Mental Health and HIV/AIDS

Organization and Systems Support for Mental Health Interventions in Anti-retroviral (ARV) Therapy Programmes
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Mental health and HIV/AIDS series
This is module 1 in the Series ‘Mental Health and HIV/AIDS’.
Other modules are:-
2. Basic counselling guidelines for anti-retroviral (ARV) therapy programmes
3. Psychiatric care in anti-retroviral (ARV) therapy (for second level care)
4. Psychosocial support groups in anti-retroviral (ARV) therapy programmes
5. Psychotherapeutic interventions in anti-retroviral (ARV) therapy (for second level care)

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Preface

The AIDS epidemic is one of the most serious public health and social challenges the world has ever faced. It not only destroys individuals, but also families, communities and the whole societal fabric. Worst hit are communities least able to put in place appropriate measures for its containment and control. It is probably the biggest hurdle to the attainment of the Millennium Development Goals.

As a bold measure to counteract it, WHO has launched the 3 by 5 Initiative that, while primarily aimed at providing treatment to millions of people in need of it, also aims at building the elements of the health system that will be needed to deliver it.

Therefore, treating mental disorders of people living with HIV/AIDS has huge humanitarian, public health, and economic consequences; the same applies to providing people in need with appropriate psychosocial support. This is not an easy task, in view of the scarcity of human, technical and financial resources.

The present series is a contribution from the Department of Mental Health and Substance Dependence to the WHO 3 by 5 Initiative, but also goes beyond that. Its production brought together experts on mental disorders in people with HIV/AIDS from around the world. They graciously contributed their knowledge, expertise, energy and enthusiasm to this endeavour. We are profoundly indebted to them all, as well as to the agencies and organizations to which they are connected. The contributors’ names are indicated in each of the modules in this series. A special thanks goes to Prof Melvyn Freeman, who steered this illustrious group, sometimes through uncharted waters, with patience and efficiency.

Now, we make this material available, not as a finalized product, but rather as a working tool, to be translated into local languages, adapted as needed, and improved along the way. A set of specific learning/training instruments, related to this series will soon be released, as another contribution to the mammoth task of improving the skills of the human resources available and needed, particularly where the 3 by 5 Initiative is being rolled out. Comments, suggestions and support are most welcome.

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Foreword

Among those affected by or at risk of acquiring HIV/AIDS are people with mental disorders. This happens primarily through two mechanisms:

(i) some mental disorders make people more vulnerable to infection with the virus (e.g., intravenous drug use, alcohol abuse, major depression and psychotic disorders, developmental disabilities, and other mental disorders that impair judgement and decision-making) and more vulnerable to situations that increase the risk of passing the virus to others; and

(ii) some forms of HIV infection affect the brain thus creating clinical pictures that initially resemble several different mental disorders.

Unfortunately the interplay between HIV/AIDS and mental disorders goes beyond the mutual facilitation of occurrence. Perhaps the most relevant practical aspect of this interaction relates to adherence to treatment. It is well known that the presence of an untreated mental disorder – particularly depression, psychotic and substance use disorders – considerably decreases adherence to the treatment of any condition, including HIV/AIDS.

The failure of adhering to the proper regimen of anti-retroviral (ARV) treatment carries three major consequences. First, the expected benefit of the treatment does not take place, the clinical situation worsens and mortality increases. Second, the irregularity of the intake of the ARVs brings new resistant strains of the virus, thus complicating its future control. Third, the interrupted or incomplete course of treatment wastes money and other resources that could otherwise have produced more cost-effective results in adherent patients.

In addition, being HIV-positive, or having someone with HIV/AIDS in the family can be stressful for some people with HIV and for carers. In many countries where HIV prevalence is high it is not infrequent to find more than one person with HIV/AIDS in the same household, at the same time. The stress of living with a chronic illness or caring for an ill relative – even if it does not lead directly to a mental disorder such as major depression – may result in a chain of psychosocial reactions that cause considerable pain and dysfunction. Such dysfunction and
distress may decrease resistance and resilience to co-morbid conditions, and contribute to reduced adherence to medical regimens.

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Introduction

Since the launch of the joint initiative by the World Health Organisation (WHO), UNAIDS and the Global Fund for AIDS, TB and Malaria, to ‘Treat 3 million by 2005’, there have been considerable efforts to roll-out antiretroviral therapy (ART) in developing countries. It has become evident however, that comprehensive and sustainable antiretroviral therapy requires a range of inter-related interventions. Structural factors (for example, a well functioning health care system, adequate human resources, consistent supply of affordable medication, and adequate nutrition) as well as factors connected to the patient, need to be taken into account. Some of the important ‘patient variables’, include the person’s mobility, understanding of the need for ongoing medication, reactions to medications and their side-effects, and very importantly, their general ‘state of mind’ or ‘mental health’.

There has been only minimal emphasis on mental health interventions within ART programmes. In this document we make recommendations about strategies and systems to provide essential mental health services within ART roll-out programmes. Moreover, a series of supporting manuals and materials have been developed to assist the process of integrating mental health within HIV/AIDS treatment programmes. These modules supplement the mental health guidelines in the Integrated Management of Adolescent and Adult Illness (IMAI) and include:-

- Mental Health and HIV/AIDS – Basic counselling guidelines for anti-retroviral (ARV) therapy programmes
- Mental Health and HIV/AIDS – Psychosocial support groups in anti-retroviral (ARV) therapy programmes
- Mental Health and HIV/AIDS – Psychotherapeutic interventions in anti-retroviral (ARV) therapy (for second level care)

There are several reasons why mental health interventions need to be included in programmes which provide antiretroviral medication. For example:
HIV/AIDS and mental illness

Mental disorders are more common in people living with HIV and AIDS than in non-infected people. This is due in some instances to mental conditions existing prior to the HIV infection (which increase the risk of infection) while in other instances mental problems are a direct or indirect consequence of the disease itself.

Some of the mental health correlates of AIDS are:

- Cognitive impairment, dementia and psychosis as a result of viral infection of the brain;
- Depression and anxiety due to the impact of the infection on the person’s life;
- Alcohol and drug use;
- Psychiatric side-effects of ARVs (notably efavirenz); and
- Social difficulties faced as a result of stigma and discrimination.

Reactions to Diagnosis

Finding out that one is HIV sero-positive is an emotional shock to almost everyone. For very many people it raises personal issues of death and dying, worries around disclosure and stigma, concerns about relationships and careers, uncertainties around what may happen to children and so on. The extent of this shock will vary from person to person, with some people feeling strongly suicidal and others experiencing relatively minor distress.

The challenge of living with HIV/AIDS

Living with HIV/AIDS is psychologically difficult for most people. Limited social support and experiences of rejection and discrimination can affect ability to cope, and increase vulnerability to stress. Some people learn to cope effectively and even manage to find meaning in their lives beyond what they experienced prior to their infection. However, others develop mental disorders that require treatment.

Starting and sustaining ARV therapy

Starting and sustaining ARV therapy requires considerable commitment, personal strength and emotional robustness on the part of the infected person.
Unfortunately, the HIV infection itself, as well as the reactions and responses of many people to being HIV sero-positive, may, without appropriate intervention, undermine the ability of some people to be successful long term participants in antiretroviral therapy programmes.

**Adherence and drug resistance**

There is evidence that, without support, people having mental disorders or who abuse substances, are less likely to adhere to medication of all types, including ART, than people without disorders. This needs to be managed very carefully. Excluding people with symptoms of mental disorder from access to ART solely on the grounds of their disorder, would be discriminatory. Moreover, to do so would, in some instances, exclude people from treatment for HIV/AIDS, due to the (treatable) symptoms or direct correlates of the disease itself. However, it is clearly inadvisable in situations of enormous demand and limited resources for management and follow-up to include ‘risky’ patients (especially where less than 95% adherence may lead to resistance in the person and there is an epidemiological risk of poor adherence leading to mutations of HIV). The solution is careful individual assessment of the adherence potential of each person (including those with mental disorders), also taking into account available support systems. In addition, assessment and treatment of symptoms of mental disorder in patients on ART may improve capacity for adherence to acceptable levels.

**Mental health is part of comprehensive ART**

Much as is the case with other medical correlates of HIV infection, such as tuberculosis, treatment of mental health needs to be considered an integral concern of ART programmes, and the necessary means need to be provided to implement programmes. By treating mental disorders, adherence levels within ART programmes may well be significantly improved.

**Psychiatric and psychosocial support**

There is evidence that both psychotropic medications, as well as non-medical interventions, such as support groups and counselling, can significantly improve mental and physical health in people living with infectious health conditions. Because mental and physical health outcomes are closely interlinked, there is evidence suggesting that HIV disease progression is likely to be slowed down by improved mental health.
The World Health Organisation (WHO) guidelines for Integrated Management of Adolescent and Adult Illness (IMAI) provide indications, including mental health guidelines, for interventions for people on ART. However, these guidelines need to be adapted by countries for cultural appropriateness and to accommodate the resources available and problems presented. Secondly, mental health programmes are required at both primary and secondary levels to support primary care interventions. Finally, the inclusion of a mental health component in HIV/AIDS support, care and treatment requires promotion, support and systems development if it is to become a reality.

Mental health is not integrated into frontline or primary health care in the majority of countries most affected by AIDS and it will be a challenge to create a mental health component in HIV/AIDS responses. However, given the scale of HIV infection in some countries, referral to specialist mental health services would overwhelm these services, as there is already a shortage of psychiatrists, psychologists, social workers, and psychiatric nurses. The provision of mental health services thus needs to be developed as an integral part of the frontline system of care, and as an extension of primary AIDS services. This requires commitment from health providers (government and non-government) to plan systems and mobilise resources (human and financial), and to facilitate implementation. In this booklet, various systemic and structural recommendations are made to assist in developing a comprehensive and integrated frontline care approach that incorporates mental health services.
Strategies for inclusion of mental health within HIV/AIDS therapy programmes

Promote recognition of the mental health support needs of people with HIV/AIDS

Awareness of mental health problems faced by people with HIV/AIDS and mental health needs in support, care and treatment programmes, needs to be built at multiple levels. The following are some steps towards this end.

A task force

A country-level task force of mental health specialists needs to be formed to spearhead the promotion of mental health as an issue in HIV and AIDS support, care and treatment. The task force would serve an advocacy function at the highest levels of policy and strategy development for HIV/AIDS care and treatment and would need to actively engage national AIDS councils (where they exist), and relevant government ministries, in efforts to put mental health on the agenda. Task forces would ideally be comprised of representatives of mental health disciplines including psychiatry, psychology, social work, psychiatric nursing and pharmacy, as well as senior public sector mental health officials and practitioners. Relevant organisations, for example depression and alcohol abuse support organisations, and associations of people with HIV/AIDS, where they exist, would also need to be involved. Members of task forces would preferably have experience in working at the interface of HIV/AIDS and mental health.

Such a task force may benefit from developing a set of tools for promoting the inclusion of mental health programmes in support, care and treatment. For example, a powerpoint presentation outlining the case for including mental health support in ART programmes that could be used in different contexts to make the case for mental health intervention.

Public sector support

Government support for integrating mental health into ART roll-out programmes is essential. Mental health needs to be built into strategic plans for AIDS responses, and budgets for drugs, facilities, personnel, and training need to be allocated.
Given the numbers of people who will eventually require ART and the strong need for mental health support, mental health needs must be addressed within the context of frontline AIDS services. However, to achieve the significant mobilisation in the form of policy, strategy, planning and resources mobilisation that is necessary, governments, and particularly health and welfare departments, need to be sufficiently convinced of the need to support developing a mental health agenda in ART. This requires a concerted advocacy effort.

**Mental health professionals**

Psychiatrists, psychiatric nurses, psychologists and social workers need to be drawn into supporting AIDS efforts in their professional work and through their respective professional associations.

This may include:

- Presentation of HIV/AIDS streams at conferences;
- Special issues on HIV/AIDS in professional journals;
- Introduction of HIV/AIDS modules in professional training courses; and
- Development and distribution of mental health resource guides to agencies that deal with people with HIV/AIDS.

**Research funding agencies (local and international)**

The integration of mental health services into ART programmes needs be supported by research. Local and international funding agencies need to be lobbied to recognise that mental health is an overlooked need and to include mental health issues in research funding priorities.

Some areas which need research, especially in developing countries, are:

- Prevalence of mental health problems in populations of people with HIV and AIDS;
- Interaction of psychiatric drugs and antiretroviral drugs;
- Psychological processes involved in living with HIV and AIDS;
- ART adherence behaviour;
- Design and efficacy research on medical and psychosocial support interventions for people with HIV and AIDS;
- Culturally specific manifestations of mental health problems related to HIV and AIDS; and
Health systems development research for integration of mental health interventions for people with HIV/AIDS.

**Non-governmental HIV/AIDS care and support organisations**

Often such organisations, which include advocacy groups representing people with HIV/AIDS, do not deal specifically with, nor recognise, mental health care needs. It would be of value for countries to develop culturally appropriate information materials, for example, a foldout brochure, describing mental health needs associated with HIV/AIDS and therapeutic options, and to actively promote recognition of the value of pursuing a mental health agenda. International NGOs and funding agencies also need to be made aware of needs in this area, and be encouraged to support pilot programmes.

**Public education**

It is important to build public recognition of mental health problems faced by people with HIV and AIDS in the interest of building understanding, tolerance and support. For many people the most effective ‘mental health service’ will not be provided by mental health professionals or other health workers, but by caring family and community members who support the infected person through emotionally difficult times when these arise. Moreover, not only do services need to be developed, but the public needs to be made aware of what to expect of such services and how to access them.

**Media support**

In many countries there are media agencies, reporters and media training institutions that have developed special expertise and interest in HIV/AIDS. These agencies and individuals need to be briefed on the need to cover mental health aspects of the AIDS epidemic. In addition to reporting on the impact of AIDS, it is useful to raise awareness about mental health issues such as depression, as it relates to AIDS, through mass media education products concerned with HIV/AIDS education. These should include television and radio drama, radio phone-in shows, and community education programmes. This would involve lobbying programme directors and executive producers to agree to support such programming, and would involve provision of briefing materials to guide those responsible for programme development. Regular press releases focusing on mental health aspects of HIV/AIDS would be important to maintain media focus on the issue.
Adapt and utilise support materials, guidelines and advocacy tools and, where needed, develop country specific resources

Training resources

Some education materials, tools and guidelines for training and frontline intervention of mental health within ART programmes have been developed by the WHO.

These include participant guidelines for mental health training within the IMAA:

- A basic counselling manual for use with ART;
- A booklet on how to organise and run support groups to assist ART programmes; and
- Secondary level medical care of people using ART and secondary level psychotherapeutic interventions for improved mental health within ART programmes.

These materials are aimed to assist first level health workers at clinics and in communities (e.g. community health workers), hospital based medical practitioners and psycho-social support workers at secondary level, as well as organisations involved in providing mental health support (e.g. for substance abuse or depression) that need to be sensitised to the mental health and ART links.

All guidelines (including the mental health components of the IMAI) should be adapted for cultural appropriateness, with particular attention given to mental health terms. The following proposals are recommended:

- Developers should include a glossary of terms, so that users are clear what they mean by various terms, in particular symptom terms (e.g. libido, delusion, hallucination). Groups of local mental health workers and specialists should be consulted to generate equivalent terms that are appropriate taking into account local idiom; and
- Materials should be translated into local languages using standard translation procedures and these should be tested on target users prior to final preparation and printing, with particular attention paid to the style of language used, the level of address, intelligibility and the appeal of materials.
Identification of mental health problems and orientation to mental health care

Mental problems can go unnoticed and untreated and primary care workers need to be assisted to identify them. They also need to understand what forms of support and care might be appropriate, and when referral is necessary. Local examples need to be introduced and ways of educating caregivers in communities need to be developed.

Patient education materials

Information booklets for people diagnosed HIV positive have been developed in many countries. These need to be updated to include information related to mental health and antiretroviral treatment. Information material relating to the stages of AIDS, treatment requirements and processes, local resources and other important information needs to be carefully developed and tested before being disseminated. Education materials also need to be presented in local languages and in a way that will be understandable for users, many of whom may have limited formal education. It also needs to be presented in a way that is instructive and helpful. For example, telling someone that they should see a psychiatrist if they exhibit certain symptoms would be disempowering if no psychiatrist was available. Where literacy is a problem, other ways of communicating such information need to be devised.

Counselling

Clinic settings are in many respects less than ideal for conducting counselling. There is often little privacy, inadequate space and staff may not have enough time to conduct counselling sessions in an optimal way. Counselling may, under such circumstances, lean more towards a teaching rather than listening style of communication. A basic counselling manual for use with ART has been developed and the principles outlined should be utilised to the extent that it is possible¹. However it is important that this be adapted for use in different contexts and taking into account the variability between settings. A cohort of trainers or master counsellors will need to be trained and periodic further training will need to take place.

¹ Mental Health and HIV/AIDS – Basic counselling guidelines for anti-retroviral (ARV) therapy programmes
Different models for counselling in support of ART programmes at secondary level have been developed. Practitioners can use these guidelines to adapt their skills to ART or may wish to acquire additional training in these models.

**Support group guides**

Guidelines for support groups for people on ART have been developed. These may need to be adapted to local contexts and operational procedures. For example age mixing and languages to be used in groups, would certainly need to be worked out in local contexts. Support groups are especially important in the first few months of ART when patients need most informational and emotional support, and where patients are more likely to experience side effects. Decisions need to be made about who will facilitate support groups, where they will be conducted, how they will be promoted and how resource needs such as venues and transport will be addressed. Support group facilitators need supervision and mentoring and this requires the services of mental health personnel.

In many countries people on ART are paired with a supporter, often a family member or close friend. This person is expected to support the patient in achieving high levels of adherence. Supporters need to be orientated to the challenges of treatment adherence, and adherence training guides need to be adapted into a short training for supporters in contexts where they are a regular feature of the ART system.

**Guidelines for primary care practitioners**

In many health systems psychiatric training for nurses is a speciality and most primary care staff will have only a rudimentary understanding of how to recognise and treat mental health conditions. Where possible the IMAI guidelines, which include checklists for recognition, treatment and referral of the most common mental health problems, need to be used. Moreover support programmes, such as groups or individual counselling, need to be introduced. Finally, recognition and treatment of basic mental health problems need to be integrated into existing HIV/AIDS training programmes such as VCT (Voluntary Counselling and Testing).

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2 Mental Health and HIV/AIDS – Psychotherapeutic interventions in anti-retroviral (ARV) therapy (for second level care)
3 Mental Health and HIV/AIDS – Psychosocial support groups in anti-retroviral (ARV) therapy programmes
4 WHO (2004) Integrated Management of Adolescent and Adult Illness; Guidelines for Acute Care and Chronic HIV Care with ARV therapy
and Testing) and PTMTC (Prevention of Mother To Child Transmission) training. Many primary care clinics rely on the support of community health workers, who would also need to be instructed on how to recognise mental health problems and what to do in such cases.

It should be noted that in many ART programmes, treatment commences at hospital facilities. When patients respond well they are referred to clinics for ongoing care, with perhaps a six-month check up at the hospital. This means that the bulk of treatment monitoring takes place at clinic level and mental health problems will need to be managed at this level.

**Guidelines for health practitioners – hospital**

Guidelines for mental health care at secondary level have been developed but need to be adapted to local circumstances. Health systems differ in the diagnostic systems used and in the treatment modalities available for medical and psycho-social care (including the psychotropic drugs available). Practitioners providing mental health interventions for people on ART need to understand drug interactions and the most appropriate mental health and ART treatments in local settings.

In addition to adaptation of guidelines, training forums will need to be held for hospital practitioners in mental health dimensions of ART, drug interactions, and so on.

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5 Mental Health and HIV/AIDS – Psychiatric care in anti-retroviral (ARV) therapy (for second level care).
Promote integration of mental health support into frontline health and social welfare delivery systems

Given that mental health services are relatively undeveloped in many of the countries most affected by AIDS, strategies that rely exclusively on the professional expertise of psychiatrists, psychologists, social workers and psychiatric nurses are unlikely to bear fruit. Mental health support programmes need to be developed that can largely be conducted by non-specialists, such as primary health care nurses and community health workers, in primary level facilities. In addition to this, referral systems need to be developed for problems that are not readily addressed at the primary care level. Appropriate professionals and organisations (e.g. organisations dealing with alcohol and substance abuse) need to be educated about the specific needs of people preparing to commence ART.

The following approaches might be pursued:

Policy, strategy, planning and resourcing

The ways in which mental health might be integrated into support, care and treatment programmes is likely to differ by context and country depending on, for example, the existing linkages between government departments, the extent to which mental health care has already been integrated into general health care and the procedures and structures for ART delivery at local level.

In the first place, mental health services need to be established as a matter of national policy as a required intervention modality in ART programmes. Guidelines developed by the WHO for developing Mental Health Policy, Plans and Programmes can be utilised for developing specific policy and plans, and programmes with respect to mental health and ART6.

Drug supply and management

Ensuring continuous drug supply and inclusion of essential psychotropic drugs on essential drug lists is critical. In many health systems the preferred mental

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health drugs are not included on the essential drugs list at primary level. Promotion of inclusion of essential psychotropic medication for treatment of common HIV/AIDS related mental health disorders in ART programmes is required.\(^7\)

**Referral systems**

Not all mental health problems can be dealt with at the primary care level, and referral systems need to be developed to deal with conditions requiring more specialised attention, such as depression, psychosis, dementia, alcohol, and substance abuse. The IMAI guidelines of when to refer, should be utilised.\(^8\)

**Support for mental health workers**

To ensure low burn-out and good quality work from people providing mental health care, it is necessary to build in support supervision, mentoring and skills building. Creative ways to ensure that mental health workers have peers or more experienced practitioners to speak about cases must be found and built into the service structure (for example, peer supervision groups and debriefing sessions).

**Funding**

Inclusion of mental health components into ART roll-out need to be adequately financed, taking into consideration the cost of drug supplies, human resources, facilities (space), training and supervision, printing of materials and guidelines, and so forth.

**Development of a model human resources strategy for Mental Health/ART interface**

New programmes offered at primary level are often faced with unanticipated implementation challenges relating to accreditation and quality assurance procedures, training and supervision, insufficient human resources for information management and administration, and conflicts about responsibilities. It is important to provide model strategies for human resource development around the mental health and ART interface.


\(^8\) WHO (2004) Integrated Management of Adolescent and Adult Illness; Guidelines for Acute Care and Chronic HIV Care with ARV Therapy
Monitoring and evaluation

The development of mental health service delivery systems in ART programmes can be significantly enhanced by formative evaluation and a step-wise, evaluation driven approach to programme development. Already there is a need to consolidate what is known from scattered attempts to provide mental health services in ART programmes, and this need is likely to increase. If done in a formal and co-ordinated way, significant benefits can be derived. Agencies adept in formative evaluation need to be recruited to support programme development in this way.

Materials developed for implementation as part of the ‘3 by 5’ (including those mentioned in this booklet), need to be assessed and changed on the basis of formal and informal feedback and evaluation. For example, trainers and trainees utilising the materials should be interviewed, or requested to provide written feedback on different aspects of the materials, both after the training and after having implemented interventions. Moreover patients and/or clients can be interviewed regarding their perceptions of the interventions. Improvements to the materials and the teaching techniques utilised can also be made through using experts in ‘knowledge translation’ who can assist in ensuring that learners gain optimally from training.

Mental health issues have a strong cultural component and it is likely that approaches and materials will need to be strongly adapted to different contexts. Adaptation of materials and procedures will need to be evaluated and this needs to be planned for and resourced with appropriate research institutions recruited to assist in such processes.

Mental health services are subject to large variations in quality. Quality assurance measures need to be put in place and quality assurance protocols need to be developed. However, some aspects of quality are not easily monitored, for example, the quality of counselling relationships or support group processes. An important way to assure quality in such areas is by instituting processes of ongoing mentoring and development. The qualities of provider-client relationships in the field of mental health are subject to great variation, even on the part of a single provider. In this case assuring quality means establishing an appropriate culture or ethos around mental health care through close mentoring and supervision.
In addition, formal outcome evaluation studies should be conducted to assess the efficacy of mental health programmes, for example, in promoting health maintenance behaviour, improving health status (physical and mental), and increasing treatment adherence levels.

It is likely that in many contexts, given the general lack of resources at local level, the development of mental health services could be regarded as a non-essential area which could easily be overlooked in favour of seemingly more pressing priorities. It will be important to track the roll-out of mental health services in ART programmes, and a simple methodology for doing this will need to be developed. Routine reporting on this will need to be incorporated, along with reporting of other service delivery data, through existing health information management systems.

Monitoring and evaluation indicators for integration of mental health into ART programmes need to be developed and incorporated into the core set of country, provincial or district indicators. A set of indicators relating specifically to mental health and ART should be promoted. Together with this, there would need to be basic forms and procedures developed relating to information management around mental health services. These would need to be integrated into existing checklist-type protocols which already form part of ART programmes in many countries.
Conclusion

Mental health is invariably a neglected part of health care. Unless its importance in ARV therapy programmes is strongly advocated and proper organization and structures are put in place, mental health is unlikely to play much part in HIV/AIDS treatment care and support in developing countries in the future. This would not only be an injustice to many people’s mental well-being but also, in all likelihood, to their physical health, either directly or through inadequate adherence to ARV therapy.