Module 6 Adolescents, HIV, and Mental Illness

Session 6.1:	**The Importance of Mental Health Services for ALHIV and Categories of Mental Illness**
Session 6.2:	**Identifying Possible Mental Illness and Providing Basic Mental Health Support to ALHIV**

Learning Objectives

After completing this module, participants will be able to:

- Identify their own beliefs and attitudes about mental illness and ALHIV
- Define and list basic categories of mental illness
- Describe why ALHIV need access to mental health services
- Discuss the role of primary health workers in providing basic mental health services to ALHIV
- Recognize when an adolescent client may have a mental illness, determine the need for follow-up care, and provide appropriate referrals for mental health services
- Apply screening tools for depression and substance use disorders with adolescent clients
- Provide basic management during mental health emergencies
- Describe how to support clients taking psychotropic medications, including understanding basic interactions between ARVs and psychotropic medications

Session 6.1 Importance of Mental Health Services for ALHIV

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Exercise 1: Values Clarification: Large group discussion	
Purpose	To discuss attitudes, values, beliefs, and prejudices about ALHIV and mental illness
Remember that, during this exercise, there **are no wrong answers!**	

Overview of Mental Illness[1,2,3,4]

What is mental health?
Mental health refers to a state of psychosocial well being and, for people with mental illness, the adoption of adequate strategies to overcome the debilitating effects of their illness. States of mental health and mental illness fall into a broad spectrum — ranging from, for example, "feeling down" to having severe depression over a period of time.

What is mental illness?

- Mental illness (or mental disorder) is characterized by the presence of one or both of the following *over time*:
  - Persistent and severe subjective distress (or discomfort)
  - Moderate or severe impairment in functioning (not being able to "get through" day-to-day activities)
- *Temporary* states of severe distress and reduced functioning, often in response to stressful life events, are not considered mental illness. Examples might include temporary mood fluctuations, extreme sadness in response to a difficult life event, or not being able to focus in school from time to time.
- Mental health problems that do not meet the threshold for mental illness can be addressed through general counseling (see Module 4), psychosocial support (see Module 5), and support to live positively with HIV (see Module 9).
- Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many are caused by a combination of factors, including genetic predisposition, injuries to or medical conditions that affect the brain, and the long-term impact of adverse life events.

Difficulties defining mental illness:

- To some extent, the line between ordinary variation and distress, and the presence of a mental illness, is an arbitrary one.
- People vary in their personalities, social and intellectual abilities, emotional expression, and coping skills, resulting in a wide range of what is considered "normal."
- Among adolescents, there are also enormous biological and psychological changes taking place. Most adolescents will experience some type of fluctuation in mood or behavior and/or problems that affect their emotional and mental functioning. For example, normal adolescent development includes transient "moodiness" and challenging parental authority.
- The problem of defining mental illness is further complicated by the lack of objective biological tests to make diagnoses.
- Definitions of mental illness are constantly being further refined.

Basic Categories of Mental Illness Seen in Adolescents

Mental illness is a broad term that covers many different disorders — many of which can emerge during late childhood and adolescence. ALHIV are susceptible to a number of mental illnesses, which can be broadly classified into the following categories:

- **Depression:** a feeling of intense sadness — including feeling helpless, hopeless, and worthless — that lasts for days to weeks and is not explained by bereavement (mourning the death of someone close). If severe and untreated, depression can lead to suicide (see box).
- **Alcohol and substance use disorders**
- **Anxiety disorders:** manifested by persistent fear or worry that is out of proportion to a person's current life circumstances
- **Behavioral disorders:** manifested by violent behavior, aggression, and impulsivity (the tendency to do things without adequate forethought)
- **Severe mental illness:** usually refers to schizophrenia or other mental illnesses that have psychotic features (in other words, loss of contact with reality)

Suicide in Adolescents

Suicide, or the act of killing oneself, is one of the most severe consequences of mental illness. While severe depression is the mental illness most commonly associated with suicide, psychosis, anxiety disorders, substance use disorders, and other mental illnesses are also associated with an increased risk of suicide.

These disorders vary in severity and can create barriers to the adolescent achieving self-protection and the expected degree of independence. Mental illness can also interfere with an adolescent's HIV care, including in the areas of retention in care, adherence to ART, positive living, and positive prevention.

Some of the more common mental illnesses are discussed further in the next session.

Importance of Mental Health Services for ALHIV[1,2,3,4]

Recognizing possible mental illness and providing/referring ALHIV for mental health services is important because:

- Primary mental illnesses usually begin in childhood, adolescence, or early adult life.
- Compared to their HIV-negative peers, ALHIV have an increased risk for mental illness as a result of the direct effect HIV has on the brain, the fact that chronic illnesses are associated with higher rates of mental illness, and the impact of stigma and discrimination.
- **A person's mental health significantly influences his or her adherence to HIV care and treatment.** Adolescents with mental health and substance use problems are more likely to forget or decide not to take their medications.
    - Studies in adults have found that, when depression is treated, clients with HIV are more likely to initiate ART, adhere to ART, and have both higher CD4 cell counts and lower viral loads.
- Mental health status influences the course of HIV disease in various ways. For example, depression can limit the energy needed to keep focused on staying healthy and research shows that depression may accelerate the progression to AIDS.
- Mental illness can make it more difficult for an adolescent to engage in positive living and positive prevention, including practicing safer sex to prevent transmission to sexual partners.
- The presence of one mental illness predisposes a person to the onset of other mental disorders (for example, it is not unusual to see a depressed adolescent who also abuses alcohol).
- People who experience mental health problems (for example, depression) are more likely to abuse drugs or alcohol and to engage in risky sexual behaviors.
- Untreated mental illness can disrupt adolescent development in a profound way, by interfering with the ability to work, attend school, and form social relationships.
- Untreated mental illness can result in suicide.

Providing Mental Health Services to Adolescents: Challenges and Solutions[2,5]

Challenges

Barriers and challenges to providing mental health services may include the following:

- An insufficient number of mental health specialists to provide services and effective training and supervision to primary health workers
- The limited information on the prevalence of mental health disorders in African countries
- A lack of validated and context-appropriate screening tools
- The few treatment options available in most settings (for example, psychotherapy, psychotropic medications)
- The very limited data available on the treatment of psychiatric disorders in ALHIV
- The high levels of social stigma and discrimination faced by people with mental illness

Solutions

Diagnosing a specific mental illness can be difficult and requires specialized training. Despite this and the many challenges related to providing mental health services to ALHIV, there are many things **health workers** can do, such as:

- Recognize that ALHIV are at risk for mental illness.
- Recognize the array of mental illnesses that are seen in adolescents.
- Include mental health as a part of routine care. This includes conducting regular psychosocial assessments (see Module 5), regularly assessing a client's mental health needs, and checking in with caregivers (when available and involved) about the clients' moods, general behavior, and any changes they have observed — at home, at school, with friends, and with family members.
- Use clinical skills and observation during routine visits to identify if an adolescent might have a mental illness.
- Know the signs that a serious mental illness may be present and know how to refer adolescents for further assessment and care.
- Use simple screening tools to determine if a mental illness may exist.
- Distinguish urgent mental illness that requires emergency management from less pressing mental health concerns.
- Provide appropriate mental health referrals and follow-up care and support to adolescent clients and their family members.
- Consider the impact of mental illness on an adolescents' HIV care (in particular adherence to care and medications).
- Respect and listen to clients' and caregivers' beliefs about the origin and treatment of mental illness. Beliefs concerning the treatment of mental health conditions vary among members of different communities and cultural groups.
- Discourage the use of alcohol and drugs among adolescent clients.

There are also many things **health facilities** can do to support and improve mental health services for adolescent clients and their family members, such as:

- Establish routine approaches and standard internal procedures for mental health screening, referrals, and treatment.
  - This can include **mapping available mental health services** at the level of the health facility (own health facility and others in the area) and the community (e.g. school-based programs for adolescents with learning disabilities; mental health specialists, such as psychologists and psychiatrists within the facility or at other health facilities; public or private inpatient and outpatient psychiatric services; individual or group counseling programs, etc.), formalizing referral linkages with these services, and providing appropriate referrals and follow-up.
  - Health facilities should also **develop and implement standard procedures** for mental health screening, referrals, and treatment. In some facilities, for examples, health workers may be responsible for mental health screening and basic management, while in others, they may only be responsible for initial screening and referral to a mental health professional if possible mental illness is detected.
- Identify a mental health point person on the multidisciplinary HIV team (this may be a social worker, counselor, psychologist, or other).
  - Support the mental health point person to attend relevant mental health trainings and make time for in-service trainings on mental health.
  - A number of mental health resources that may be used for discussion and training in the clinical setting can be found here: http://www.who.int/mental_health/en/.
- Ensure a multidisciplinary team approach to the care of clients with mental illness — for example, that their care is managed jointly by the mental health professional (e.g. psychologist, psychiatrist, social worker) and the nurses and physicians providing HIV care and treatment.
- Ensure that mental health is discussed as a routine part of HIV care in multidisciplinary team meetings and case conferences.

Session 6.2 Identifying Possible Mental Illness and Providing Basic Mental Health Support to ALHIV

Session Objectives

After completing this session, participants will be able to:

- Recognize when an adolescent client may have a mental illness, determine the need for follow-up care, and provide appropriate referrals for mental health services
- Apply screening tools for depression and substance use disorders with adolescent clients
- Provide basic management during mental health emergencies
- Describe how to support clients taking psychotropic medications, including understanding basic interactions between ARVs and psychotropic medications

Recognizing Possible Signs of Mental Illness During Routine Clinic Visits

Remember: Diagnosing a specific mental illness can be difficult and requires specialized training. However, all health workers should know the signs that a serious mental illness may be present and know how to refer adolescents for further assessment and care.

There are many types of information readily available to the health worker that can help determine if an ALHIV may have a mental illness. See also *Appendix 6A: Tips for Health Workers on Identifying Possible Mental Illness.*

1. Use a client's recent and past history

Recent history: An adolescent may self-report symptoms of mental illness. On the other hand, an adolescent suffering from a mental illness may not be aware that something is wrong or may be too afraid to talk about it. Concerns about the changes brought about by possible mental illness may be initially expressed by a client's family members, other adults, or peers. The health worker who knows an adolescent well may also notice these changes over time. For example:

- The adolescent has shown a dramatic change in behavior and/or a major decrease in psychosocial functioning (e.g., used to be friendly, but now only wants to be alone; used to be calm, but is now behaving in a violent way; was a good student, but is now failing in school, etc.)
- The adolescent has been saying things that do not seem plausible (e.g., "my grandmother is trying to poison me," "voices are telling me that I'm a bad person," etc.)

Somatic symptoms: Mental illness, especially depression and anxiety disorders, affect the mind and body and, when severe, are routinely accompanied by physical (or somatic) complaints.

- These may include: fatigue, headaches/migraines, abdominal pain/gastrointestinal problems, backaches, difficulty breathing, changes in appetite and weight, changes in sleep patterns, and chest pains.

Review the client's clinical and ART history:

- If signs of possible mental illness are observed or reported, health workers should review the client's HIV history, recent changes in disease status, and ART regimen (including any dosing or medicine changes) to determine if they are contributing to changes in the client's mental health.
- While rare, some ARVs, including efavirenz, can have neuropsychological side effects that may contribute to mental health problems. In these cases, drug changes may need to be considered in clients with new onset mental health problems.

Past history: Many mental illnesses are persistent or recurrent, and some can begin in early childhood. The client or an accompanying family member or friend may report past events that suggest the presence of a mental illness. These include:

- Past psychiatric hospitalization
- Past use of psychotropic medication (any medication capable of affecting the mind, emotions, and behavior) — this is discussed further later in this session
- History of severe behavioral disturbances
- History of mental illness in the family (e.g., depression, schizophrenia)
- History of school failure

2. Make observations during routine visits (and ask caregivers' about their observations)

Health workers can make observations about the following during their routine visits with clients, which may alert them to the existence of a possible mental illness.

- **Appearance and presentation**: The adolescent's hygiene and grooming are poor; the client comes across as frightening or frightened; the client has alcohol on his or her breath and/or appears intoxicated; the adolescent makes no eye contact or is crying
- **Attitude and behavior**: The adolescent is restless, belligerent, uncooperative; the adolescent is making threats, is unwilling/unable to speak, is behaving in odd and unusual ways
- **Mood and emotions:** The adolescent looks or seems to be frightened, sad, angry
- **Speech, thinking, and perception**: The adolescent is speaking very rapidly or overly loudly or softly; is saying things that make no sense; is saying things that are unlikely to be true (e.g. my grandmother is poisoning me); is reporting hallucinations (hearing or seeing things that are not there)
- **Level of alertness and orientation**: The adolescent is having trouble staying alert and attentive; is drowsy; is confused about things like where he or she is and what time of day it is
- **Social and intellectual skills**: The adolescent does not have the verbal, behavioral, and/or social skills that would be expected of someone his or her age; the adolescent is behaving like a younger child would

If the history and observations reveal problems, it is helpful to ask a few simple follow-up questions that are specific to the problems reported or observed. For example:

- *What is making you cry?*
- *You look frightened today — did something scare you?*
- *What are you feeling angry about?*
- *You are usually so neatly dressed — is something wrong?*
- *Have you noticed how quickly you're speaking?*

If health workers are not afraid to ask this type of simple questions based on their observations, they may quickly learn whether an adolescent client is having serious problems that suggest the presence of mental illness.

As mentioned above, it is also important for health workers to review the client's HIV history, recent changes in disease status, and ART regimen (including any dosing changes or new medications) to determine if they might be contributing to any new mental health issues.

A note about delirium
Delirium is a serious *medical* (i.e., not psychological) condition that can present with signs of mental illness, such as delusions, hallucinations, and agitation. Prior to concluding that an adolescent has a primary mental illness, it is very important for health workers to first assess whether the adolescent has delirium and is in urgent need of medical care. Note that delirium is not as common in adolescents as it is among the elderly, especially hospitalized and critically ill patients.

Causes of delirium:

- Rapidly reversible causes of delirium are hypoglycemia (check blood glucose level), severe dehydration (check for signs of shock, heat stroke, high temperature; provide hydration and cooling), and hypoxia (look for cyanosis and shortness of breath; give oxygen).
- Other causes of delirium include meningitis, cerebral malaria, sepsis from any cause, the direct impact of HIV on the brain, elevated blood sugar, organ failure, metabolic or endocrine abnormalities, alcohol/drug/medication intoxication or overdose, poisoning, status epilepticus, post seizure state, neurotoxic snake bites, and head trauma.

3. Conduct regular psychosocial assessments

As discussed in Module 5, health workers should conduct a psychosocial assessment when an adolescent enrolls in care and treatment and annually thereafter — as well as when there is a significant change in the client's situation. Health workers may find it helpful to use the Psychosocial Assessment Tool in *Appendix 5A* as a guide to conduct and record key points of psychosocial assessments.

- Psychosocial assessment findings can reveal important things about the client's mood, mood changes over time, coping strategies, eating and sleeping habits, drug and alcohol use, and support systems.
- Information gained from psychosocial assessments can help health workers identify areas for additional follow-up and support, as well as possible signs of mental health problems that require further assessment by a trained mental health provider.

Remember: The way mental illnesses present in clients varies from culture to culture and person to person. There are also differences in younger versus older adolescents. For example:

- It is common for younger children to manifest mental health issues through acting out behaviors or by complaining about stomach pain or other unexplained somatic problems.
- Older adolescents may demonstrate more pronounced difficulties with schoolwork, truancy, running away from home, and substance abuse. Mental illness interferes with their sense of well being and/or the ability to carry out usual activities.

Exercise 2: Mental Illness in ALHIV: Small group work and peer teaching	
Purpose	To learn more about the major categories of mental illness, including common signs and symptoms that health workers should watch out for and suggested next steps health workers can take if they think an adolescent client may have a mental illness
This exercise consists of 2 parts: • Part 1: Small Group Work • Part 2: Large Group Discussion Refer to Tables 6.1-6.5.	
For Part 1, prepare to teach your peers about the category of mental illness assigned to your group, including: • Basic information about the mental illness (the definition, locally used terms, etc.) • Possible signs and symptoms • What the health worker should do • Screening tools that health workers can use to get more information (note that examples of screening tools for depression, alcohol abuse, and drug use are included in *Appendices 6B, 6C,* and *6D*, respectively).	

Mental Illness in ALHIV: Signs and Symptoms and Tips for Health Workers[2,6]

The content and tables below summarize basic information on common categories of mental illness, including basic definitions, possible signs and symptoms health workers should watch out for, and suggestions for what health workers should do if they observe these signs and symptoms.

Depression

Depression is the most common mental illness seen in ALHIV.

Table 6.1: Depression - Tips for health workers

Possible Signs and Symptoms of Depression	• Depressed mood, feelings of helplessness or hopelessness • Really tired with no energy • Cannot find good in anything • Does not enjoy things (loss of interest or pleasure) • Sleeps too much or not enough • Gets angry for no reason • Cannot eat or eats too much • Does not feel like being social with friends or family • Feelings of guilt or low self-worth • Poor concentration • Talks about running away • Thinks about suicide • Talks of self-injury or has had prior episode(s) of self-injury • Prior attempts or expressions of suicide
What the Health Worker Can Do	• Symptoms of depression are very common among adolescents. They are often transient and respond to support from friends, family, and health workers. • If problems are mild, try psychosocial counseling and support strategies (see Modules 4 and 5). • Refer client to trained counselor or other mental health provider, peer support group, and group/individual therapy, if available. • Ask about alcohol and drug use (see below). • Review the client's HIV history, recent changes in disease status, and ART regimen (including any dosing changes or new medications). • Screen the client for depression; for example, using the screening tools in ***Appendix 6B: Sample Screening Tools for Depression and Suicide*** • If depression is severe, does not improve, or worsens, refer client to a mental health provider. **Screen for suicide risk. Clients require urgent intervention if:** • They indicate they might hurt themselves or another person, or if they show any evidence of self-harm. • Their families cannot cope with them anymore. • They are thinking about, threatening, or have attempted to kill themselves. ◦ If suicidal, ensure immediate safety and refer to the nearest psychiatric hospital; provide constant supervision during transfer (see the section on "Managing Psychiatric Emergencies" below for more information).

Alcohol and substance use disorders

Experimentation is common among adolescents (this will be discussed further in Module 9). However, there are patterns of use that warrant the diagnosis of an alcohol or substance use disorder. Note that, in addition to alcohol, some commonly used drugs include marijuana, glue (sniffing), chat, and methamphetamines. In some places, efavirenz is also crushed and smoked.

Table 6.2: Alcohol and substance use disorders - Tips for health workers

Possible Signs and Symptoms of Alcohol and Substance Use Disorders	• Sudden changes in personality without another known cause • Loss of interest in favorite hobbies, sports, or other activities • Sudden decline in performance or attendance at school or work • Changes in friends and reluctance to talk about new friends • Deterioration of personal grooming habits and personal hygiene • Difficulty paying attention or forgetfulness • Sudden aggressive behavior, anger, nervousness, or giddiness • Increased secretiveness, heightened sensitivity to being asked questions • Sudden changes or unexplained problems with adherence to medications or missed appointments
What the Health Worker Can Do	• Provide general education and counseling on risk reduction and behavior change. For example, assess the safety of the client and others while client is under the influence of alcohol or drugs (if operating a motor vehicle, having sex, etc.) and provide risk reduction counseling. • Provide referrals for individual and group counseling and treatment (e.g. Alcoholics Anonymous). • Review the client's HIV history, recent changes in disease status, and ART regimen (including any dosing changes or new medications). • Screen for alcohol misuse and drug use and abuse upon initial intake and whenever suspected, based on medical history, reports from family/partner, client's behavior in the clinic, or findings from psychosocial assessments. **See *Appendix 6C: Screening for Alcohol Dependency with the CAGE Questionnaire* and *Appendix 6D: The Drug Abuse Screening Test (DAST).*** • Be patient and accepting of the client's situation; recovery can be a gradual process. • Provide ongoing support and follow-up at every visit. • See Module 9 for more information

Anxiety disorders

Anxiety disorders are different from the normal, everyday anxiety that is commonly seen among adolescents. Anxiety disorders are more intense (e.g., panic attacks), last longer, and/or interfere with daily life.

Table 6.3: Anxiety disorders - Tips for health workers

Possible Signs and Symptoms of Anxiety Disorders	• Cannot eat • Cannot breathe or has frequent shortness of breath • Panic attacks (may include shaking, sweating, fast heartbeat, difficulty breathing) • Tingling in the hands or feet • Chronic headaches • Trouble sleeping; nightmares • Cannot concentrate on anything • Feels jumpy, stressed out, or restless • Feels overwhelming sense of worry • Fearful of participating in normal activities
What the Health Worker Can Do	• Symptoms of anxiety are very common among adolescents. They are often transient and respond to support from friends, family, and health workers. • If problems are mild, try psychosocial counseling and support strategies (see Modules 4 and 5). • Refer client to peer support group and group/individual therapy, if available. • Teach client relaxation techniques and explore other coping mechanisms to manage anxiety. • Review the client's HIV history, recent changes in disease status, and ART regimen (including any dosing changes or new medications). • If anxiety is severe, interferes with the client's functioning, and/or does not improve or worsens over time, refer client to a mental health provider.

Behavioral disorders

Disruptive behavioral disorders are marked by poorly regulated and socially unacceptable behaviors that interfere with an adolescent's ability to carry out daily activities and negatively affects school performance. Symptoms are typically observed in younger adolescents.

Table 6.4: Behavioral disorders - Tips for health workers

Possible Signs and Symptoms of Behavioral Disorders	• Frequent defiance of authority • Arguing and refusing to obey rules at home and at school • Failure to take responsibility for bad behavior or mistakes • Resentment, looking for revenge • Regular temper tantrums **In older children/adolescents:** • Aggressive behaviors that threaten/harm people or animals • Behaviors that destroy property • Stealing, bullying, or lying • Serious violations of rules at home or at school **Adolescents with attention deficit hyperactivity disorder (ADHD) often exhibit the following symptoms:** • Trouble paying attention and concentrating • Difficulty in organizing activities • Easily distracted and fails to finish tasks • High activity level • Cannot sit still • Impulsivity • Cannot wait for a turn • Interrupts when others are talking or doing something
What the Health Worker Can Do	• Counsel the client, focusing on self-regulation. • Counsel caregivers, focusing on improving parenting skills and giving advice on how to create a structured home environment. • Review the client's HIV history, recent changes in disease status, and ART regimen (including any dosing changes or new medications). • Talk with a mental health specialist about prescribing medication • Provide referrals to local support services.

Severe mental illness

Severe mental illness usually refers to schizophrenia, schizoaffective disorder, or other mental illnesses that can have psychotic features (in other words, loss of contact with reality).

Table 6.5: Severe mental illness - Tips for health workers

Possible Signs and Symptoms of Severe Mental Illness	• Bizarre delusions • Auditory or visual hallucinations (client reports hearing or seeing things) • Paranoia • Agitation • Suspiciousness • Hostility • Exaggerated sense of self
What the Health Worker Can Do	• First, rule out delirium, a serious *medical* (i.e., not psychological) condition that can present with signs of mental illness, such as delusions, hallucinations, and agitation. Always check for fever — an agitated adolescent who is febrile should always be presumed to be medically ill. See the content about delirium in the previous section for more information. ◦ Adolescents suspected of delirium should be referred for urgent medical evaluation and treatment. • Review the client's HIV history, recent changes in disease status, and ART regimen (including any dosing changes or new medications). • If delirium is ***not*** suspected, refer to a psychiatrist or other mental health professional for assessment and treatment. • Clients with severe mental health disorders should not be discriminated against when ART is considered. Stabilization of psychiatric symptoms and directly observed treatment by a caregiver will likely improve adherence.

Managing Psychiatric Emergencies[6]

Sometimes an adolescent may present in a violent or agitated way, making it necessary to provide immediate management prior to emergency medical treatment (if the cause is delirium, for example) or transfer to a psychiatric hospital.

Each health facility should develop standard operating procedures on the management of psychiatric emergencies, should train all health workers on these procedures, and should ensure that they are implemented.

How to manage a client who is violent or very agitated

Calm and protect:

- Protect the client from harming him- or herself, you, or others.
- Ensure that you are in a quiet area where there is no audience.
- Use space to protect yourself.
- Get help from other colleagues, security, or family members who can help mediate the situation and calm the client down, for the safety of both the client and staff.
- Approach the client in a calm and confident manner.
- Speak in a calm and reassuring way.
- Be non-confrontational, non-judgmental, and deflect criticism.
- Keep your own emotions in check. Do not let yourself be affected by verbal abuse or threats.
- Be aware of potential weapons and remove unsafe objects.
- Consider sedation with diazepam or haloperidol if these medications are available on-site with instructions for use in adolescents.

A note on restraining patients: In some places, it is currently or was previously customary practice to restrain violent or agitated patients, such as by using hand and feet restraints. The global community recognizes such extreme restraint as both cruel and unnecessary. Health workers should not restrain patients in this way unless it is absolutely necessary to protect the patient.

How to manage a suicidal or self-harm client
Sometimes an actively suicidal adolescent may present and require immediate management prior to transfer to a psychiatric hospital.

Evaluate whether the client has attempted a medically serious act of self-harm or suicide:
- Ask the client and any accompanying friends or family about any past self-harm attempts.
- Look for signs of poisoning, intoxication, or self-injury.
- Medically treat as necessary. Engage mental health experts to help with this.
- Ensure that the client is closely monitored to prevent further self-harm.
- Do not leave the client alone or unsupervised.

Evaluate whether there is an imminent risk of self-harm or suicide:
- Ask the client about current thoughts or plans to commit suicide or self-harm, and about means to follow through on those thoughts or plans.
- Look for signs of severe emotional distress, hopelessness, agitation, uncommunicative behavior, or social isolation.

If risk of suicide or self-harm is imminent:
- Remove access to means of self-harm.
- Create a secure and supportive environment and ensure that the person is not left alone.
- Transfer the client to a psychiatric hospital, with accompaniment by a family member or other reliable escort, including, if available, a health worker.

Psychotropic Medications and ARVs [2]

Key points about the use of psychotropic medications in ALHIV

- Health workers should learn the basics about interactions between psychotropic medications and ARVs.
  - Most ARVs are not affected by psychotropic medications.
  - There is one important exception: carbamazepine is used to treat both seizures and mania (a state of abnormally elevated or hyperactive mood/mental state). It can lower the levels of certain ARVs in the body, which can result in failure of 1st and 2nd line ART regimens. Therefore, another medication should be used in place of carbamazepine if at all possible.
  - It is more common that ARVs change the levels of psychotropic medications. In general, most psychotropic medications can be used, but the following rule should be followed: *"start low and go slow."*

Psychotropic medications: Any medication capable of affecting a person's mind, emotions, and behavior.

- Like all medications, psychotropic medications — including antidepressants — can have side effects and require careful monitoring. It is important to be aware that the use of antidepressants in adolescents is sometimes associated with an increased risk of suicide.
- Any behavioral changes in a client require further assessment for possible medical problems.
- If medication for mental illness is prescribed to a client, it should, whenever possible, be combined with counseling and psychotherapy.
- In cases of clients who are mentally ill, an important consideration is adherence to both HIV and any other medication regimens. Health workers should assess each client's adherence to ALL prescribed medications at every visit.
- It is especially important to use a multidisciplinary team approach for the care of ALHIV with mental illness, including those clients taking psychotropic medications.

Exercise 3: Mental Health Case Studies: Large group discussion	
Purpose	To apply the information covered in this module to specific case studies

Case Study 1:
M___ is an 18-year-old client who was recently diagnosed with HIV. M___ missed his last appointment 2 weeks ago, but has come to the clinic today. He tells you that he is too busy with "life" to come to the clinic and he appears shaky and nervous. You conduct a psychosocial assessment, during which you learn that M___ recently got fired from his job and spends most nights getting drunk with his friends to "forget about everything."

Case Study 2:
N___ is 16 years old. She has been on ART and has been coming to the clinic for many years. As a child, she maintained good grades in school and was described by her grandmother as being helpful around the house. Recently, however, N___'s relationship with her family has deteriorated. She is not eating or sleeping regularly, she goes through periods of extreme anger followed by periods of complete withdrawal, and she has run away from home to live with her boyfriend twice in the past year. N___ says, *"life is not worth living if I can't be with my boyfriend."* Her grandmother is very concerned that N___ is going to do something to hurt herself.

Case Study 3:
P___ is a 14-year-old boy with HIV. He and his aunt arrive at the clinic for a routine checkup. P___'s aunt tells you that she is worried about her nephew because he often seems to get agitated and "jumpy." He does not want to go to school or play with his friends like he used to. He also has "episodes," usually at night or right before he is supposed to leave for school in the morning, where he has trouble breathing and sweats. P___ was living with his mother until she died two years ago.

Case Study 4:
B___ is 13 years old and comes for a routine visit with her mother. When you do a clinical checkup with B___, you notice that she is having trouble paying attention, that she is suspicious when you ask her questions, and that her clothes and hair are unkempt (which is unusual). At one point, she mentions "a voice" that is telling her to do bad things that she doesn't want to do and then she starts crying. You then meet with B___'s mother, who tells you that B___ has "turned into a different person" during the last few months. She cannot focus at school, she seems suspicious when anyone wants to talk with her, she hides her medications, she does not care about her appearance any more, and her behavior in general just seems "off."

Module 6: Key Points

- People with mental illness are often stigmatized, discriminated against, and excluded from school, social activities, and, at times, even health care services. Health workers can combat this stigma and discrimination by setting an example and treating people with mental illness respectfully.
- It is very important to include mental health services as part of comprehensive care for ALHIV.
- Mental illness is a broad term that covers many disorders characterized by persistent and severe subjective distress and/or moderate to severe impairment in functioning over time.
- Many mental illnesses may emerge during late childhood and adolescence.
- Adolescents are susceptible to a range of mental illnesses that can be classified into these broad categories: depression; alcohol and substance use disorders; anxiety disorders; behavioral disorders; and severe mental illness.
- Mental illness can influence the course of HIV disease, impact adherence to care and treatment, increase the likelihood of drug and alcohol use, and lead to risky sexual behavior.
- Untreated mental illness can disrupt adolescent development and, in the most extreme cases, result in suicide.
- Although there are barriers to providing mental health services in many settings, there are many things health workers and health facilities can do to establish routine approaches and standard procedures to recognize possible mental illness and provide basic care, referrals, and follow-up.
- There are many ways that health workers can recognize signs of a possible mental illness during routine clinic visits with ALHIV (and caregivers), including: the client's recent and past history; basic observations of the client; and findings of routinely conducted psychosocial assessments.
- Health workers should know the basic categories of mental illness, be alert to their signs and symptoms, and know the steps to take if a client exhibits these signs and symptoms. Simple screening tools are available to assist health workers.
- If a client is behaving violently or is very agitated, the most important priorities are to calm and protect him or her. Clients who are suicidal, who have harmed themselves, or who have an intention of self-harm require **immediate emergency care**.
- Most ARVs are not affected by psychotropic medications. Exceptions include the use of carbamazepine (used to treat seizures and mania), which can lower ARV levels in the body.

Appendix 6A: Tips for Health Workers on Identifying Possible Mental Illness

√	Categories	Signs of a possible mental illness that require follow-up
1. Ask the client and caregiver about:		
	Present history (reported by client or caregiver)	• Reports symptoms of mental illness or mental distress • Reports new problems functioning at home, school, work, or new problems with friends and family • Reports a dramatic change in behavior and/or a major decrease in psychological functioning (e.g., used to be very calm, now violent; used to do well in school, now falling behind; used to be friendly, is now withdrawn, etc.) **Note:** Review the client's HIV history, recent changes in disease status, and ART regimen (including dosing or medicine changes)
	Past history (reported by adolescent client or caregiver)	• Reports a past history of mental distress; problems functioning at home, school, work; or problems with friends and family • History of psychiatric hospitalization, treatment, or psychotropic medication use • History of school failure • History of severe behavioral disturbances • History of mental illness in the family
2. Observe and ask for the caregivers observations of the client's:		
	Appearance and presentation	• Hygiene and grooming are poor • Comes across as frightening or frightened • Has alcohol on his or her breath or appears intoxicated • Does not make eye contact • Crying, shouting, or laughing uncontrollably
	Attitude and behavior	• Restless, belligerent, or uncooperative • Making threats • Unwilling or unable to speak • Behaving in odd and unusual ways
	Mood and emotions	• Seems frightened, sad, or angry • Unusually happy for no apparent reason
	Speech, thinking, and perception	• Speaking very rapidly or overly loud • Whispering or speaking very softly • Saying things that make no sense • Saying things that are unlikely to be true • Claiming to hear voices or to see visions of people/things that are not there
	Level of alertness and orientation	• Having trouble staying alert and attentive • Drowsy • Confused about things such as where he or she is or the time of day
	Social and intellectual skills	• Lacks verbal, behavioral, and/or social skills that would be expected of someone his or her age • Behaving like a much younger child/adolescent
3. Conduct regular psychosocial assessments and document major findings (see Module 5)		
	Conduct a psycho-social assessment (at enrollment, annually, and when the client's situation changes significantly)	• Major changes in mood • Experiencing chronic sadness or anxiety • Changes/problems in sleeping, eating, or other routines • Harmful coping strategies, including use of alcohol or drugs • Problems in school, with friends, or with family members

Appendix 6B: Sample Screening Tools for Depression and Suicide

Patient Health Questionnaire-2 (PHQ-2)

This simple questionnaire can be used as an initial screening test for a major depressive episode.

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things
0 = Not at all
1 = Several days
2 = More than half of the days
3 = Nearly every day

Feeling down, depressed, or hopeless
0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

Total point score: _____

Score interpretation:

PHQ-2 score	Probability of major depressive disorder (%)	Probability of any depressive disorder (%)
1	15.4	36.9
2	21.1	48.3
3	38.4	75.0
4	45.5	81.2
5	56.4	84.6
6	78.6	92.9

Source: Kroenke, K., Spitzer, R.L., & Williams, J.B. (2003). *The Patient Health Questionnaire-2: Validity of a two-item depression screener.* Med Care, *41,* 1284-92.

PHQ-9 Questionnaire, Modified for Adolescents

Name _____ Clinician _____

Medical Record or ID Number _____ Date _____

How often have you been bothered by each of the following symptoms during the past two weeks?

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired or having little energy?				
6. Feeling bad about yourself or feeling that you are a failure or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead or thoughts of hurting yourself in some way?				

10. *In the **past year**, have you felt depressed or sad most days, even if you felt okay sometimes?*

☐ Yes ☐ No

11. *If you are having any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?*

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

12. *Has there been a time **in the past month** when you have had serious thoughts about ending your life?*

☐ Yes ☐ No

13. *Have you **ever, in your whole life,** tried to kill yourself or made a suicide attempt?*

☐ Yes ☐ No

Score: _____

Administering the PHQ-9 Questionnaire:

- This questionnaire can be used with patients between the ages of 12 and 18 and takes less than 5 minutes to complete and score.
- It can be administered and scored by a nurse, medical technician, physician assistant, physician, or other office staff.
- Patients should be left alone to complete the questionnaire in a private area, such as an exam room or a private area of the waiting room.
- Patients should be informed of their confidentiality rights before administering this questionnaire.
- Depression screening should be conducted annually.

Scoring:

- For every X:
  Not at all = 0
  Several days = 1
  More than half the days = 2
  Nearly every day = 3
- Add scores of all "X"ed boxes.
- Total score of 11 or above indicates a positive screen.
- Regardless of the total score, endorsement of serious suicidal ideation OR past suicide attempt (questions 12 and 13) should be considered a positive screen.

Total score: depression severity

1-4: Minimal depression
5-9: Mild depression
10-14: Moderate depression (score of 11 or above = positive score)
15-19: Moderately severe depression

Interpreting the screening results:

- Patients who score positive on the questionnaire should be evaluated by their primary provider to determine if the depression symptoms they expressed on the screen are significant, causing impairment, and/or warrant a referral to a mental health specialist or follow-up treatment by the provider.
- It is recommended that the provider inquire about suicidal thoughts and previous suicide attempts with all patients that score positive, regardless of how they answered these items on the questionnaire.
- For patients who score negative, it is recommended that the provider briefly review with the patient the symptoms marked as "more than half days" and "nearly every day".
- The questionnaire indicates only the likelihood that a youth is at risk for depression or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

Depression severity:

- The overall score provides information about the severity of depression, from minimal to severe depression.
- The interview with the patient should focus on their answers to the screen and the specific symptoms with which they are having difficulties.
- Additional questions also explore dysthymia, impairment of depressive symptoms, recent suicide ideation, and previous suicide attempts.

Source: Spitzer, R.L., Williams, J.B., Kroenke, K., et al. (2005). *Patient Health Questionnaire modified for teens (PHQ-9).*

Appendix 6C: Screening for Alcohol Dependency with the CAGE Questionnaire

✓	Screening for alcohol dependency
	1. Use the CAGE questionnaire
	• Have you ever felt that you should **C**ut down on your drinking?
	• Have people **A**nnoyed you by criticizing your drinking?
	• Have you ever felt bad or **G**uilty about your drinking?
	• Have you ever had an **E**ye-opener — a drink first thing in the morning to steady your nerves or get rid of a hangover?
	2. If the client responded "yes" to 2 OR MORE of the above questions, then he or she may have alcohol dependency.
	3. Give feedback about the results of the screening; provide support and referrals.
	• Provide information about the hazards of drinking (including poor adherence to HIV care and treatment). • Involve the adolescent's caregiver(s), if appropriate and if the adolescent gives consent. • Emphasize the benefits of changing and assess the client's level of motivation to change. • If the client wants to change his or her drinking behavior, discuss goals and provide advice and encouragement. • Provide referrals to a support group and for further counseling. If needed, find a facility that may be able to help the patient overcome physical dependency and, if necessary, detoxification to treat delirium tremens (severe alcohol withdrawal).

Source: Ewing, J.A. (1984.) *Detecting alcoholism: The CAGE Questionnaire.* J. Am. Med. Assoc, *252,* 1905-1907.

Appendix 6D: The Drug Abuse Screening Test (DAST)

✓	**Screening for drug abuse**
	Use the DAST questionnaire. Ask: *In the last 12 months…:*
	1. *Have you used drugs other than those required for medical reasons?*
	2. *Have you abused prescription drugs?*
	3. *Do you abuse more than 1 drug at a time?*
	4. *Can you get through the week without using drugs?*
	5. *Are you always able to stop using drugs when you want to?*
	6. *Have you had "blackouts" or "flashbacks" as a result of drug use?*
	7. *Do you ever feel bad or guilty about your drug use?*
	8. *Do your parents (or spouse) ever complain about your involvement with drugs?*
	9. *Has drug abuse created problems between you and your parents (or spouse)?*
	10. *Have you lost friends because of your use of drugs?*
	11. *Have you neglected your family because of your use of drugs?*
	12. *Have you been in trouble at work/school because of your use of drugs?*
	13. *Have you lost a job because of drug abuse?*
	14. *Have you gotten into fights when under the influence of drugs?*
	15. *Have you engaged in illegal activities in order to obtain drugs?*
	16. *Have you been arrested for possession of illegal drugs?*
	17. *Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?*
	18. *Have you had medical problems as a result of your drug use (for example, memory loss, hepatitis, convulsions, bleeding, etc.)?*
	19. *Have you gone to anyone for help for a drug problem?*
	20. *Have you been involved in a treatment program, especially related to drug use?*
	Score the questionnaire.

	• Score 1 point for each "yes" response, EXCEPT for the following two questions:
	  ◦ *Can you get through the week without using drugs (4)?*
	  ◦ *Are you always able to stop using drugs when you want to (5)?*
	For these two questions, score 1 point for "no" responses.
	• **If the client's score is 6 OR MORE, then he or she may have a substance use problem.**
	• **If the client's score is 16 OR MORE, this may indicate very severe substance abuse.**

	Give feedback about the results of the screening; provide support and referrals.
	• Supply information about the hazards of drug use (including poor adherence to HIV care and treatment). • Involve the adolescent's caregiver(s), if appropriate and if the adolescent gives consent. • Emphasize the benefits of changing and assess the client's level of motivation to change. • If the client wants to change his or her behavior related to drug use, discuss goals and provide advice and encouragement. • Provide referrals to a support group and for further counseling. If needed, find a facility that may be able to help the patient overcome physical dependency and provide counseling and support.

Source: Gavin, D.R., Ross H.E., & Skinner, H.A. (1989). *Diagnostic validity of the Drug Abuse Screening Test in the assessment of DSM-III drug disorders*. Brit J Addict, *84(3),* 301-307.

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