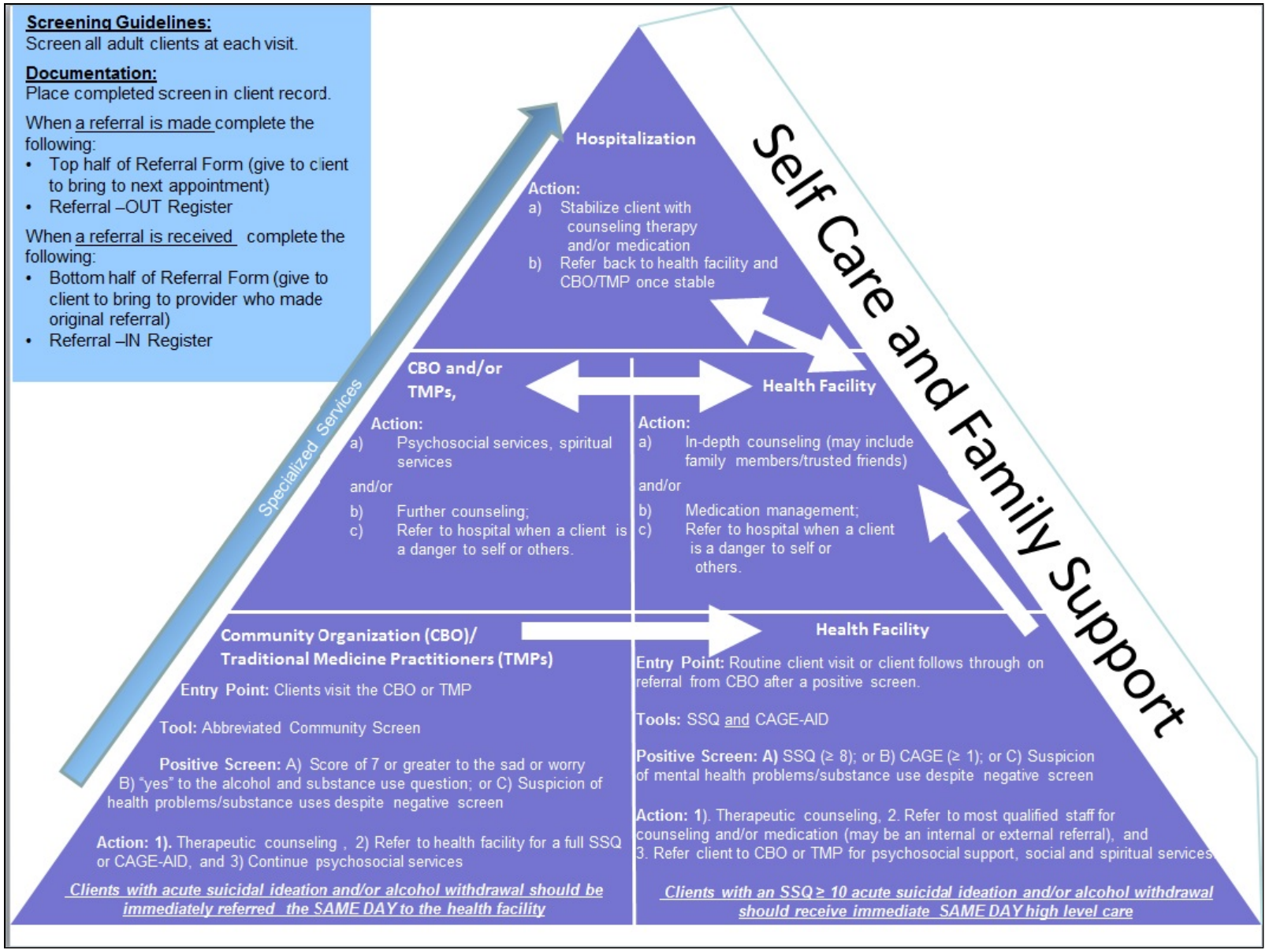
ANNEX A. THE STEPPED-CARE MODEL



ANNEX B. MENTAL HEALTH AND HIV INTEGRATION PROTOCOL



ANNEX C. HEALTH FACILITY JOB AID

The Mental Health/HIV Integration Pilot Activity
Health Facility Job Aid

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

A Positive SSQ (score 8 or greater)

1. **Determine if the client is suicidal by asking:**
- Are you thinking of hurting yourself?
- Have you ever attempted suicide in the past?
- Do you have a plan? If yes, what is it?

If the client is actively suicidal or has an SSQ score ≥10 seek immediate SAME DAY medical attention per protocol.

2. **Tell the client that:**
- depression is common, treatable and temporary
- coping can sometimes be more difficult if someone is experiencing depression, but this is only temporary
- it is normal to experience difficulties, but there are things that you can do to help yourself feel better

3. **Give advice and do a WRAP:**
- encourage a healthy diet, exercise, social activities and a routine sleep schedule, discourage substance use
- encourage the client to follow through on referrals for community-based support and talk with trusted family and friends about their feelings

4. **Refer the client to a health care provider using the Client Referral Form** for further counseling and medication.

5. **Refer the client to CBO services using the Referral Form** for supplementary care

6. **Record the referral** in the Referral Register.

A Positive CAGE-AID (score 1 or greater)

1. **Assess for Acute Alcohol Withdrawal** symptoms through determining if the client is tremulous, sweating, nauseous, vomiting, has a headache, is irritable and smells of alcohol.

If Acute Alcohol Withdrawal is suspected the client should receive immediate SAME DAY medical attention per protocol.

2. **Tell the client that:**
- It would be better if you cut down or abstained
- I understand the difficulty of cutting down or quitting, but I am optimistic that you will succeed
- I am willing to help you make plans
- I am willing to help you think about where this falls in relationship to your other goals and priorities

3. **Utilize the Readiness to Change Rulers** to assist with an assessment of the client's readiness to quit the behavior and to guide discussion with the client.

4. **Refer the client to a health care provider using the Client Referral Form** for further counseling.

5. **Refer the client to CBO services using the Referral Form** for supplementary care

6. **Record the referral** in the Referral Register.

Data Collection Tips

- Record data after each client encounter.
- Place screen in client record after the visit and use as a visual prompt at next visit to inquire if the client followed through on any referrals and if they have documentation from the visit.
- Notify the Integration Leader if you are running low screens and client referral forms.

Referral Tips

- Instruct client how to arrive to appointment.
- Give client the Client Referral Form with the top half completed. Tell them to give the form to the provider when they attend the referral appointment.
- Document each referral in the Referral Register-OUT form.
- Document each referral received in the Referral Register-IN form.

Clients who are suspected of mental health problems or alcohol and substance use, but have a negative screen should be treated as if they had a positive screen and receive integrated mental health and HIV services

ANNEX D. CBO AND TMP JOB AID

The Mental Health/HIV Integration Pilot Activity
Community-Based Organization and Traditional Practitioner Job Aid

Screening Protocol

All adult clients should receive an abbreviated community screen at each visit.

Counseling Tips

- Maintain the client's confidentiality at all times.
- Open the visit with a general greeting, "How have you been?".
- Make sure that the client feels comfortable prior to beginning the screen
- Do not judge
- Express empathy
- Let the client know that you are interested in what they have to share
- Actively listen
- Thank the client for sharing

A "yes" to the alcohol and substance use question:

1. **Assess for Acute Alcohol Withdrawal** symptoms through determining if the client is tremulous, sweating, nauseous, vomiting, has a headache, is irritable and smells of alcohol.

If Acute Alcohol Withdrawal is suspected the client should receive immediate SAME DAY medical attention per alcohol withdrawal guidelines.

2. Refer the client to a health facility for a full assessment.
3. Continue CBO services and link the client into additional supplementary CBO services.

A score of 7 or greater on the sad or worry questions:

1. **Determine if the client is suicidal by asking:**

- Are you thinking of hurting yourself?
  - If the client answers yes, then ask:
- Have you ever attempted suicide in the past?
- Do you have a plan? If yes, what is it?

If the client is actively suicidal seek immediate SAME DAY medical attention per suicidal ideation guidelines.

2. Refer the client to the health facility for a full assessment.
3. Continue CBO services and link the client into additional social and spiritual services.

Clients who are suspected of mental health problems or alcohol and substance use, but have a negative screen should be treated as if they had a positive screen and receive the above services

Data Collection Tips

- Record data after each client encounter.
- Place screen in client record after the visit.
- At the client's next visit, utilize the screen in the chart as a reminder to inquire if the client followed through on any referrals.
- Notify the Integration Leader if you are running low on screening tools or Client Referral Forms.

Referral Tips

1. Provide and explain to the client:
   - The reason for the referral
   - Written and oral instructions for how to arrive to appointment
   - The Client Referral Form with top half completed. Tell the client to bring the form to their appointment, and give the referring provider for form. Tell referring provider will complete the bottom half and give it back to the client to bring back to the original provider.
2. Document each referral made in the Referral Register-OUT sheet
3. Document each referral received in the Referral Register-IN sheet

ANNEX E. MOHCW GUIDELINES FOR SUICIDAL IDEATION

RISK FACTORS

- Older age groups
- Male
- Depression
- Alcohol abuse and drug use
- Personality disorder
- Chronic painful conditions, such as cancer, HIV and AIDS, or schizophrenia
- People who are experiencing adverse effects, such as divorce, separation, conflicts within relationships, loss of job, or isolation.

ASSESSING SUICIDAL RISK

- Is the patient serious?
- Is death a welcome outcome?
- Has the patient made any plans?
- Has the patient written a suicidal note?
- What plans is the patient making not to be discovered?
- Are there feelings of hopelessness, helplessness, and worthlessness?

The patient who is suicidal will usually tell someone about his or her intent.

MANAGEMENT OF THE SUICIDAL PATIENT

The decision to admit or not admit depends on whether there is an adequate social support network. If the decision to admit is reached, the patient is to be stripped of all dangerous items, such as knives, razor blades, and belts.

LEVEL I OBSERVATION

The patient and the nurse must be together always. When the patient is in the toilet, he or she should not lock the door.

LEVEL II OBSERVATION

The nurse must be able to see where the patient is at all times.

LEVEL III OBSERVATION

The nurse must know where the patient is, such as in group therapy or occupational therapy. Care must be taken when the patient is recovering because he or she will have enough energy to kill him- or herself.

The current condition must be treated accordingly.

ANNEX F. MOHCW GUIDELINES FOR ACUTE ALCOHOL WITHDRAWAL

Acceptable Levels: Male: 21 units per week Female: 14 units per week	***1 unit*** = pint of beer = small glass of wine = a tort of whisky or vodka = a tort of liquor and so on
Abuse of alcohol is drinking more than the accepted amount per week.	
Clinical Features: Drinking alcohol excessively Development of tolerance Drink seeking behavior over other activities Feeling guilty about drinking The patient may develop the Alcohol Dependency Syndrome, which comprises: 1. Privacy of drinking seeking behavior 2. Developing of drinking routine 3. Tolerance 4. Repealing withdrawal symptoms 5. Reinstatement after a period of abstinence.	Being annoyed about comments made over drinking Felt the need to cut down but without success Need to take an "eye opener" to steady nerves.
Treatment: General: • A careful appraisal of nutritional status • Rehydration • Vitamin supplements—particularly thiamine and nicotinamide. Detoxification with diazepam in reducing doses e.g. Diazepam 20 mg tds x 2 days Diazepam 15 mg tds x 2 days Diazepam 10 mg tds x 2 days Diazepam 5 mg tds x 2 days Diazepam 5 mg bd x 2 days Diazepam 5 mg nocte x 2 days	***After Detoxification:*** A thorough reappraisal of the drinking behavior: What has happened to cause the drinking behavior? How can drinking be substituted with something more profitable? Focus needs to be emphasized on behaviors that discourage drinking.
Then stop if the patient has blackouts. You may want to prevent seizures by giving an antiepileptic. If the patient has psychotic symptoms, you may want to give an antipsychotic medication. Care needs to be observed in using CPZ, which may further precipitate a seizure.	

ANNEX G. MENTAL HEALTH/HIV INTEGRATION REFERRAL DIRECTORY

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

ANNEX H. CLIENT REFERRAL FORM

The provider making the referral should complete the top half of this form, give it to the client to bring to their referral appointment. The provider at the referral appointment should complete the bottom half and give it back to the client to bring to the original provider to allow for bi-directional communication.

Name of facility:	**CLIENT REFERRAL FORM**					
Referred by:	Name:			Position:		
Initiating Facility Name and Address:				Date of referral:		
Telephone arrangements made:	YES	NO	Facility Tel No.	Fax No.		
Referred to Facility Name and Address:						
Client Name						
Identity Number			Age:	Sex:	M	F
Client address						
Screening Scores	SSQ score (health facility only)	CAGE-AID score (health facility only)	Abbreviated Community Screen score (CBO & TMP only)			
Reason for referral						
Additional notes:						
Print name, sign & date	Name:	Signature:	Date:			
Note to receiving facility: On completion of client management please fill in and detach the referral back slip below and send with patient or send by fax or mail.						

-----✂----------receiving facility - tear off when making **back referral**----------✂-----

Back referral from Facility Name		Tel No.	Fax No.		
Reply from (person completing form)	Name:		Date:		
	Position:	Specialty:			
To Initiating Facility: *(enter name and address)*					
Client Name					
Identity Number		Age:	Sex:	M	F
Client address					
This client was seen by: *(give name and specialty)*			on date:		
Services provided to client					
Additional notes					
Refer back to:			on date:		
Print name, sign & date	Name:	Signature:	Date:		

ANNEX I. REGISTER OF REFERRALS – OUT FORM

Register of Referrals OUT							
Date referral made	**Client identification number**	**Male or female (M/F)**	**Age**	**Referred to (name of facility / specialty)**	**Internal or external referral (I/E)**	**Reason referred**	**Referral completed (Y/N)**

ANNEX J. REGISTER OF REFERRALS – IN FORM

Register of Referrals IN							
Date referral received	**Client identification number**	**Male or female (M/F)**	**Age**	**Referred from (name of facility / specialty)**	**Referred for**	**Summary of treatment provided**	**Date client back-referred**

ANNEX K. SHONA SYMPTOM QUESTIONNAIRE

As part of routine services, we are providing mental health screening for all of our clients. The information that you share is confidential and will not be shared with other clients or local authorities. I will use your answers to help provide you with better services that meet your mental health needs.

Client Name: _____ Date: _____

Musvondo rapfuura… ***During the course of the past week…***	**Ehe** ***Yes***	**Aiwa** ***No***
1. pane pamaimboona muchinyanya kufungisisa kana kufunga zvakawanda here? *Did you have times in which you were thinking deeply or thinking about many things?*		
2. pane pamaimbotadza kuisa pfungwa dzenyu pamwechete here? *Did you find yourself sometimes failing to concentrate?*		
3. maimboshatirwa kana kuita hasha zvenhando here? *Did you lose your temper or get annoyed over trivial matters?*		
4. maimborota hope dzinotyisa kana dzisina kunaka here? *Did you have nightmares or bad dreams?*		
5. maimboona kana kunzwa zvinhu zvangazvisingaonekwe kana kunzwikwa nevamwe here? *Did you sometimes see or hear things which others could not see or hear?*		
6. mudumbu menyu maimborwadza here? *Was your stomach aching?*		
7. maimbovhundutswa nezvinhu zvisina maturo here? *Were you frightened by trivial things?*		
8. maimbotadza kurara kana kushaya hope here? *Did you sometimes fail to sleep or lose sleep?*		
9. pane pamaimbonzwa muchiomerwa neupenyu zvekuti makambochema kana kuti makambonzwa kuda kuchema here? *Were there moments when you felt life was so tough that you cried or wanted to cry?*		
10. maimbonzwa kuneta here? *Did you feel run down (tired)?*		
11. pane pamaimboita pfungwa dzekuda kuzviuraya here? *Did you at times feel like committing suicide?*		
12. mainzwa kusafara here mune zvamaiita zuva nezuva? *Were you generally unhappy with things you were doing each day?*		
13. basa renyu raive rave kusarira mumashure here? *Was your work lagging behind?*		
14. mainzwa zvichikuomerai here kuti muzive kuti moita zvipi? *Did you feel you had problems deciding what to do?*		
Scoring: Add together the number of questions to which the client responded "yes".	**TOTAL SCORE:**	

Scoring Information

Total score 8 to 14: refer for further assessment.

Clients with suspected mental health problems despite a negative screen should also receive counseling services and referrals.

Action Taken:

Referred: (circle one) YES NO

Referred to: _____

ANNEX L. CAGE-AID SCREENING TOOL

As part of routine services, we are providing alcohol and substance use screening for all of our clients. The information that you share is confidential and will not be shared with other clients or local authorities. I will use your answers to help provide you with better services that meet your mental health needs.

Pindurai ehe kana aiwa pane mibvunzo inotevera: **Please answer yes or no to the following questions:**	**Ehe** ***Yes***	**Aiwa** ***No***
1. Unombonzwa here kuti unofanirwa kudzikisira manwiro aunoita doro, uye maputiro kana mashandisiro aunoita zvinodhaka? *Have you ever felt you should cut down on your drinking or drug use?*		
2. Pane munhu kana vanhu vanombokushatirisa here nekushoropodza kwavanoita manwiro ako edoro, uye maputiro kana mamwe mashandisiro aunoita zvinodhaka? *Have people annoyed you by criticizing your drinking or drug use?*		
3. Unombozvitongesa here pamusoro pekunwa doro, kuputa kana kushandisa kwaunoita zvinodhaka? *Have you ever felt bad or guilty about your drinking or drug use?*		
4. Wakambotanga nekumwa doro, kuputa kana kushandisa zvinodhaka uchangobva mukumuka mangwanani kuti unzwe zvakanaka kana kuti upedze bhabharasi?*Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (an "eye-opener")?*		
Scoring: Add together the number of questions to which the client responded "yes".	**TOTAL SCORE:**	

Scoring Information

Score:

1= At risk; indicates a need for further clinical investigation, including questions on amount and frequency of intake.

2= A current problem; indicates a need for further clinical investigation and/or referral as indicated by the clinician's expertise.

3 or 4= Evidence of alcohol dependence until proven otherwise. Evaluate, treat, and/or refer the client as indicated by the clinician's expertise.

Action Taken:

Referred: (circle one) YES NO

Referred to: _____

Additional notes: _____

_____

_____

_____

_____

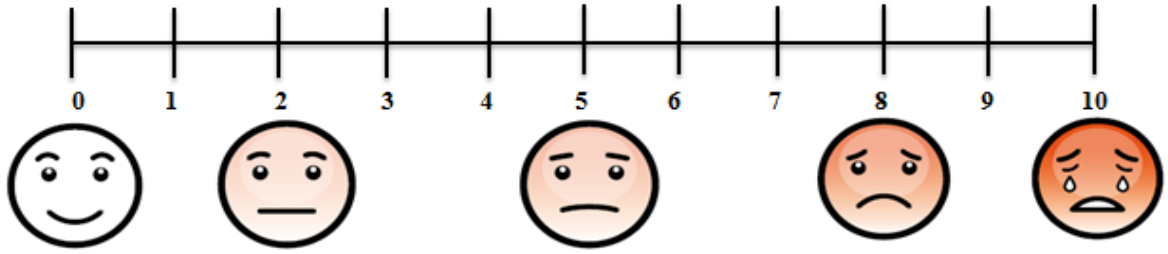
ANNEX M. ABBREVIATED COMMUNITY SCREEN

As part of our routine services, we are providing mental health screening for all of our clients. The information that you share is confidential and will not be shared with other clients, or local authorities. I will use your answers to help provide you with better services that meet your mental health needs.

Instructions: Ask the client the following questions. The client should be referred to the health facility if: They answer ≥ 7 to questions 1 or 2 or if they respond "yes" to question 3.

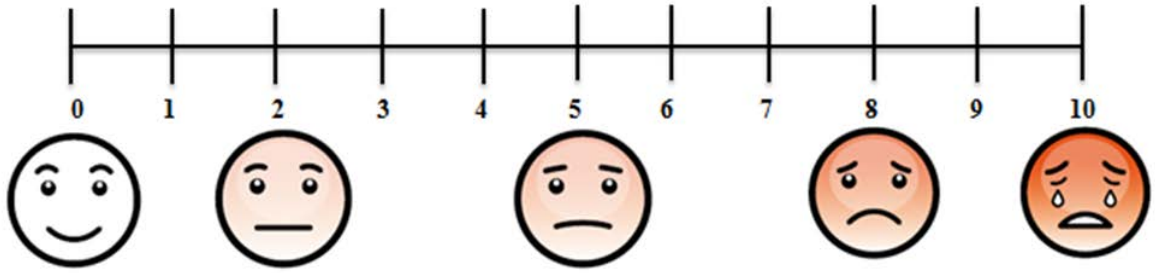
1. Wakambonzwa kusuwa here musvondo rapfuura?

Have you been feeling sad over the past 7 days?



2. Wakambonzwa kushushikana here musvondo rapfuura?

Have you been worried over the past 7 days?



	Ehe *Yes*	**Aiwa *No***
3. Wakambotanga nekumwa doro, kuputa kana kushandisa zvinodhaka uchangobva mukumuka mangwanani kuti unzwe zvakanaka kana kuti upedze bhabharasi?		

Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover (an "eye-opener")?

Action Taken:

Referred: (circle one) YES NO

Referred to: _____

ANNEX N. ADDITIONAL SCREENING TOOLS

Tool	Basics
CES-D	• Brief 20-item self-report scale focused on depression • Widely used • Free and available at http://idacc.healthbase.info/questionnaires.html.
PHQ-9	• Depression only • Nine questions and takes approximately two minutes to complete and score in most cases • Free of charge • Not available in a range of languages • Available at www.cqaimh.org/pdf/tool_phq9.pdf.
HADS	• Assesses both anxiety and depression, and the overall score gives one of four severity categories • Longer and takes more time to complete compared with PHQ-9 • Used in multiple countries with reliable and valid results • Cost associated with use • See www.ehow.com/how_5069944_use-hospital-anxiety-depression-scale.html and Herrmann (1997) for more information.
BDI-II and BAI	• Use of both to screen for anxiety and depression • Longer and takes more time to complete compared with PHQ-9 and HADS • Used in multiple countries with reliable and valid results • Cost associated with use • Available in a range of languages • See www.ehow.com/how_5642339_interpret-beck-depression-inventory.html and www.ehow.com/how_5078582_score-beck-anxiety-scale.html for more information.
CHS	• Brief self-report 14-item questionnaire; takes approximately 10 minutes to complete • Designed for youth aged 11 to 18 in the United States • Comprehensive: includes depression, anxiety, suicide risk behaviors (i.e., suicide ideation and attempts), alcohol and drug use, and general health problems • Not validated outside the Unites States • Availability and more information can be found at www.teenscreen.org.
PCL	• Brief self-report 17-item scale • Is available in different languages and has been used internationally • Availability and free to use, with credit given to the developers, available at http://idacc.healthbase.info/questionnaires.html.

ANNEX O. WELLNESS RECOVERY ACTION PLAN (WRAP)

The WRAP may be used as a brief counseling intervention when a client is suspected of mental health problems. Ask the following questions to help the client identify mental health symptoms and use the Toolkit at the bottom of the page to assist them to identify activities to improve their mental health. (Adapted from Copeland 2012)

DAILY MAINTENANCE

1. Describe yourself and how you feel when you are feeling alright
2. List what you need to do daily to keep yourself feeling alright

WHEN THINGS ARE BREAKING DOWN OR GETTING WORSE

1. Describe how you feel when things have gotten worse
2. List the things that you have done in the past or that you could do when you notice that things are getting worse to avoid a crisis

CRISIS PLANNING

1. What are the symptoms that indicate that you need others to take action to help you
2. Who are the individual(s) who you want to help you
3. What are the actions that they can take that will be helpful
4. What actions should be avoided

MENTAL HEALTH TOOLKIT

- Talk to a friend or family member
- Take a walk
- Go to a religious service
- Speak with a spiritual healer
- Exercise
- Take a nap
- Take a bath or shower
- Practice deep breathing
- Sing
- Read a book
- Other _____
- Other _____

ANNEX P. THE READINESS TO CHANGE RULERS

The Readiness to Change Ruler is a quick assessment that can be used to determine a client's readiness to change a specific behavior, such as harmful alcohol or drug use. The two rulers below look at the importance of and confidence about change from a client's perspective and measure both desire and motivation to change. The Readiness to Change Rulers can help assess where the client is on a continuum between "not important" and "very important." Once the client has identified where he or she is on these rulers, use the questions to determine the client's readiness to change a behavior (Zimmerman, Olsen, and Bosworth 2000).

How *important* is this change for you?

1	2	3	4	5	6	7	8	9	10
NOT				IMPORTANT					VERY

How *confident* are you about making the change?

1	2	3	4	5	6	7	8	9	10
NOT				IMPORTANT					VERY

	Importance	Confidence
If the mark is on left side	• If it is not important to change, how will you know when it is time to change? • What would be the benefits if you did consider changing?	• What prevents you from changing? • What could you do to increase your ability to change?
If the mark is in the middle	• Why did you put your mark here? • What are the benefits that you are experiencing as you try to change? • What are the barriers to changing? • How can you overcome these barriers?	• Why did you put your mark here? • What may be some actions you take to try to change? • When you made other changes in your life, how did you do it? • What are the barriers to changing? • How can you overcome these barriers?
If the mark is on the right side	• What will be different for you when you reach your goal? • What people, places, or things do you still need to consult/go to, or what things do you still need to do to maintain your behavior?	• What will be different for you when you reach your goal? • What people, places, or things do you still need to consult/go to, or what things do you still need to do to maintain your behavior?
If the client has taken a serious step to make a change	• What made you decide to take this step? • What has helped you to be successful in taking this step? • What else will help? • What is your next step?	• What made you decide to take this step? • What has helped you to be successful in taking this step? • What else will help? • What is your next step?
If the client has had a relapse	• What worked for a while? • What did you learn from the experience? • How will this help you give it another try?	• What worked for a while? • What did you learn from the experience? • How will this help you give it another try?

ANNEX Q. EMERGENCY ACTION TEMPLATE

The following protocol should be followed in case of emergency situations, including suicidal ideation and acute alcohol withdrawal.

SUICIDAL IDEATION:

Clients who are acutely suicidal should receive immediate SAME DAY referrals for observation and treatment. Ensure that the client has transportation to this facility if it is at a different location. This may require you to contact a trusted family member or friend to assist with transportation.

The most appropriate location for a client to receive this level of service is: _____

Name of facility: _____

Contact information (telephone): _____

Additional notes: _____

_____

_____

_____

_____

ACUTE ALCOHOL WITHDRAWAL:

Clients who are experiencing acute alcohol withdrawal require immediate SAME DAY treatment. Ensure that the client has transportation to this facility if it is at a different location. This may require you to contact a trusted family member or friend to assist with transportation.

The most appropriate location for a client to receive this level of service is: _____

Name: _____

Contact information (telephone): _____

Additional notes: _____

ANNEX R. INTEGRATION LEADER'S CHECKLIST

- ❒ Train colleagues on mental health and HIV integration pilot activity.
- ❒ Provide guidance to colleagues throughout pilot activity as needed.
- ❒ Check in with colleagues routinely to ensure correct screening protocol is carried out.
- ❒ Ensure that adequate screening tools are available throughout pilot.
- ❒ Monitor referral system to ensure that the correct protocol is carried out by reviewing Referral-Out and Referral-In forms and client referral forms.
- ❒ Ensure that clients' confidentiality is maintained throughout pilot activity.

ANNEX S. SAMPLE DATA COLLECTION SHEET FOR HEALTH FACILITIES

Mental Health/HIV Integration Data Collection Sheet at the Health Facility Level									
MR#	Gender (M or F)	Age	Date of assessment	SSQ score	CAGE-AID score	Referral (Y/N)	Client Given Referral Form (Y/N)	Referral Recorded in Referral Register (Y/N)	Comments

ANNEX T. SAMPLE DATA COLLECTION SHEET AT THE COMMUNITY AND TRADITIONAL PRACTITIONER LEVELS

Mental Health/HIV Integration Data Collection Sheet at the Community and Traditional Practitioner Levels										
Client ID#	Gender (M or F)	Age	Date of assessment	Abbreviated Community Screen scores			Referral (Y/N)	Client Given Referral Form (Y/N)	Referral Recorded in Referral Register (Y/N)	Comments
				Question #						
				1	2	3				

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