REPUBLIC OF KENYA

MINISTRY
OF HEALTH

# NATIONAL GUIDANCE ON INTEGRATING MENTAL HEALTH

## into Key and Vulnerable Populations Programming in Kenya

National AIDS & STI Control Programme
Ministry of Health
Nairobi, Kenya
May 2022

# NATIONAL GUIDANCE ON INTEGRATING MENTAL HEALTH

## into Key and Vulnerable Populations Programming in Kenya

# Contents


| | | |
|---|---|---|
| | **Abbreviations and acronyms** | iv |
| | **Definition of key terms** | v |
| | **Acknowledgements** | viii |
| | **Foreword** | ix |
| | **Executive summary** | x |
| **Chapter 1** | **Introduction and background** | 1 |
| 1.1 | Rationale for this guidance | 2 |
| 1.2 | Goal of the guidance | 2 |
| 1.3 | Anchoring documents | 3 |
| 1.4 | Process of developing this guidance | 3 |
| **Chapter 2** | **Need for dedicated mental health support for key and vulnerable populations** | 4 |
| 2.1 | The global and national context | 5 |
| 2.2 | Mental health in key and vulnerable populations | 6 |
| 2.2.1 | Mental health among female sex workers | 6 |
| 2.2.2 | Mental health among men who have sex with men | 7 |
| 2.2.3 | Mental health among people who inject or use drugs | 7 |
| 2.2.4 | Mental health in the transgender population | 7 |
| 2.2.5 | Mental health in vulnerable populations | 8 |
| 2.3 | Summing up | 9 |
| **Chapter 3** | **Experience of providing mental health support to key and vulnerable populations** | 10 |
| 3.1 | Mental health support for female sex workers | 11 |
| 3.2 | Mental health support for people who inject drugs | 11 |
| 3.3 | Mental health support for substance use clients | 12 |
| 3.4 | Mental health response in an MSM-led programme | 12 |
| 3.5 | Mental health support with transgender people | 13 |
| **Chapter 4** | **Integrating mental health support into KVP programming** | 14 |
| 4.1 | Implementation considerations | 15 |
| 4.2 | Existing service delivery model for KVPs | 15 |
| 4.3 | Framework for mental health support | 15 |
| 4.3.1 | Overview | 15 |
| 4.3.2 | Interventions at the community level | 16 |
| 4.3.3 | Interventions at the facility | 17 |
| 4.4 | Respect for clients and self-care for healthcare workers | 18 |
| 4.5 | The roles of various actors | 19 |
| **Chapter 5** | **Screening, assessment and management of mental disorders in key and vulnerable populations** | 20 |
| 5.1 | Step 1: Screening | 21 |
| 5.2 | Step 2: Assessment | 21 |
| 5.3 | Step 3: Management | 22 |

| | | |
|---|---|---|
| **Chapter 6** | **Monitoring and evaluation** | 28 |
| 6.1 | Tracking progress | 29 |
| 6.2 | Roles of staff in M&E | 29 |
| **Annexure 1** | **History-taking in mental health** | 32 |
| **Annexure 2** | **Screening tool for use in the community** | 33 |
| **Annexure 3** | **Screening tools for use in the facility** | 35 |
| 3a | Gender Dysphoria Test | 35 |
| 3b | Generalised Anxiety Disorder Assessment (GAD-7) | 36 |
| 3c | Patient Health Questionnaire for Depression Screening (PHQ-9) | 37 |
| 3d | Primary Care PTSD Screen DSM-5 (PC-PTSD-5) | 38 |
| 3e | Drug Abuse Screening Test (DAST-10) | 39 |
| 3f | Alcohol use disorders identification test (AUDIT) | 40 |
| 3g | ASSIST tool (modified) | 42 |
| | Tools for self-use by healthcare providers | |
| 3h | Maslach Burnout Inventory (MBI) | 47 |
| 3i | Stigma Attribution Questionnaire (AQ 27) | 50 |
| **Annexure 4** | **Screening and assessment algorithms** | 54 |
| 4a | Algorithm for common mental health disorders | 54 |
| 4b | Algorithm for depression | 55 |
| 4c | Algorithm for suicide/self-harm plus management protocols | 58 |
| 4d | Algorithm for acute stress | 61 |
| 4e | Algorithm for disorders due to substance use plus management protocols | 63 |
| | **Special populations** | 69 |
| | **References** | 71 |

# Abbreviations and acronyms

| | |
|---|---|
| **AIDS** | Acquired immunodeficiency syndrome |
| **ART** | Antiretroviral therapy |
| **ASSIST** | Alcohol, Smoking and Substance Involvement Screening Tool |
| **CBO** | Community-based organisation |
| **CDC** | Centers for Disease Control and Prevention |
| **CHEW** | Community health extension worker |
| **CHV** | Community health worker |
| **DAST -10** | Drug Abuse Screening Test |
| **DICE** | Drop-in centre |
| **DSM-5** | Diagnostic and Statistical Manual for Mental disorders version 5 |
| **EMR** | Electronic medical record |
| **FSW** | Female sex worker |
| **GAD-7** | Generalised Anxiety Disorder Assessment |
| **GNC** | Gender non-conforming |
| **GPARG** | GBMSM Policy and Advocacy Reference Group |
| **HIV** | Human immunodeficiency virus |
| **HOYMAS** | Health Options for Young Men with HIV, TB and STI |
| **IAVI** | IAVI (formally International AIDS Vaccine Initiative) |
| **KP** | Key population |
| **KP COE** | Key Populations Committee of Experts |
| **KVPs** | Key and vulnerable populations |
| **KASF II** | Kenya AIDS Strategic Framework II |
| **LMIC** | Low- and middle-income countries |
| **MBI** | Maslach Burnout Inventory |
| **mhGAP** | Mental Health Gap Action Programme |
| **MAT** | Medically assisted treatment |
| **M&E** | Monitoring & evaluation |
| **MNS** | Mental, neurological and substance use disorders |
| **MSM** | Men who have sex with men |
| **NASCOP** | National AIDS & STI Control Programme |
| **NGO** | Non-governmental organisation |
| **NPD** | Non-specific psychological disorder |
| **NTDS** | National Transgender Discrimination Survey |
| **PC-PTSD-5** | Primary care post-traumatic stress disorder screen |
| **PHDA** | Partners for Health and Development in Africa |
| **PHQ-4** | Patient Health Questionnaire-4 |
| **PHQ-9** | Patient Health Questionnaire-9 (for depression screening) |
| **PLHIV** | People living with HIV |
| **PHQ-4** | Patient Health Questionnaire-4 |
| **PPK** | Professionals in Pride Kenya |
| **PTSD** | Post-traumatic stress disorder |
| **PWID** | People who inject drugs |
| **QST** | Quick screening tool |
| **SAPTA** | Support for Addictions Management and Treatment in Africa |
| **STI** | Sexually transmitted infection |
| **SRH** | Sexual and reproductive health |
| **SWOP** | Sex Workers Outreach Programme |
| **WHO** | World Health Organization |

# Definition of key terms

- **Anxiety disorder:**
  a cluster of mental disorders characterised by significant and uncontrollable feelings of anxiety and fear, such that the person's social, occupational and personal functioning is significantly impaired.

- **Community health workers:**
  an umbrella term referring to a variety of health workers, known by different titles, who have been selected, trained and work in the communities from which they come. Kenya's *Community Health Strategy* calls these workers community health volunteers (CHVs) and their role is to make home visits, deliver health promotion messages, and treat common ailments and illnesses. CHVs are supervised by community health extension workers (CHEWs) and operate within community health units, each serving a population of about 5 000. Areas with active community health programmes have demonstrated improvements in antenatal care visits, testing and treatment for diseases like HIV and malaria, and child immunisation. Community health workers in various programmes are known as outreach workers and peer educators.

- **Depression:**
  a mood disorder characterised by persistent sadness, hopelessness, feeling down and a loss of interest or pleasure in daily activities once enjoyed. Aside from emotional problems, individuals can present with physical symptoms such as chronic pain, digestive issues or insomnia.

- **Drop-in centres (DICEs):**
  also known as safe spaces, these are premises rented by implementing partners for key population programmes to provide members of key populations a comfortable place to relax, rest, access information, receive services and interact with each other.

- **Female sex workers:**
  women aged 18 years and older who receive money or goods in exchange for consensual sexual services, provided either regularly or occasionally. Sex work can take many forms, and practices vary in different localities.

- **Gender identity:**
  an individual's personal sense and internal experience of gender.

- **Gender dysphoria:**
  a conflict between a person's physical or assigned gender and the gender with which the person identifies. Emotional and mental dysphoria causes significant distress and/or difficulty in functioning. Physical dysphoria is sometimes described as being uncomfortable within one's body.

- **Gender non-conforming:**
  an expression of gender that does not match masculine or feminine gender norms. People who exhibit gender non-conformity may also be called gender variant, gender diverse, gender atypical or non-binary. They include transgender people who may be perceived, or perceive themselves, as gender non-conforming before transitioning, but not after transitioning. Some intersex people also exhibit gender variance.

- **Key populations:**
  groups who are at increased risk of HIV – irrespective of the epidemic type and local context – due to specific behaviours. The Kenyan AIDS Strategic Framework II (KASF II) considers gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs as the four main key population groups. These populations are often subject to punitive laws that criminalise their practices and facilitate violence, stigma and discrimination against them.

- **Mental health:**
  a state of well-being in which all individuals realise their potential, can cope with the normal stressors of life, work productively and fruitfully, and are able to contribute to their communities.

- **Mental disorders:**
  health conditions involving changes in emotion, thinking or behaviour, or a combination of these. Mental health problems are associated with distress and/or problems in functioning in social, work or family activities.

- **Methadone:**
  a powerful synthetic analgesic drug, similar to morphine but with less sedative effect, that is used as a substitute drug in the treatment of morphine- and heroin-use disorders.

- **Men who have sex with men (MSM):**
  all men who engage in sexual and/or romantic relations with other men. The words "men" and "sex" are interpreted differently in diverse cultures and societies. Therefore, the term encompasses a variety of contexts in which male-to-male sex takes place, regardless of motivations for engaging in sex, self-determined sexual and gender identities, and identification with any community or social group.

- **Post-traumatic stress disorder (PTSD):**
  a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war or combat, rape or threat of sexual violence, or serious injury or threats of death.

- **Paralegals:**
  grassroots workers who use their knowledge of the law to seek concrete solutions when key and vulnerable populations (KVPs) are unjustly treated. They may employ tools such as mediation, community organising, education and advocacy that address formal or customary authorities.

- **Peer educators:**
  members of the key populations (KPs) who work voluntarily or for an honorarium in KP programmes to provide accurate information and promote and advocate for positive behaviours.

- **People who inject drugs (PWID):**
  individuals who inject psychoactive substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other routes. People who self-inject medicines for medical purposes are not included in this definition. Nor are individuals who self-inject non-psychotropic substances, such as steroids or hormones for body shaping or improving athletic performance.

- **Psychoeducation:**
  provision of information on mental health and mental disorders to those seeking or receiving mental health services.

- **Psychiatry:**
  a branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioural disorders.

- **Psychosis:**
  a mental disorder characterised by distorted thoughts, perceptions, emotions, speech and behaviour. Symptoms include hallucinations, delusions, severe abnormalities of behaviour and disturbances of emotions.

- **Psychosocial interventions:**
  structured psychological or social interventions used to address mental and substance-related problems. Often referred to as counselling and behavioural therapies, these interventions are applied to establish and address underlying problems and teach skills that enhance coping.

- **Self-harm:**
  the act of purposely hurting oneself (for instance, by cutting or burning the skin) as an emotional coping mechanism.

- **Stigma:**
  a mark of disgrace that sets a person or a group apart from others. Stigma includes the holding of negative attitudes and beliefs about an individual or group, creating prejudice which leads to negative actions and discrimination. An example is labelling a person by his/her illness and ceasing to view the person as an individual.

- **Substance-related disorder:**
  falls into two groups: a) substance-induced disorder, where mental problems are the direct effects of a drug; and b) substance-use disorder, characterised by a sustained pattern of pathological use of a psychoactive substance that results in adverse physiological, behavioural and social consequences. The latter involves drugs that directly activate the brain's reward system, causing various feelings of pleasure. These drugs fall largely into the following classes: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants and tobacco.

- **Suicidal attempts:**
  self-inflicted harmful actions undertaken by individuals intending to end their lives – but which do not result in death.

- **Transgender people:**
  an umbrella term for people whose gender identity and expression do not conform with norms and expectations traditionally associated with the sex assigned to them at birth. It includes people who are transsexual or otherwise gender non-conforming. The high vulnerability and specific health needs of transgender people necessitate their distinct and independent status in the global HIV response.

- **Transgender man:**
  a transgender individual who identifies as a man and does not conform to the gender expression assigned to his female sex at birth. This can be shortened to "transman".

- **Transgender woman:**
  a transgender individual who identifies as a woman and does not conform to the gender expression assigned to her male sex at birth. This can be shortened to "transwoman".

- **Vulnerable population:**
  groups and communities at higher risk of acquiring and transmitting HIV. KASF II identifies the following vulnerable populations in Kenya: fisherfolk, people in prison and closed settings, long-distance truckers and HIV sero-discordant couples.

- **Young key populations:**
  groups of adolescents and young people aged 15 - 24 years who, due to specific higher-risk behaviours, are at increased risk of acquiring HIV. The young key populations identified in Kenya are young women who sell sex, young men who have sex with men, and young people who inject drugs.

# Foreword

Mental health disorders play a critical role in HIV acquisition, increasing the risk from fourfold to tenfold. People living with HIV (PLHIV) are more susceptible to psychiatric morbidity than the general population and major depressive disorder is the most common psychiatric diagnosis among PLHIV. Other frequent psychiatric morbidities in PLHIV include suicidal thoughts and attempts, anxiety, post-traumatic stress disorder (PTSD), and alcohol and substance use disorder. Higher mortality is evident among persons with mental, neurological, and substance use (MNS) disorders. Mental health disorders also contribute to poor HIV treatment outcomes.

Social stigma and criminalisation intersect to present additional challenges to Key and Vulnerable Populations (KVPs) who are already disproportionately affected by HIV. The stigma that members of these groups experience relate to their sexual orientation and gender identity, conduct of sex work and drug use. It may take the form of perceived stigma, enacted stigma (that is, discrimination) or internalised stigma, all of which can negatively affect mental health. The harm is compounded by the reality that mental health disorders are themselves often stigmatised.

Over the last 12 years of implementing programmes for key and vulnerable populations (KVPs) in the country, conviction of the need to address the mental health of KVPs has grown among implementers and members of these populations alike. Although our national guidelines identify mental health as a desirable element in the package of biomedical services for key populations (KPs), there is a need to recognise these services as absolutely essential. This *National Guidance on the Integration of Mental Health in Key and Vulnerable Populations Programming* provides evidence to justify investment in relevant training and the provision of appropriate services.

It is my sincere hope that this document will serve as a working tool for the national STI Control program and assist implementing partners, the community and health workers in the management of mental health disorders in Kenya.

**Dr. Patrick Amoth, EBS**
Ag. Director General for Health
Ministry of Health

# Acknowledgements

I would like to recognise the leadership of Dr. Rose Wafula, Head, Division of National AIDS and STI Control Programme (NASCOP) for her support and technical guidance in the development of this document. Thank you to Mary Mugambi, Key Populations Programme Manager, for her able leadership and technical inputs in development of this guidance. I would like to thank and acknowledge IAVI for providing financial support for the development of this national guidance, George Victor Owino and Dr. Daniel Ochiel (IAVI) for their expert leadership and technical guidance. And express appreciation to the entire team that participated in the writing and development of the document:

- Mary Mugambi (NASCOP)
- George Victor Owino (IAVI)
- Kasera Ogolla (Trans Alliance)
- Frankline Odiwuor (PHDA – NASCOP KP TSU)
- Dr Tina Masai (UMB)
- Lucie Adagi (EGPAF)
- Evanson Gichuru (KEMRI WT)
- Jafred Mwangi (CHS)
- Joyce Odhiambo (SWOP - PHDA)
- Dr Ruth Korir (Mathari Hospital - NMS)
- Diana Gatwiri (LVCT Health)
- Dr Brenda Mogaka (Ngara Hospital – NMS)
- Philip Ndono (Northstar Alliance)
- Obwiri Kenyatta (CDC)
- Parinita Bhattacharjee (UoM)
- Peter Hagono (HOYMAS)
- Fatmah Jeneby (MEWA)
- Esther Nelima (GPARG)
- Elijah Odhiambo Ochieng (GPARG)
- Hilary Oneya (GPARG)
- Silvano Tabbu (GPARG)
- Manas Migot (GPARG)
- Ezekiel Achims Amenya (GPARG)
- Seanny Odero (Trans*Alliance)

I would also like to thank Dr Susan Graham, Dr Manasi Kumar, Dr Gary Harper, Dr Tara Beattie, Naomi Anyango, Dr Paul Bolton, Dr Ilana LapidosSalaiz and Kent Klindera for reviewing the document and providing expert feedback. I would also like to thank Jo-Anne Collinge (Meropa Communications) for editing support, 129 Degrees Design Studio for designing and Ecomedia for layout and printing services for this document. I hope that KP programme implementers and partners across Kenya use this valuable resource in ensuring that all KVPs in the country have access to good quality mental health services.

**Dr. Mulwa A.M.**
Ag. Director of Medical Services/
Preventive and Promotive Health
Ministry of Health

# Executive summary

The key objectives of the National Key Populations Programme, led by the National AIDS and STI Control Programme (NASCOP), include reducing the acquisition and transmission of HIV among key and vulnerable populations (KVPs). The *National Guidelines for HIV and STI Programming with Key Populations* [1] prioritise several critical interventions to achieve this objective, including mental health support which is highlighted as a desirable biomedical intervention.

The guidelines state that stigma and discrimination against KVPs are significant drivers of poor physical and mental health outcomes across diverse settings. In addition to being disproportionately burdened by HIV and other STIs, key and vulnerable populations – especially men who have sex with men (MSM) and transgender people – experience higher rates of depression, anxiety, smoking, alcohol and substance abuse, and suicide. Some of these are maladaptive coping mechanisms adopted in the face of chronic stress, social isolation, and disconnection from a range of health and support services because of the stigma KVPs face.

There is evidence that several mental health programmes have been effective in addressing mental health symptoms and disorders among KVPs. These interventions have become even more important since the explosion of the global COVID-19 pandemic, which has disproportionally affected the lives of KVPs in Kenya and elsewhere, causing immense stress, anxiety and loss of livelihoods, homes and social networks. This guidance has been developed in recognition of the urgency of the task of integrating of mental health within KVP programmes.

Considering the high prevalence of mental health disorders [10], the complexity of management, and resource limitations [3], the Kenya National Key Populations Programme recommends focusing efforts on the mental health problems most frequently experienced by KVPs: depression, anxiety, gender dysphoria, substance-related disorder, post-traumatic stress disorder (PTSD) and some of the maladaptive coping mechanisms they take, such as suicidal attempts/self-harm. This guidance envisages that key population (KP) programmes will offer psychosocial interventions through their existing service channels by adopting three programme elements:

## Community-level interventions

Providing support through community outreach entails early identification of mental health disorders, psychoeducation and first-line support.

Critical aspects of implementation are educating and training KP peer educators and outreach workers on mental health problems, the use of screening tools to facilitate early identification of depression and alcohol-related disorders, providing first-line support and making referrals for clinical or specialised support and services.

## Facility-level interventions

Support in the clinical setting encompasses screening, diagnosis, psychosocial counselling, group therapy and other treatment.

A prerequisite for implementation is training clinicians and counsellors on the response to mental health disorders, clinical screening for priority mental health disorders, and psychosocial counselling and treatment.

Structured psychological group interventions at the facility level are a central feature of the approach.

## Referral for specialised support

The KP programme is expected to map out the specialised mental health treatment and support available in its locality and develop partnerships with these providers for referral.

Some mental health problems may be challenging to manage at the KP facility level as they require either short-term intensive support (for example, for suicidal ideation) or long-term interventions (for example, for major depression or schizophrenia).

The KP programme is responsible for follow-up of the client.

This guidance recognises the importance of monitoring of key mental health indicators and outlines how this can be incorporated into the routine monitoring of the KP programme and by means of surveys.

# 01

# Introduction and background

This *National Guidance on Integrating Mental Health into Key and Vulnerable Population Programming in Kenya* aims to enhance the response of healthcare providers to the specific mental health needs of significant groups of people designated as key and vulnerable populations (KVPs) for the purposes of managing the HIV and STI epidemics in the country.

The background to the development of this guidance document is the growing burden of mental health disorders across the globe, the detrimental impact of mental disorders on the prevention and treatment of HIV, and indications that many factors that make KVPs exceptionally prone to HIV acquisition also contribute to their fragility in respect of mental health. Evidence of this – and of the potentially beneficial impact of mental health services that focus on KVPs – is presented in Chapters 2 and 3 of this document.

**KVPs recognised in Kenya's HIV programme:**

**Key populations (KPs)**

Female sex workers (FSWs)

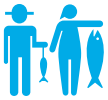
Men who have sex with men (MSM)

People who inject drugs (PWID)

Transgender people

**Vulnerable populations**

HIV-discordant couples



Fisherfolk

People in prison settings

Long-distance truck drivers

## 1.1 Rationale for this guidance

In the *National Guidelines for HIV and STI Programming with Key Populations*, the National AIDS and STI Programme (NASCOP) identified mental health interventions as desirable aspects of the KP response [1]. A closer examination of available evidence and the direct experience of working with KPs have convinced programme providers that mental health services are not only desirable but absolutely essential for KVPs.

The COVID-19 pandemic and its consequences have underscored this realisation that mental health services can no longer be ignored in KVP programming. Some implementers have taken the lead and piloted mental health support for KPs. The Key Populations Programme has consolidated learnings from such pilot interventions to develop this document that clearly defines the interventions and supports the integration of mental healthcare and its subsequent scale up in all KVP interventions.

## 1.2 Goal of the guidance

The goal of this guidance is to inform programme implementers and other stakeholders and provide tools for the prioritisation, integration and implementation of mental health support within the National Key Populations Programme in Kenya.

### 1.3 Anchoring documents

This document draws from the following global and national guidance:

- *WHO Consolidated Guidelines for Key Populations, 2016 [2]*: This recognises that people from KPs may face the double burden of mental health issues associated with HIV infection plus those related to marginalisation, discrimination and stigma. The WHO consolidated guidelines recommend inclusion of mental health interventions in programmes for KPs.
- *WHO mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialised Health Settings (Version 2.2), 2016 [3]*: The document provides evidence-based guidance and tools to advance interventions that address mental health disorders.
- *The Kenya Mental Health Policy 2015 – 2030 [4]*: The policy sets the direction for prevention, management and control of mental disorders in Kenya in line with country's Vision 2030.
- *Kenya Mental Health Action Plan 2021 – 2025 [5]*: *This plan operationalises the main objectives of the national mental health policy*:
  - Effective leadership and governance
  - Access to comprehensive, integrated, high-quality mental healthcare services at all levels of care.
  - Promotive and preventive mental health strategies.
  - Strengthening mental healthcare systems.
- *The National Protocol for Treatment of Substance Use Disorders in Kenya, 2017 [6]*: This protocol was developed to enable standardised, quality healthcare services for persons who use alcohol and drugs. It outlines pharmacological treatment, psychosocial interventions and aftercare support which accord with international standards and procedures while respecting national social and economic realities.
- *National Guidelines for HIV and STI Programming with Key Populations, 2014 [1]*: The guidelines recommend inclusion of mental health as a desirable component of the package of services for key populations.
- *National Implementation Guide for HIV and STI Programming among Transgender People [7]*: This recommends mental health services be included in the essential package of services for transgender people.

### 1.4 Process of developing this guidance

This guidance was developed with support from IAVI. Several discussions took place among members of the KP Technical Working Group (KP TWG) on the need for integration of mental health services into KVP programmes and the development of a guidance document to enable the scale-up of mental health support. A virtual consultation took place in June 2021 to share evidence and experience of implementing mental health interventions with KVPs in Kenya. Participants exceeded 100 and represented diverse communities, expertise and competencies. The consultation was followed by an in-person writing workshop in Nairobi in July 2021 when mental health experts, members of KVPs, policy makers and implementers collectively drafted the guidance. The document was reviewed by experts, including members of the GBMSM Policy and Advocacy Reference Group, on 1 November 2021 and approved virtually by the KP TWG on 3 March 2022.

# 02

# The need for dedicated mental health support for KVPs

### 2.1 The global and national context

The World Health Organization (WHO) defines mental health as a state of well-being in which all individuals realise their own potential, and can manage the normal stresses of life, work productively and fruitfully, and contribute to community to which they belong [8]. Mental health disorders are health conditions involving changes in emotion, thinking or behaviour – or a combination of these. Mental health problems are associated with distress and/or difficulties in performing social, work or family activities [9].

Globally about 25% of people experience mental or neurological disorders at some point in their lives [10]. Around 450 million people in the world currently suffer from such conditions, placing mental health disorders among the leading causes of ill-health and disability [10]. The burden of mental health disorders has increased by nearly 50% in the past 25 years and now accounts for one in every 10 years lost due to ill-health globally. The 2010 Global Burden of Disease study, involving 187 countries, showed that mental health and substance disorders were leading contributors to the total burden [11].

However, the magnitude of the mental health challenge is not matched by the scale and effectiveness of the response. According to the WHO:

More than **40%** of countries have no mental health policy

More than **30%** have no mental health programmes

Around **25%** of countries do not even have mental health legislation [3]

Currently, more than 33% of countries allocate less than 1% of their total health budgets to mental health, with another 33% spending just 1% of their budgets on mental health [3]. There is only one psychiatrist per 100 000 people in more than half the countries in the world, and 40% of countries allocate less than one hospital bed per 10 000 people for mental disorders [12].

Mental health disorders play a critical role in HIV acquisition, increasing the risk from fourfold to tenfold [13]. People living with HIV (PLHIV) are more susceptible to psychiatric morbidity than the general population [13] and major depressive disorder is the most common psychiatric diagnosis among PLHIV [14]. Other frequent psychiatric morbidities in PLHIV include suicidal thoughts and attempts, anxiety, post-traumatic stress disorder (PTSD), and alcohol and substance use disorder. Higher mortality is evident among persons with mental, neurological, and substance use (MNS) disorders and their lifespan is shorter by approximately 15 - 20 years [15]. Mental health disorders also contribute to poor HIV treatment outcomes [16].

Social stigma and criminalisation intersect to present additional challenges to KVPs who are already disproportionately affected by HIV. The stigma that members of these groups experience relates to their sexual orientation and gender identity, conduct of sex work and drug use. It may take the form of perceived stigma, enacted stigma (that is, discrimination) or internalised stigma, all of which can negatively affect mental health. The harm is compounded by the reality that mental health disorders are themselves often stigmatised [17].

In Kenya, there have been no epidemiological studies of mental health at the household level. However, it is estimated that up to 25% of outpatients and up to 40% of in-patients suffer from mental health disorders [18]. The most frequent diagnoses of mental health disorders in general hospital settings are depression, substance use disorder, stress, and anxiety disorders [19]. The probable prevalence of psychosis in Kenya is 1 % of the population [20].

Evaluation of mental health services in Kenya confirms that the country's healthcare system has extremely limited financial resources [21]. Conversations about mental health are rarely held largely because many myths and misconceptions exist about the causes of mental health disorders [22]. Specialist care is mainly delivered by psychiatric nurses at selected district-level hospitals with inpatient units and outpatient clinics and by national referral hospitals [23].

A growing number of studies demonstrate that untreated mental illness, especially depression and alcohol/substance use disorder, is associated with HIV-related risk behaviours, acquisition of HIV infection, failure to access HIV care and treatment, failure to adhere to HIV care and treatment, and

increased morbidity and mortality from HIV-related diseases and comorbidities [24, 25]. In addition, with an increased focus on antiretroviral treatment (ART) as a strategy for primary and secondary HIV prevention, addressing mental disorders that interfere with adherence to ART is essential to the success of treatment-as-prevention.

*Kenya has launched the Kenya Mental Health Policy 2015 - 2030* [4] which provides direction on the prevention, management and control of mental disorders in accordance with Vision 2030. *The Kenya Mental Health Action Plan 2021 - 2025* [5] operationalises the policy and provides for:

- Effective leadership and governance.
- Access to comprehensive, integrated, high-quality mental healthcare services at all levels.
- Promotive and preventive mental health strategies.
- Strengthening of mental health systems.

The policy and accompanying action plan envisage an optimistic future for Kenya in terms of addressing mental health disorders and improving the overall mental health of its citizens and residents.

## 2.2 Mental health in key and vulnerable populations

In addition to being disproportionately burdened by HIV, members of KVPs have higher rates of depression, anxiety, substance dependence and suicide compared to the general population.

PLHIV, including those from KVPs, and their families and caregivers also have a wide range of mental health needs [26]. Studies suggest that mental health disorders in PLHIV may interfere with treatment initiation and adherence and lead to poor HIV treatment outcomes [14]. Stigma and discrimination, stressful work and home life, and subjection to violence (in the case of KVPs) have been described as important drivers of poor physical and mental health outcomes in diverse settings [27]. Not only can substance abuse lead to mental health disorders, but the reverse is also true: substances are often used as a form of self-medication by people with distressing mental health symptoms [15].

### 2.2.1 Mental health among female sex workers

A meta-analysis of mental health among FSWs in 17 low- and middle-income countries (LMIC) showed a high prevalence of depression, suicidal thoughts, attempted suicide, PTSD and anxiety [28]. In a study of gender-based violence among female sex workers in Mombasa, women with severe GBV experiences – involving physical, emotional and sexual abuse – had higher scores for depressive symptoms, PTSD symptoms and disordered alcohol use, and had more sex partners compared to women in the low GBV reference category [31]. In a slum in Nairobi alcohol use was shown to hamper FSWs' ability to seek healthcare for their children [29]. A review of global literature on alcohol use and sex work found that alcohol use was associated with poor physical health, illicit drug use, mental health problems, and subjection of FSWs to sexual violence [30].

The Maisha Fiti project implemented by Partners for Health and Development in Africa (PHDA) found that FSWs in Nairobi experienced emotional, physical, sexual and economic abuse from regular partners, clients and the police. They also faced illegal arrest and imprisonment. The study established high rates of mental illness, with 9.7% reporting recent suicidal thoughts and behaviours, and 45% reporting alcohol and substance use disorder [32].

**Table 1:** Prevalence of depression, suicidal thoughts and attempts among FSWs in LMIC

| | |
|---|---|
| Prevalence of depression among FSWs in LMIC | 52% |
| Prevalence of recent suicidal ideation | 23.7% |
| Prevalence of ever suicidal ideation | 26.4% |
| Prevalence of recent suicidal attempt | 14.1% |
| Prevalence of ever suicidal attempt | 12.2% |

*Source: Smilenova B et al, 2016 (31)*

### 2.2.2 Mental health among men who have sex with men

Research suggests that MSM are at greater risk of psychiatric disorders – especially depression, substance use disorder and suicide – than their heterosexual counterparts. In the United States, the lifetime prevalence of depression among MSM is 1.5 times to twice the rate among heterosexuals [33]. A meta-analysis of articles on sexual orientation and suicidal behaviour in adolescents and young adults indicates gay, bisexual and queer men are more likely than heterosexual men to report suicide attempts, and there is a positive association between depression and suicide attempts in these groups [34].

In a Kenyan study of MSM mental health, conducted at three sites between 2014 and 2016, 31% of participants reported having moderate to severe depression, 44% reported hazardous alcohol use and 51% reported problematic substance use [35]. In a study in coastal Kenya among MSM, higher experience of stigma was associated with depressive symptoms, and there were significant correlations between alcohol abuse, other substance abuse, sexual stigma and childhood and recent abuse [36]. In 2012, Professionals in Pride Kenya (PPK) conducted a national survey on access to healthcare by sexual minorities and found a need for mental health services. It was clear that sexual minorities – gay, bisexual and MSM – were not coping with the stress, stigma and discrimination they experienced. The study documented alcohol and substance abuse, suicidality and other maladaptive responses to mental health disorders among sexual and gender minorities [37].

### 2.2.3 Mental health among people who inject or use drugs

Substance use disorders occur more frequently in the presence of other mental health problems, including depression, schizophrenia, anxiety and personality disorders [38]. In a study on the prevalence and overlap of psychiatric symptoms among 2 784 clients at a treatment facility in Ontario, Canada, 27.4% of clients scored positive for one mental health disorder, 18.9% for two disorders, and 22.3% for three or more clusters, the most frequent being depression and anxiety [20]. Multi-morbidity was significantly correlated with female gender, unemployment, low levels of social support, cannabis problems, fewer legal problems, and increased treatment engagement. Clients with increased substance use disorders presented with more mental health disorders [39].

At Mathari Hospital Medically Assisted Treatment (MAT) Clinic in Nairobi, 7.4% of all deaths among the MAT clients between 2017 and 2019 were due to suicide [40]. A recent study by the Muslim Education and Welfare Association (MEWA) in Mombasa and Lamu counties showed a high prevalence of mental health disorders, including depression, anxiety, substance use disorder, schizophrenia and psychosis, among people who used drugs. Many participants reported having suicidal thoughts (23%) and having attempted suicide (55%) [41]. Support groups were regarded as the most useful harm-reduction service by 39% of participants, while 38% preferred support workers.

At the Ngara MAT Clinic, among 105 patients receiving methadone, 32 % had major depressive disorder, 16% had alcohol use disorder, and 16% schizophrenia, while anxiety, PTSD, bipolar disorder and personality disorder each registered a prevalence of 7% [42].

### 2.2.4 Mental health in the transgender and intersex population

Social attitudes to gender incongruence and non-conformity with societal expectations vary and, in many cultures, prejudices and social stigma are common. The challenges that transgender persons face in relation to discrimination and negative attitudes among the public are associated with adverse mental health outcomes among them [42]. Gender dysphoria starts early in childhood and in some transgender people it continues into adulthood, needing long-term management with a qualified psychiatrist [43].

A research partnership, comprising LGBT CBOs in nine African countries, researchers at the Gender Health and Justice Research Unit at the University of Cape Town, and COC Netherlands, conducted a survey of 3 796 people from sexual and gender minority groups in participating countries. This indicated the precarious state of mental health of transgender populations in southern and East Africa [44].

The study's Kenya report included 217 respondents identifying as gender minorities: 89 transgender women, 57 transgender men, 65 gender non-conforming (GNC) individuals and six "other". In terms of mental health:

- 48% were classified as depressed.
- 19% experienced moderate to severe anxiety.
- 38% had suicidal thoughts and 29% had attempted suicide at some point.
- 45% used alcohol in a hazardous or harmful way or were alcohol-dependent.
- 35% used drugs harmfully or were drug-dependent.

In terms of experiences of violence, the Kenya report showed:

- The rate of lifetime experience of sexual violence was 52% for all gender minority respondents and the past year rate was 33%.
- The rate of lifetime experience of physical violence was 59% for all gender minority respondents, rising to 69% for transwomen.
- Intimate partner violence (IPV) was common: 40% had experienced sexual violence from an intimate partner and 43% physical violence.

Half of gender minority respondents reported being insulted at a health facility because of their gender non-conformity, and 39% said they were denied healthcare "rarely, sometimes or often".

The Kenya National Transgender Discrimination Survey (NTDS), involving 280 respondents, showed only 18% of transgender and intersex respondents had received a gender-related mental health diagnosis [45]. However, most respondents (58%) suffered from clinical depression, 17% reported experiencing anxiety, 10% harmful alcohol use, and 5% suicidality. Transwomen were most affected by mental disorders at 52%, followed by transmen (20%).

The study found 28% of respondents had attempted suicide. Major reasons were rejection by family (53%), rejection by community (20%), inability to meet daily expenses (10%) and a violent intimate partner (9%). Among participants responding to the drug use question, 26% were currently using drugs and 24% had used a drug previously.

### 2.2.5 Mental health in vulnerable populations

#### Fisherfolk

Fishing is a challenging occupation, affected by environmental change, economic fluctuations and the pressures of self-employment, as well as policy changes that may impact on the health and wellbeing of fisherfolk. Fishing carries risks to physical and mental health [47] but anecdotal information suggests that fisherfolk are less likely than other groups to access healthcare [48].
A 2017 study of female fisherfolk in Zambia indicated they were exposed to multiple traumatic events and daily stressors, and experienced severe mental health symptoms, including anxiety, depression, PTSD and complicated grief, as well as engaging in substance abuse and HIV sexual risk behaviours. The results suggest a relationship between trauma and HIV sexual risk behaviour in this population [49].

#### People in prison settings

According to WHO, in many prisons the following factors undermine mental health: overcrowding, various forms of violence, enforced solitude or, conversely, lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about future prospects, and inadequate health services, especially mental health services [50]. The increased risk of suicide in prisons (often related to depression) is a tragically common manifestation of the cumulative effects of these factors [51].

The disproportionate number of people with mental disorders in prisons is also related to their inappropriate incarceration [52]. Factors behind this are: the widespread misconception that all people with mental disorders are a danger to the public; general intolerance of many societies to difficult or disturbing behaviour; the failure to promote treatment, care and rehabilitation; and, above all, poor access to mental health services. Where mental disorders are present before admission to prison, they may be exacerbated by the stress of imprisonment. Mental disorders may also emerge during imprisonment because of prevailing prison conditions and, possibly, torture or other human rights violations.

#### Long-distance truckers

Long-distance truck drivers spend long hours isolated in their cabs on monotonous highways.

Unsurprisingly, many suffer from mental conditions and continue to drive without reporting these issues. Many drivers attempt to self-medicate with illegal substances, which generally only makes the situation worse. A study of 316 male truck drivers in North Carolina, US found significant mental health issues, such as loneliness (27.9%), depression (26.9%), chronic sleep disturbances (20.6%), anxiety (14.5%), and other emotional problems (13%) [53]. There is limited data on mental health of truckers in Kenya but anecdotal reports from programme implementers, such as North Star Alliance, indicate that truckers face work-related stress, isolation due to separation from their families, and pressure when they travel the Mombasa-Malaba corridor. In addition, they generally lack good nutrition and have a high rate of PTSD.

**Discordant couples**

Members of HIV-discordant couples can experience non-specific psychological distress (NPD) from their own diagnosis, from knowing their partner is HIV-infected, or from the burden placed on their relationship by factors such as stigma and mistrust. In a qualitative study in three countries, discordant couples reported stigma-influenced experiences that included gossip, rumours and name-calling by family members, co-workers and health workers [54]. Another study conducted in Africa showed that being HIV-positive was associated with marriage breakup and being neglected or disowned by family [55].

Sero-discordancy in couples is associated with varying levels of psychological distress, including heightened anxiety, poor emotional adaptation and increased or excessive substance use. These are most often coupled with exclusion and social isolation within the family and neighbourhood [56].

### 2.3 Summing up

Although the specific circumstances contributing to mental health disorders vary across Kenya's prioritised KVPs, available evidence suggests these groups share a high prevalence of disorders. Furthermore, the types of disorder most commonly experienced are quite similar for various KVPs and this common ground may facilitate planning, preparation and implementation of interventions for these populations.

# 03

# Experience of providing mental health support to KVPs

Studies have not only shown the negative impact of mental health disorders on HIV and AIDS, but also demonstrated the positive impact of mental health treatment on the mental health of participants and their adherence to ART. For example, anti-depressant treatment has been associated with improved adherence to ART in PLHIV with depression [15].

The Kenya National KP Programme has had some experience of integrating mental health support into HIV prevention and care services. This chapter shares the insights of KP implementers responsible for these KP pilot projects.

### 3.1 Mental health support for female sex workers

PHDA, working through the sex worker outreach programme (SWOP) clinics, has provided psychosocial support to FSWs since 2010 as part of its comprehensive HIV prevention, care and treatment package. The need for such support intensified after COVID-19 was reported in March 2020 when restrictions on movement and the closure of entertainment venues resulted in loss of livelihoods and interruption of social connections for sex workers. Under the Maisha Fiti project, supported by the London School of Hygiene and Tropical Medicine, SWOP clinics intensified and expanded their mental health support [57]. The project trained healthcare workers and peer educators at SWOP clinics on the management of mental health and substance use disorders. It used the WHO Mental Health Gap Action Programme (mhGAP) curriculum on mental health and counselling for alcohol problems [58].

Community health workers were also trained to screen sex workers so that mental health disorders could be identified early. Peer educators and outreach workers used a simple mental health screening tool to screen sex workers at hotspots and anyone who was found to have a mental health disorder was referred to a SWOP clinic for further screening and management by a healthcare worker. Clinicians, nurses and counsellors at the SWOP clinics were trained to interpret the mental health screening tool and manage common mental disorders with medication (for example, antidepressants) and counselling. Additional referrals for specialised care were made in instances where the mental disorder exceeded the ability of staff to manage it at clinic level. Such referrals were made to a specialised facility managed by Nairobi Metropolitan Services. Healthcare workers also engaged clients with mental health disorders in group sessions using the *Healthy Activity Programme (HAP)*[1] *and Counselling for Alcohol Problems (CAP)*[2] *curriculum.*

Key learnings from the project were:

- There is a need to train peer educators to screen and provide first-line support to sex workers with mental health disorders.
- It is important to advocate for safe working environments for FSWs as violence and stigma at their workplaces cause stress and anxiety.
- Group support sessions are beneficial for sex workers with mental health disorders. The element of social and peer support is critical.

### 3.2 Mental health support for people who inject drugs

MEWA, a civil society organisation in Mombasa, piloted mental health support with people who inject and use drugs. The intervention aimed to assist young people at risk of transitioning into drug use, those already using drugs, and those who were chemically dependent [41]. It was based on evidence that most drug use begins at a relatively young age and drug use is generally associated with poor mental health outcomes.

The intervention focused on:

- Screening clients for substance use disorder. A modified version of the PHQ-4 screening tool was used and this included two questions on suicide and three questions on psychosis.
- Screening clients for HIV, TB, COVID-19, STIs and pregnancy in order to avoid missed

[1] Healthy Activity Programme (HAP) manual developed by Sangath, India provides lay counsellors with information about counselling patients with moderate to severe depression in primary care settings. It is designed to accompany the Counselling Relationship Manual which is a practical guide that can be referred to on an ongoing basis to develop a counsellor's skills in helping clients with moderate/severe depression.

[2] Counselling for Alcohol Problems (CAP) is a brief psychological treatment developed by Sangath, India. The intervention is delivered by lay counsellors to clients with harmful drinking behaviour who attend primary care facilities.

opportunities to provide care for other health conditions.
- Enrolment of clients for detoxification and rehabilitation, as needed and preferred by clients.
- Family tracing and reintegration.
- Support for vocational training and provision of start-up capital to initiate small businesses.
- Referral to facilities and psychologists providing specialised services.
- The offer of *pro bono* legal support to those who needed it.

Key learnings from the project were:
- There is a need for a standardised guide on the process for routine screening and service provision – including referral to specialists – by community mental health practitioners.
- Clients with mental health disorders need other tailored harm-reduction services, such as drop-in centres, emergency shelter services, detox and rehabilitation services, and legal services.
- Investing in research is critical to developing evidence-based programming and advocacy.

### 3.3 Mental health support for substance use clients

At the Ngara Medically Assisted Treatment (MAT) Clinic, managed by Nairobi Metropolitan Services, mental health assessment and treatment are key elements of care, as mental health disorders are associated with substance use. The programme integrates mental health services into its service pillars which include: prevention, harm reduction, enforcement, treatment/recovery, and integration/community safety.

The clinic generally provides the following mental health support: individual counselling, monthly group therapy, family therapy, marital therapy, referrals and linkages, psychological assessment, relapse prevention counselling, after-care counselling and development of a social support network. During the COVID-19 period, the clinic designated days for mental health clinics and took precautions to prevent the spread of COVID-19 to clients and staff [42]. Peer supervision was introduced at this time to enhance self-care among healthcare workers and subsequently became standard practice. The clinic also collaborated with the prisons department to dispense methadone to patients who were incarcerated.

The project recommends the following to improve the mental health response within harm reduction facilities:
- Adequate human resources are required.
- Essential medicines for mental illnesses must be made available.
- The appointment system for mental healthcare should be improved.
- A system should be established to continually review the mental health of clients.
- There should be continuous capacity building of teams.

### 3.4 Mental health response in an MSM-led programme

Health Options for Young Men with HIV, TB and STI (HOYMAS), an MSM-led organisation, felt the need to include mental health in its HIV prevention programmes as it realised that MSM experienced high rates of substance use and mood disorders due to stigma and discrimination, rejection by family and society, inadequate sources of income, and violence [59]. The mental health support the organisation offered included: access to a *pro bono* counsellor who could be reached via WhatsApp; referral to Nairobi Metropolitan Services facilities for specialised psychosocial support; peer-to-peer support services; and, for staff, ongoing training on quality mental health services. The organisation received positive feedback from clients who received these services.

Some of the key learnings were:
- Within HIV prevention programmes for MSM, the focus should be on supporting mental wellness of clients and service providers rather than management of mental health disorders.
- Formation of support groups for clients with mental health disorders is very important.
- Screening and reporting tools for mental health interventions should be standardised.
- Building family support is a critical mental health intervention for MSM with mental health disorders.

- Peer educators and clients should be encouraged to undertake online addiction counselling classes to make care more affordable. This resource is available and managed by Support for Addictions Management and Treatment in Africa (SAPTA). Problem Management Plus (PM+) is a good example of a low-cost psychosocial intervention that can be provided at community level.

### 3.5 Mental health support with transgender people

As COVID-19 spiralled into a pandemic, its consequences were felt by transgender people in Kenya who experienced increased violence, stress, anxiety and hopelessness, along with loss of earnings and social support. Trans Alliance, an organisation led by transgender people in western Kenya, put in place a legal office to document and respond to human rights violations against their transgender clients and provide psychosocial support through an in-house psychiatrist.

Between August 2020 and March 2021, the psychiatrist assisted 126 transgender people to address their mental health concerns [60]. Of this group, 60% were transgender women, 25% were transgender men, 10% gender non-conforming people and 5% intersex. Their mental health disorders included clinical depression, attempted suicide, stress and gender dysphoria. The main reported causes were family rejection, intimate partner violence, substance abuse, loss of livelihood due to the pandemic, lack of access to hormones, stigma and social discrimination. The psychiatrist assisted clients in making informed decisions, developing adaptive life skills, coping better with illnesses and trauma, and dealing effectively with stigma and discrimination.

Some key lessons from this intervention were:

- There is a need to enable psychosocial counsellors to offer transgender-specific services.
- Strong referral pathways to private and public health systems must be created in order to offer gender-affirming health services to the transgender community.
- It is essential to support and resource mental health interventions within HIV prevention programmes for transgender people.

# 04

# Integrating mental health support into KVP programming

## 4.1 Implementation considerations

WHO recommends the provision of integrated, comprehensive services that are patient-centred for the prevention, care and treatment of the multiple mental health issues affecting key populations [2]. Integrated services enhance communication among service providers working with KVPs and are likely to result in better care.

In light of the prevalence of various mental health disorders, the complexity of management and change, and the lack of additional resources, the Kenya National Key Populations Programme recommends focusing on the most prevalent mental health problems among KVPs: depression, anxiety, gender dysphoria, substance-related disorder, suicidal attempts/self-harm and PTSD. It is further recommended that KVP programmes offer integrated mental health support through direct service provision and indirect service provision – that is, through referral.

## 4.2 Existing service delivery model for KVPs

The KVP programme in Kenya adopts a two-pronged approach to reaching identified populations:

A robust community-based model driven by peer educators, outreach workers and community health workers.

A facility-based model which relies on standalone specialised KP clinics managed directly by the programme and referral clinics, run in partnership with public and private health clinics.

At the community level, KP peer educators and outreach workers identify their peers at physical and virtual sites and regularly reach out to them, offering health education, prevention products like condoms and lubricant, and referral to services plus follow-up contact. The key population guidelines [1] establish the ratio of peer educators and outreach workers for each population and define their roles and responsibilities. Programmes for vulnerable populations engage with community health workers (either peer educators or community health volunteers [CHVs]) to reach out to various populations in order to share information and provide other prevention services.

At the facility level, KP programmes provide clinical services using:

- The static clinic model, comprising interventions at standalone, specialised KP clinics or integrated clinics in Ministry of Health facilities.
- The outreach clinic model, which operates at hotspots or sites where sex work and drug use occur.
- Referral clinics, mostly hosted at government clinics or private facilities, like mission hospitals, and accessed through accompanied referral or a KP link desk at the referral site.

Most KP standalone clinics have clinicians (doctors, clinical officers and nurses), counsellors (for HIV testing services, treatment adherence, addiction and psychosocial assistance) and paralegal officers. These facilities offer HIV prevention and treatment services, including sexual and reproductive health (SRH) services. The package of services offered by the facilities is guided by the national KP guidelines [52]. A similar model exists for vulnerable populations, with standalone clinics for truckers and integrated clinics for people in prison settings, discordant couples and fisherfolk.

The integration of mental health support with KVP programmes can leverage existing systems, strengthen available human resources through extensive capacity building (including on-the-job training, self-directed training, routine mentorship and specialised training), and establish the approaches described below.

## 4.3 Framework for mental health support

### 4.3.1 Overview

NASCOP regards mental health as a matter of wellbeing rather than illness. The focus of interventions should be health promotion and the prevention of mental disorders, while ensuring treatment is available where needed. Creating awareness about mental health issues and providing information on coping skills can improve self-care for members of KVPs.

Most mental health problems are already managed by the individual, using constructive coping mechanisms (for example, physical exercise or attending religious services). However maladaptive coping (for example, drinking heavily or starting fights) is unfortunately common.

Beyond self-care, many mental health problems can be managed by structured community care and support systems provided by community health workers. Members of KVPs who need more support, can be referred to various facilities implementing the mental health programme. A small group of KVPs may also need specialised care and they will be referred through a formal linkage system to specialised services offered by mental health professionals like psychiatrists or psychologists.

This guidance adapts the NASCOP framework on mental health support for KVPs by incorporating aspects of other Kenyan guidelines on mental health and lessons gained in providing community-based mental health interventions for KPs in Kenya, as described in Chapter 3. The evidence indicates most mental health problems can be assessed, diagnosed and managed in the community by trained lay workers or at facilities by trained primary healthcare workers, with only a small minority needing specialised psychiatric referral [61]. NASCOP proposes that integration of mental health support should have two programme elements: interventions at community level and interventions at facility level.

### 4.3.2 Interventions at community level

**Screening:**
Community health workers – peer educators, outreach workers, CHVs, community champions – screen KVPs in the cohort for which they will be responsible for identifying early signs of mental health disorders. This will occur alongside the routine provision of HIV prevention and harm reduction services. Before screening, community health workers will receive training in identifying the presenting signs and symptoms of common mental health conditions using a screening tool (See Annexure 2). At community level, health workers will only screen for depression, anxiety, gender dysphoria, substance-related disorder, suicidal attempts/self-harm and PTSD. Gender dysphoria will also be screened at the facility level.

**Psychoeducation:**
Members of KVPs need information and knowledge related to mental health disorders that are prevalent among them. This includes information to help affected individuals understand their condition, accept it, and achieve a positive attitude towards management and support. It also includes information on where to access support. Information can also be used to assist other individuals and communities to overcome the stigma that prevails in relation to mental health disorders.

Community health workers are generally the first point of contact for KVPs and are well-placed to provide psychoeducation and first-line support. Information sharing can take place at sites or hotspots, or during clinic days, events and other activities at the drop-in centre (DICE). Community health workers will need training not only to develop their understanding of mental health disorders, but also to build their skills in delivering important mental health messages using simple interpersonal communication materials.

**First-line support:**
This includes sharing with the person basic information about the mental disorder he or she is experiencing and the availability of treatment, as well as addressing the person's immediate concerns. Community health workers will identify psychosocial stressors impacting on the person, including dynamics in the family, difficult relationships, economic issues, and matters related to sexual orientation and gender identity. Community health workers can assist the person to adopt problem-solving techniques, identify a support system, reactivate the person's social network, and identify activities that can provide direct or indirect social support. They will also encourage participation in fun and stress-relieving activities at the DICE or at other safe spaces. Community health workers will be expected to refer the person to the facility for further assessment and support.

NASCOP will develop a standard curriculum for training of community health workers on mental health disorders among KVPs and create communication materials to assist them to communicate key messages clearly. The KP programme can also collaborate with other health and non-health campaigns to focus public attention on mental health issues.

### 4.3.3 Interventions at the facility

Interventions at the facility fall into three main categories: screening and identification of symptoms; management of the condition; and referral where specialised professional help, is required.

**Screening and identification of symptoms:**
Most KP programmes have standalone DICEs and clinics while most VP programmes have structured referrals to government or private clinics. All the clinics are staffed by healthcare workers (for example, clinician, HIV testing counsellor, treatment adherence counsellor or psychosocial counsellor). Screening tools like the Gender dysphoria test, PHQ-9, GAD-7, AUDIT (if alcohol is the focus), ASSIST (if multiple substances are used), and DAST – or an adapted version of these – will be used by clinical teams to screen KVP clients. (See Annexures 3c and 3h) Routine screening, assessment and management for mental health disorders should be provided to all members of KVPs, irrespective of HIV status, in order to optimise health outcomes. Research facilities working with or providing services to KVPs need to use these same tools to screen and identify mental health symptoms and disordered substance use among study participants and clients.

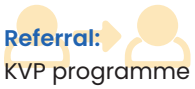
**Management:**
Management of mental disorders ranges from psychosocial support and psychotherapy to pharmacological treatment, as detailed in Chapter 5.

- Psychosocial support includes psychoeducation, case management, promotion of functioning in daily activities, and life and social skills training. This can be done at individual or group level. Family counselling can be provided, and family group sessions and events can be organised to ensure families understand the mental health needs of the KVPs and provide support.
- Psychotherapy includes interpersonal therapy, motivational enhancement therapy, behavioural activation and relaxation therapy. This can be offered on an individual basis or in groups. NASCOP-approved curricula, like STEPS[3], can be used for structured sessions and can be facilitated by NASCOP-trained facilitators. Organisations like the National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK) in West Pokot have used sport to initiate group mental health interventions among FSWs.[4] Group therapy, when facilitated well, can help participants realise they are not alone and

[3] STEPS is a group session curriculum developed and tested among KPs by SAPTA, Kenya
[4] Presented by NEPHAK during National Stakeholder Meeting, 23 – 24 May 2019, Nairobi, Kenya

others who have had similar experiences can provide support and encouragement. These structured psychological group sessions can be conducted in the DICE, clinic or safe space under the supervision of clinical team. Peer support groups can help improve self-esteem and address self-stigma.

- Pharmacological treatment includes prescription of medication in accordance with the protocol for management of each mental health disorder. This also includes monitoring of dosing and side-effects of the drugs and follow-up. Currently, basic psychiatric medications are not available at DICE clinics for KPs, and therefore NASCOP will advocate to include them in the essential medicines list for KVPs. However, these medications are available in designated public health facilities and the KP programme can establish partnerships with these clinics to provide support. KVP Programmes should monitor referral outcomes and support patients in their adherence to mental health medications whenever possible.



**Referral:**

KVP programme facilities should establish a formal referral network with practising psychiatrists and specialised services to which more complex or severe cases can be referred. These psychiatrists will be sensitised to the specific needs of KVPs and issues affecting them. Referral may also be necessary for individuals who are unresponsive to treatment, have serious side-effects from pharmacological intervention, or comorbid conditions. A structured system for two-way feedback must be established between the KVP programme and referral services.

NASCOP will provide training, based on a standard curriculum, to all healthcare workers placed in KP clinics or clinics serving KVPs. This will cover screening, diagnosis and management of depression, anxiety, gender dysphoria, substance-related disorder, suicidal attempts/self-harm, and PTSD.

The programme team should meet on a regular basis to discuss the status of the client and develop follow-up plans.

On the basis of a positive screen conducted by a community health worker at the community level, a member of a KVP will be referred to the facility for further screening and assessment. The healthcare worker/clinician at the facility will review the screening tool used by the community health worker and conduct a detailed screening and assessment which will help to diagnose the individual's condition. The diagnosis and management plan for the KVP member will be shared with the community health worker who referred the person for further follow up and support. Regular meetings of the team will help provide feedback to community health workers. In the event that community screening is not aligned with the screening used at the facility level, refresher trainings will be organised. Such regular meetings between the community and facility team members will strengthen the management and support plan for the client.

It must be noted that care providers may experience burnout and the programme should put in place processes for care providers to participate in debriefing sessions where they can give vent to their feelings and address their burnout and other mental health issues. A psychiatrist or clinic psychologist (accessed through the referral service) can facilitate some debriefing sessions.

Evidence-generation and documentation of these new services are important in ensuring that there is continuous learning and improvement of mental health support. Facilities and research institutions need to document and disseminate evidence-based best practices to facilitate scale-up of such practices.

### 4.4 Respect for clients and self-care for healthcare workers

Members of KVPs with MNS conditions should be treated with respect, in a culturally appropriate manner and without being subjected to stigma or discrimination. Healthcare providers must make every effort to respect and promote the wishes and preferences of people with MNS conditions. They must engage them and their caregivers in the most inclusive way. Persons with MNS conditions are often more vulnerable to human rights violations than the general population. Therefore, it is essential that workers in healthcare settings promote the rights of people with MNS conditions in accordance with international standards, including the *UN Convention on the Rights of Persons with Disability (CRPD)* [62].

It is recommended that healthcare workers and counsellors providing services in KVP clinics

undergo stigma and discrimination training, gender-sensitivity and diversity training, violence prevention training (using LIVES or NASCOP training systems) and mental health training. Additionally, it is recommended that healthcare workers and counsellors assess themselves on stigma attributes, using the Stigma Attribution Questionnaire-27 *(See Annexure 3i)*.

WHO defines self-care as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider." It is a concept that encompasses hygiene, nutrition and seeking medical care when needed. Many healthcare workers and counsellors who neglect to practise self-care end up experiencing burnout, a syndrome resulting from chronic workplace stress that has not been successfully managed.

Additionally, peers who work to support KVPs are vulnerable to burnout and often not well supported by formal compensation and job benefits.

As a healthcare worker, counsellor or peer worker, it is important to assess honestly one's ability to provide support. It is also important to have realistic expectations of what one can and can't do. Providers potentially experiencing burnout should screen themselves using the Burnout self-test – Maslach Burnout Inventory (MBI) *(See Annexure 3g)*. Institutions or implementing partners providing mental healthcare should also consider the need for self-care by all categories of providers and offer continuous support through peer sessions, counselling, debriefing sessions and mentorship.

**4.5 The roles of various actors**

This guidance recommends that the stakeholders and partners play specific roles in addressing the mental health of KVPs, as set out below.

- **Policy makers:** These include National AIDS Control Council (NACC), NASCOP and county governments. They will be responsible for monitoring the implementation of the guidance for KVPs alongside other mental health policies. NASCOP will also provide leadership, technical support and capacity strengthening to implementing partners and foster a collaborative environment among stakeholders.

- **Implementing partners:** These include partners offering HIV services to KVPs. They will be responsible for implementing the guidelines and ensuring that mental health support is integrated into programmes. They will provide education and training, undertake early identification, screening and assessment for common mental health disorders, conduct activities to promote mental health and prevent disorders, offer counselling and make referrals.

- **Members of KVPs, community-based organisations (CBOs) and networks:** These include individual members of KVPs and organisations led by them. It is recommended that they advocate for safe environments and provide constructive feedback to NASCOP and implementing partners on the quality of mental health services provided. They would also provide information on the service needs and preferences of KVPs, and the support provided to peer counsellors, navigators and outreach staff.

- **Research organisations:** These include organisations that conduct HIV prevention research, clinical trials for new prevention technologies such as preventive vaccines, and social and behavioural research. It is recommended that these organisations conduct implementation science research to generate evidence on effective approaches to providing mental health support, assessing the needs and priorities of key and vulnerable populations, and disseminating the evidence widely.

- **Donors:** These include funders and KVP programme partners that support the strengthening of health systems. It is recommended that donors provide resources to implementing partners to provide mental health support as described in this guidance document.

# 05

# Screening, assessment and management of mental disorders in KVPs

Mental health disorders are increasingly prevalent in sub-Saharan Africa because of persistent poverty, the demographic transition, substance use, HIV and AIDS, and laws that criminalise KPs [63]. Against this backdrop, as shown in Chapter 2, members of KVPs are particularly susceptible to mental health disorders.

Persons with mental health disorders are at higher risk of premature morbidity and mortality from preventable diseases. This risk can be reduced through effective mental health programmes.

Many disorders – such as depression, anxiety, gender dysphoria, substance-related disorders, suicidal attempts or self-harm and PTSD – are potentially preventable or treatable with currently available interventions. These interventions are encompassed in three steps essential to a mental health service: screening, assessment and management.

## 5.1 Step 1: Screening

It is critical for HIV outreach and clinical teams at community level to screen for mental health and substance use disorders among KVPs. As they provide HIV prevention, treatment and harm reduction services, community health teams need to assess any changes in thinking, feelings and behaviour among members of KVPs. Mental health screening involves asking a series of questions contained in a screening tool.

The mental health or substance use screening tool is designed to identify individuals at risk of common mental health disorders such as depression, anxiety, gender dysphoria, substance-related disorder, suicidal attempts/self-harm and PTSD.

Community health workers and peer workers will use the screening tool presented in Annexure 2. After screening, if there is a positive screen, they will then refer the client to the facility for further detailed screening and assessment by healthcare provider or clinical staff member.

## 5.2 Step 2: Assessment

Assessment establishes the extent of the problem and should be conducted with informed consent of the person. After a positive screen by the community health worker, the KVP client will be referred to the healthcare worker or clinician at the facility for further screening and assessment. Sometimes a positive screen leads to a referral but the patient is not at all clear that his or her symptoms indicate a "mental health" problem. Conducting a detailed assessment will help to better understand the symptoms, conditions, context and reasons behind some of the symptoms, to make a diagnosis and develop a management plan. Conducting an assessment for mental health and substance use disorders involves the following:

**1. The presenting complaint is explored by asking:**

- What brings you here today? When and how did the problem start? How did it change over time? How do you feel about this problem? Where do you think it came from? How does this problem impact on your daily life?
- How does the problem affect you at school/work or in daily community life?
- What kinds of things did you try to solve this problem? Did you try any medication? If so, what kind (for example, prescribed, non-prescribed, herbal)? What effect did it have?

**2. A history is obtained, and this includes asking about past mental, neurological and substance use (MNS) problems, general health problems, family MNS history, and psychosocial history.**

- Explore a possible family history of MNS conditions.
- Do you know of anyone in your family who has had a similar problem?
- Explore the person's general health history.
  - Ask about any previous physical health problems: Have you had any serious health problem in the past? Do you have any health problem for which you are currently receiving care?
  - Ask if the person is taking any medication: Has a healthcare provider prescribed any medication you are supposed to be taking right now? What is the name of that medication? Did you bring it with you? How often do you take it?
  - Ask if the person has ever had an allergic reaction to any medication.
- Explore current stressors, coping strategies and social support.
  - Has your life changed in the last few months? Have you lost a loved one? How severe is the stress in your life? How is it affecting you? What are your most serious

problems right now? How do you deal/cope with these problems day by day? What kind of support do you have? Do you get help from family, friends or people in the community?

- Explore possible alcohol and drug use. Questions about alcohol and drugs can be perceived as sensitive and even offensive. However, this is an essential component of MNS assessment. Explain to the person that this is part of the assessment and try to ask questions in a non-judgmental and culturally sensitive way.
  - I need to ask you a few routine questions as part of the assessment. Do you take alcohol (or any other substance known to be a problem in the area)? [If yes] How much per day/week?
  - Do you take any tablets when you feel stressed, upset or afraid? Is there anything you use when you have pain? Do you take sleeping tablets? [If yes] How much/many do you take per day/week? Since when?
  - Do you use any recreational drugs to relax or get high? If so, what drugs do you use? How much/many do you take per day/week? Since when?
  - Do you ever inject drugs in order to relax or get high? If so, what drugs do you inject? How do you inject? With whom do you inject? Do you share needles or other injection equipment?
- Conduct a physical examination. This should be a focused physical examination, guided by the information given in the MNS assessment. If any physical condition is found at this stage, either manage it or refer the person to appropriate resources.

**3. The person is observed. This is known as the mental status exam and it covers:**

a) Appearance – what you see as the clinician
b) Behaviour – eye contact (poor, good or piercing), psychomotor activity
c) Agitation – hand wringing, pacing, crying out
d) Movements – ticks or tremors, slowing of movement, abnormal gait
e) Speech – rate, rhythm, volume, content
f) Mood – the prevalent emotional state the patient describes
g) Affect – the emotional state you observe
h) Thought process – the rate of thoughts, how they flow and how they connect
i) Thought content – the themes that occupy the patient's thoughts and perceptual disturbances (hallucinations, delusions, illusions)
j) Cognition – level of consciousness, attention and concentration, memory, abstract reasoning, proverb interpretation
k) Insight – awareness of one's own illness or situation – and judgement, the ability to anticipate the consequences of one's behaviour and make decisions to safeguard oneself and others

**4. Establish a differential diagnosis – that is, a list of possible conditions suggested by the assessment process.**

**5. Identify the MNS condition.**

The physical examination forming part of the assessment may require basic laboratory tests, such as serum glucose, blood urea nitrogen, creatinine, urinalysis, or thyroid function tests (when indicated).

### 5.3 Step 3: Management

After completing the assessment, the healthcare worker needs to arrive at a diagnosis and develop a management plan. This plan is developed with the client and, if the client agrees, with the caregiver. It is important to discuss and determine achievable treatment goals with the client and for the client to agree with the management plan, which will include management of both mental and physical conditions, where necessary.

In order for the client to participate in developing the management plan, the healthcare worker must provide the client with information about his or her condition. If the client agrees, the health worker should also provide this information to the caregiver.

Such information should include: expected benefits of treatment, duration of treatment, the importance of adhering to treatment (including performing relevant psychological interventions, such as relaxation techniques, at home), potential side-effects of prescribed medication, and the potential involvement of social workers, case managers, community health workers or other trusted members in the community. The role of the caregiver in supporting treatment may also be discussed.

**Table 1:** Presentation and management of mental health disorders
(Adapted from WHO Mental Health Gap Action Programme [*mhGAP*] Intervention Guide [3])

| | Presentation | Psychosocial and pharmacological treatment options |
|---|---|---|
| | **Common mental disorders among key and vulnerable populations** | |
| **Depression** | Multiple persistent physical symptoms with no clear cause<br><br>Low energy, fatigue, sleep problems<br><br>Persistent sadness or depressed mood<br><br>Loss of interest or pleasure in activities that are normally pleasurable | Provide psychoeducation to the person and the caregiver<br><br>Reduce stress and strengthen social supports<br><br>Promote functioning in daily activities and community life<br><br>If available, consider referral for one of the following: brief psychological treatments: interpersonal therapy, cognitive behavioural therapy, behaviour activation and problem-solving counselling<br><br>Offer regular follow-up during routine clinical visits to assess progress |
| **Anxiety** | Excessive worry and difficulty controlling worry<br><br>Feelings of panic<br><br>Physical symptoms such as increased heart rate, breathing rapidly, sweating and gastrointestinal problems<br><br>Decreased concentration<br><br>Avoiding situations that cause anxiety<br><br>Symptoms cause significant distress clinically and in social, academic and occupational activities or other important functional areas | Provide psychoeducation on signs, symptoms and causes of anxiety<br><br>Teach breathing and relaxation techniques to help reduce physical symptoms of anxiety<br><br>Help identify stressors contributing to anxiety and enable client to exercise stress management and problem-solving<br><br>Consider referral for cognitive behaviour therapy for the management of anxiety if service is available |
| **Gender dysphoria** | A marked incongruence between the person's experienced/expressed gender and primary and/or secondary sex characteristics<br><br>A strong desire to be and to be seen and treated as the other gender<br><br>A strong desire to have sex characteristics of the other gender<br><br>A desire to be rid of the primary sex characteristics of the gender assigned at birth | Provide psychoeducation on stress in relation to gender identity and gender dysphoria<br><br>Assist client to identify unhelpful thoughts and feelings and teach coping strategies that promote positive thinking<br><br>Assist client to identify supportive and identity-affirming activities<br><br>Support development of a plan for building a supportive network |

| | Presentation | Psychosocial and pharmacological treatment options |
|---|---|---|
| **Substance-related disorder** | Taking a drug in larger amounts over a longer period than was intended<br><br>Cravings for the drug(s)<br><br>Spending a lot of time looking for and using the drug and recovering from its effects<br><br>Continuing to use the drug despite it negatively affecting work, school or family life<br><br>Giving up important work, social or leisure activities due to drug use<br><br>Having a need for increased amounts of the drug to achieve effect<br><br>Experiencing withdrawal when the drug is not in the system or its level is reduced<br><br>Signs and symptoms of alcohol intoxication. These include:<br>Smell of alcohol on the breath<br>Slurred speech<br>Uninhibited behaviours<br>Disturbance in the level of consciousness, cognition, perception, affect or behaviour<br><br>Signs and symptoms of alcohol withdrawal. These may vary considerably among individuals and include:<br>• Tremor in the hands, sweating, vomiting, increased pulse and blood pressure, agitation, headache, nausea and anxiety<br>• Seizures and confusion, in severe cases<br>• Problems with balance, walking and coordination of movement<br>• Nystagmus (rapid, involuntary eye movements)<br>• Unresponsiveness or minimal responsiveness, slow respiratory rate, pinpoint pupils<br>• Dilated pupils, excited, racing thoughts, disordered thinking, strange behaviour, recent use of cocaine or other stimulants, increased pulse and blood pressure, aggressive, erratic or violent behaviour | Provide psychoeducation on risks and effects of drug use and benefits of reducing/stopping substance use<br><br>Discuss the impact of substance use on self and family members. Discuss the same with family and caregivers<br><br>Use motivational interviewing approaches to help client reflect on substance use<br><br>If person is willing to reduce/stop, discuss strategies for reducing or stopping<br><br>Refer to mutual help support groups |

| | Presentation | Psychosocial and pharmacological treatment options |
|---|---|---|
| | **Additional considerations for persons with mental disorders** | |
| **Suicide attempts/self-harm** | Act of self-harm with signs of: Poisoning or intoxication.<br><br>Bleeding from self-inflicted wound(s) Loss of consciousness and/or extreme lethargy<br><br>Current thoughts about, plans for or acts of self-harm or suicide<br><br>A history of thoughts about, plans for or acts of self-harm or suicide in a person who is now extremely agitated, violent, distressed or lacks the ability to communicate<br><br>Extreme hopelessness and despair or extreme emotional distress | DO NOT LEAVE THE PERSON ALONE<br><br>Arrange immediate referral for management of poisoning<br><br>Care for the person with self-harm<br>Place the person in a secure and supportive environment at a health facility<br>(Do not leave the person alone)<br><br>If there is a wait for treatment, offer the person an environment that minimises distress, if possible, a separate, quiet room with constant supervision and contact with a designated staff or family member to ensure safety at all times<br><br>Remove all means of self-harm<br><br>Consult a mental health specialist, if available<br><br>Mobilise family, friends, other concerned individuals or available community resources to monitor and support the person during the period of immediate risk (See Offer and activate psychosocial support)<br><br>Treat the person with the same care, respect and privacy given to other people, and be sensitive to the emotional distress associated with self-harm<br><br>Include the caregivers if the person wants their support during assessment and treatment. If possible, the psychosocial assessment should include a one-to-one interview between the person and the health worker to explore private issues<br><br>Provide emotional support to caregivers/family members if they need it<br><br>Ensure continuity of care. Hospitalisation in non-psychiatric services of a general hospital is not recommended for the prevention of self-harm. However, if admission to a general (non-psychiatric) hospital is necessary to manage the medical consequences of self-harm, monitor the person closely to prevent further self-harm in hospital<br><br>See relevant mhGAP-IG modules for pharmacological interventions in the management of concurrent conditions<br><br>Offer and activate psychosocial support<br>Offer support to the person<br><br>Explore reasons and ways to stay alive<br><br>Focus on the person's strengths by encouraging the person to talk about how earlier problems have been resolved |

| | Presentation | Psychosocial and pharmacological treatment options |
|---|---|---|
| | | Consider problem-solving therapy to help people who have enacted self-harm within the last year, if sufficient human resources are available<br><br>Activate psychosocial support: mobilise family, friends, concerned individuals and other available resources to ensure close monitoring of the person as long as the risk of self-harm/suicide persists<br><br>Advise the person and caregivers to restrict access to means of self-harm/suicide (such as pesticides/toxic substances, prescription medication and firearms) when the person has thoughts of or plans for self-harm/suicide<br><br>Optimise social support from the community, including informal resources – such as relatives, friends, acquaintances, colleagues and religious leaders – or formal resources, such as emergency call centres and local mental health centres, if available<br><br>Provide caregiver support<br>Caregivers and family members of people at risk of self-harm often experience severe stress. Provide emotional support to them if they need it<br><br>Reassure caregivers and family members that asking about suicide will often help the person feel relieved, less anxious and better understood<br><br>Advise caregivers that, even though they may feel frustrated with the person, they should avoid expressing hostility and severe criticism of a person at risk of self-harm/suicide<br><br>Provide psychoeducation<br>Convey the following key messages to the person and the caregivers:<br><br>Anyone who has thoughts of self-harm/suicide should seek help immediately from a trusted family member, friend or healthcare provider<br><br>It is okay to talk about suicide. Talking about suicide does not provoke the act of suicide<br><br>Suicide is preventable:<br>• An episode of self-harm/suicide is an indication of severe emotional distress by a person who does not see an alternative or a solution. It is important to get the person immediate support for emotional problems<br>• Means of self-harm (such as pesticides, firearms and medication) should be removed from the home<br>• The social network, including the family, is important for provision of social support |

| | Presentation | Psychosocial and pharmacological treatment options |
|---|---|---|
| **Acute PTSD** | Recent exposure to a traumatic incident<br><br>Nightmares, flashbacks, recurrent dreams and intrusive memories<br><br>Avoiding reminders of the incident<br><br>Being frequently startled<br><br>Changes in sleep patterns | Provide psychoeducation on effects of trauma<br>Encourage the person to get rest, activate social support and engage in stress reduction<br><br>If the person continues to experience symptoms for longer than one month and this interferes with ability to function, refer the person to a specialist for the management of PTSD |

# 06
# Monitoring and evaluation

Monitoring and evaluation (M&E) generate data and lessons that assist programme administrators to: conduct strategic planning and reviews; identify problems promptly; allocate resources appropriately; and improve programme quality, efficiency and effectiveness. Stakeholders require different types of data and evidence on how various activities contribute to achieving KVP programme objectives. Ideally, implementing partners should coordinate and streamline their internal M&E efforts without duplicating data collection or analysis.

For this guidance, the M&E structure is derived from and guided by the existing *Key Populations National M&E Framework*. The indicators are drawn from monthly and quarterly reports, the Kenya Health Information System (KHIS) and electronic medical records (EMR). The structure proposes an annual assessment and mid- and end-term reviews to measure the outputs and outcomes of mental health support.

## 6.1 Tracking progress

Successful implementation of mental health support requires continuous monitoring and adjustment of the implementation process. National indicators and targets have been specified and will be used for tracking the performance. Data collection and reporting on strategic indicators will be through routine monitoring, operations research, programme reviews and population-level surveys. The set of three core indicators is outlined below.

### Outcome indicators

At the national and county level, outcomes will be measured through polling booth surveys conducted by NASCOP on a biennial basis. The outcome indicators will be:

- Proportion of KVPs experiencing symptoms of specified mental health disorders (depression, anxiety, gender dysphoria, substance-related disorder, suicidal attempts/self-harm and PTSD).
- Proportion of KVPs receiving support for mental health symptoms.

### Output indicators

Mental health-related output indicators will be tracked in the KP programme through monthly reports (MoH 731 plus) submitted by all implementers. The monthly report will track the following indicators at the national and county level:

- Number of KPs screened for mental health disorders (community and facility).
- Number of KPs diagnosed with mental health disorders.
- Number of KPs treated for mental health disorders.

### Process indicators

At the implementing partner level, mental health support activities will be monitored at community and facility level.

At the community level the partners will monitor: a) number of KVPs screened for mental health disorders; b) number of KVPs provided front-line support; c) number of KVPs referred to the facility. The quality of interaction between community health workers and KVPs will be also monitored by outreach workers.

At the facility level partners will monitor: a) number of KVPs screened; b) number of KVPs diagnosed with mental health disorders by type of disorder; c) number of diagnosed KVPs treated for mental health disorders by type of treatment; d) proportion change in AUDIT/ ASSIST/ PHQ9 scores. (See Annexures 3c and 3h)

## 6.2 Roles of the staff in M&E

### Community health workers (peer educators and CHVs)

Filling in the screening form and submitting it to the outreach worker/supervisor.
Documenting the number of KPs who received psychoeducation through the peer calendar.
Completing the client referral form for those who need referral to a facility post screening.

### Outreach worker/ supervisor

Consolidating peer calendars and developing ORW summary report.
Validating feedback from client referral forms.

### Clinician

Filling in the clinical screening tool accurately.
Filling in the applicable forms in client files.
Documentation of all services provided using the clinic visit form.
Documentation of referral for specialised services and follow-ups made.
Data feedback meetings on service provision with community team and facility team.

### M&E staff

Validation of data against source documents.
Accurate and timely compilation of reports (monthly and quarterly) and submission.
Monthly analysis of outputs.
Conduct of routine data quality assessments.
Conduct of weekly or monthly data review meetings with community and facility teams.

# Annexures

## Annexure 1: History-taking in mental health

**Presenting complaint**
- Establish main symptom or reason that the person is seeking care.
- Ask when, why and how the problem started. It is important at this stage to gather as much information as possible about the person's symptoms and situation.

**Past psychiatric history**
- Ask about similar problems in the past, any psychiatric hospitalisations or medications prescribed for mental disorders, and any past suicide attempts.

**Past substance use history**
- Ask about past and current tobacco, alcohol and substance use.
- Ask about frequency, mode of use and circumstances of use. Ask about impact of substance use on their relationships and daily activities.

**General health history**
- Ask about physical health problems and medications.
- Obtain a list of current medications.
- Ask about allergies to medications.

**Family history of mental disorders**
- Explore possible family history of mental health disorders and ask if anyone had similar symptoms or has received treatment for a disorder.

**Psychosocial history**
- Ask about current stressors, coping methods and social support.
- Ask about current socio-occupational functioning (how the person is functioning at home, work and in relationships).
- Obtain basic information including where the person lives, level of education, work/employment history, marital status, number/ages of children, income and household structure/living conditions.

**Sexual and gender identity history**
- Ask about perceived sexual and gender identity in relation to mental disturbance.
- Ask about the person's sexual and gender identity history in relation to daily interaction.

**Physical examination**
- Conduct a targeted physical examination guided by the information found during the assessment.

**Mental status examination**
- Ask about and observe the person for any perceptual and cognition disturbances.
- Appearance – This is based on what you see as the clinician.
- Behaviour – Note eye contact (poor, good or piercing), psychomotor activity, agitation for example, hand wringing).
- Movements
- Speech – Rate, rhythm, volume and content.
- Mood – The prevalent emotional state the patient tells you he or she feels.
- Affect – The emotional state you observe.
- Thought process – The rate of thoughts, how they flow and how they are connected.

**Differential diagnosis**
- Consider the differential diagnosis – that is, all possible conditions suggested by the history-taking – and rule out conditions that have similar presenting symptoms.

**Identifying the mental health disorder**
- Identify the disorder.
- Assess for other symptoms and priority conditions.
- Follow the appropriate management algorithm and treatment protocols.

## Annexure 2: Screening Tool for Use in the Community

## Community Quick Screening Tool (QST) for mental disorders

| | | |
|---|---|---|
| 1. Over the **past two weeks** have you been bothered by these problems? (Report the score for each question) | | |
| 1.a | Feeling nervous, anxious or on edge | Not at all (0)<br>1 - 4 days (1)<br>5 - 9 days (2)<br>10 - 14 days (3) |
| 1.b | Not being able to control worrying | Not at all (0)<br>1- 4 days (1)<br>5 - 9 days (2)<br>10 - 14 days (3) |
| 1.c | Feeling down, depressed or hopeless | Not at all (0)<br>1 - 4 days (1)<br>5 - 9 days (2)<br>10 - 14 days (3) |
| 1.d | Little interest or pleasure in doing things | Not at all (0)<br>1 - 4 days (1)<br>5 - 9 days (2)<br>10 - 14 days (3) |
| 2. Over the past **two weeks**, have you thought about harming yourself? | | |
| | | No (0)<br>Yes (2) |
| 3. In the past, did you **ever** attempt suicide? | | |
| | | No (0)<br>Yes (2) |
| 4. How often do you take drugs/a drink containing alcohol? | | |
| | | Not at all (0)<br>Monthly or less (1)<br>2 - 4 times a month (2)<br>2 - 3 times a week (3)<br>4 or more times a week (4) |
| 5. How many drugs do you use or alcoholic drinks do you take on a typical day when you take drugs or drink? | | |
| | | 1 or 2 (0)<br>3 or 4 (1)<br>5 or 6 (2)<br>7 or 9 (3)<br>10 or more (4) |

| | |
|---|---|
| 6. Have you been exposed to (that is, experienced or witnessed) a potentially traumatic event? This includes acts of violence, an accident or injury to yourself/others. | |
| | No (0)<br>Yes (2) |
| 7. How much time has passed since the traumatic event? | |
| | 0 - 3 days (0)<br>3 days - a month (2)<br>More than one month (4) |
| 8. Do you feel your gender identity is at odds with your biological sex? | |
| | No (0)<br>Yes (2) |
| 9. Do you wish that the people in your life would treat you the same way they treat males (if your assigned gender is female) or the way they treat females (if your assigned gender is male)? | |
| | No (0)<br>Yes (2) |

**Global score:** _____ **If any score is more than 2 = QST-positive**

Refer all persons positive on the QST for mental health assessment.
If you wish to refer a person for mental health assessment despite QST-negative result, explain why:

**Interpretation**
Question 1 a and b: Screen for anxiety
Question 1 c and d: Screen for depression
Question 2 and 3: Screen for self-harm and suicide attempts
Question 4 and 5: Screen for substance use disorders
Question 6 and 7: Screen for acute and post-traumatic stress disorder
Question 8 and 9: Screen for gender dysphoria

## Screening Tools for Use in Facilities

## Annexure 3a: Gender dysphoria test

Below is a list of questions[5] that relate to life experiences common among adolescents and adults diagnosed with gender dysphoria. **Positive answers to two or more** of the items below, indicating the person has experienced the specified thoughts or exhibited the listed behaviours for at least the **past six months**, meet diagnostic criteria for gender dysphoria in adults and adolescents (that is, young people who have passed puberty).

| | |
|---|---|
| Do you feel your gender identity is at odds with your biological sex? | ☐ Yes<br>☐ No |
| Do you dislike your genitals and secondary sex characteristics (such as facial hair or breasts) of your assigned gender? | ☐ Yes<br>☐ No |
| Would you be happier if you had the primary or secondary sex characteristics of the opposite gender? For example, have you considered procedures to physically alter your sexual characteristics? | ☐ Yes<br>☐ No |
| Do you have a desire to be of the other gender or some alternative gender different from your assigned gender? | ☐ Yes<br>☐ No |
| Do you wish that the people in your life would treat you the same way they treat males (if your assigned gender is female) or females (if your assigned gender is male)? | ☐ Yes<br>☐ No |
| Are you experiencing distress or difficulties in social, occupational or other important areas of functioning as a result of the disconnect you experience between your natural gender and your expressed/preferred gender? | ☐ Yes<br>☐ No |

[5] https://www.psycom.net/adult-gender-dysphoria-test/

## Annexure 3b: Generalised Anxiety Disorder Assessment (GAD-7)

The seven-item Generalised Anxiety Disorder Assessment (GAD-7) is used to perform initial screening. The GAD-7 score is obtained by adding the score for each question to yield total points across the tool.

| Over the **last two weeks,** how often have you been bothered by the following problems? | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | +1 | +2 | +3 |
| 2. Not being able to stop worrying or control worrying | 0 | +1 | +2 | +3 |
| 3. Worrying too much about different things | 0 | +1 | +2 | +3 |
| 4. Trouble relaxing | 0 | +1 | +2 | +3 |
| 5. Being so restless that it is hard to sit still | 0 | +1 | +2 | +3 |
| 6. Becoming easily annoyed or irritable | 0 | +1 | +2 | +3 |
| 7. Feeling afraid – as if something awful might happen | 0 | +1 | +2 | +3 |

**Interpretation**
When screening for anxiety disorders, a score of 8 or greater represents a reasonable cut-off point for identifying probable generalised anxiety disorder. In such instances, further diagnostic assessment is warranted to confirm the presence of anxiety disorder and determine the type of anxiety disorder. Using a cut-off of 8 points, the GAD-7 has a sensitivity of 92% and specificity of 76% for diagnosis of generalised anxiety disorder.

The following cut-offs correlate with the severity of anxiety:
- Score 0 - 4: Minimal anxiety
- Score 5 - 9: Mild anxiety
- Score 10 - 14: Moderate anxiety
- Score greater than 15: Severe anxiety

[5] https://www.psycom.net/adult-gender-dysphoria-test/

## Annexure 3c: Patient Health Questionnaire-9 for Depression Screening (PHQ-9)

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. The PHQ-9 score is obtained by adding the score for each question to produce the total points for the individual.

| Over the **last two weeks**, how often have you been bothered by the following problems? | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | +1 | +2 | +3 |
| 2. Feeling down, depressed or hopeless | 0 | +1 | +2 | +3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | +1 | +2 | +3 |
| 4. Feeling tired or having little energy | 0 | +1 | +2 | +3 |
| 5. Poor appetite or overeating | 0 | +1 | +2 | +3 |
| 6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down | 0 | +1 | +2 | +3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | +1 | +2 | +3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | +1 | +2 | +3 |
| 9. Beliefs that you would be better off dead or of hurting yourself in some way | 0 | +1 | +2 | +3 |

**Interpretation**

Provisional diagnosis and proposed treatment actions

| **PHQ-9 Score** | **Depression severity** | **Proposed treatment actions** |
|---|---|---|
| 0 - 4 | None-minimal | None |
| 5 - 9 | Mild | Watchful waiting. Repeat PHQ-9 at follow-up |
| 10 - 14 | Moderate | Treatment plan, considering counselling, follow-up and/or pharmacotherapy |
| 15 - 19 | Moderately severe | Active treatment with pharmacotherapy and/or psychotherapy |
| 20 - 27 | Severe | Immediate initiation of pharmacotherapy and, if there is severe impairment or a poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management |

## Annexure 3d: Primary Care PTSD Screen DSM-5 (PC-PTSD-5)

The primary care PTSD Screen DSM-5 (PC-PTSD-5) is designed to identify persons with probable PTSD. Available data suggest the PC-PTSD-5 screen should be considered "positive" if the respondent answers "yes" to **any three items** in the questions listed below. Those screening positive should be further assessed for PTSD through a structured interview, preferably performed by a mental health professional who has experience in diagnosing PTSD.

**Introductory explanation to client**
Sometimes things happen to people that are unusually frightening, horrible or traumatic.
For example:

- A physical or sexual assault or abuse.
- Seeing someone being killed or seriously injured.
- Having a loved one die through homicide or suicide.
- A serious accident or fire.
- An earthquake or flood.
- A war

If the answer to all the above is "no", please stop here. The screen total is 0.

If you have **ever experienced** this type of event, please answer the following:

**In the past month have you:**

| | Yes | No |
|---|---|---|
| 1. 1. Had nightmares about the event(s) or thought about the event(s) when you did not want to? | | |
| 2. Tried hard not to think about the event(s) or gone out of your way to avoid situations that reminded you of the event(s) | | |
| 3. Been constantly on guard, watchful or easily startled? | | |
| 4. Felt numb or detached from people, activities or your surroundings? | | |
| 5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? | | |

## Annexure 3e: Drug Abuse Screening Test (DAST-10)

The Drug Abuse Screening Test (DAST-10) is a 10-item tool that can be administered by a clinician or self-administered. Each question requires a "yes" or "no" response, and the tool can be completed in less than eight minutes. This tool only assesses drug use and does not include alcohol or tobacco use.

**Introductory explanation to client**
I'm going to read you a list of questions concerning your potential involvement with drugs, **excluding** alcohol and tobacco, during the **past 12 months**.

When the words "drug abuse" are used, they mean (1) the use of prescribed or over-the-counter medications/drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (marijuana or hash), solvents, tranquillisers (like Valium), barbiturates, cocaine, stimulants (speed), hallucinogens (such as LSD) or narcotics (such as heroin). Remember that the questions **do not include** alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right.

You may choose whether to **answer or not answer** any of the questions.

| **These questions refer to the past 12 months** | **No** | **Yes** |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons? | 0 | 1 |
| 2. Do you abuse more than one drug at a time? | 0 | 1 |
| 3. Are you always able to stop using drugs when you want to?(If you never use drugs answer "yes") | 0 | 1 |
| 4. Have you ever had "blackouts" or "flashbacks" as a result of drug use? | 0 | 1 |
| 5. Do you ever feel bad or guilty about your drug use? (If you never use drugs choose "no") | 0 | 1 |
| 6. Does your spouse (or do your parents) ever complain about your involvement with drugs? | 0 | 1 |
| 7. Have you neglected your family because of your use of drugs? | 0 | 1 |
| 8. Have you engaged in illegal activities in order to obtain drugs? | 0 | 1 |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | 0 | 1 |
| 10. Have you had medical problems as a result of your drug use (for example, memory loss, hepatitis, convulsions or bleeding)? | 0 | 1 |

## Annexure 3f: Alcohol use disorders identification test (AUDIT)

AUDIT is a comprehensive 10-question alcohol harm screening tool. It was developed by the World Health Organization (WHO) and modified for use in the UK. It has been used in a variety of health and social care settings.

| Questions | Scoring system | | | | | Your score |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times a month | 2 to 3 times a week | 4 times or more a week | |
| How many units of alcohol do you drink on a typical day when you are drinking? | 0 to 2 | 3 to 4 | 5 to 6 | 7 to 9 | 10 or more | |
| How often have you had 6 or more units, if female, or 8 units, if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you failed to do what was normally expected of you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| Have you or somebody else been injured as a result of your drinking? | No | | Yes, but not in last year | | Yes, during the last year | |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No | | Yes, but not in last year | | Yes, during the last year | |

**Total AUDIT score:**

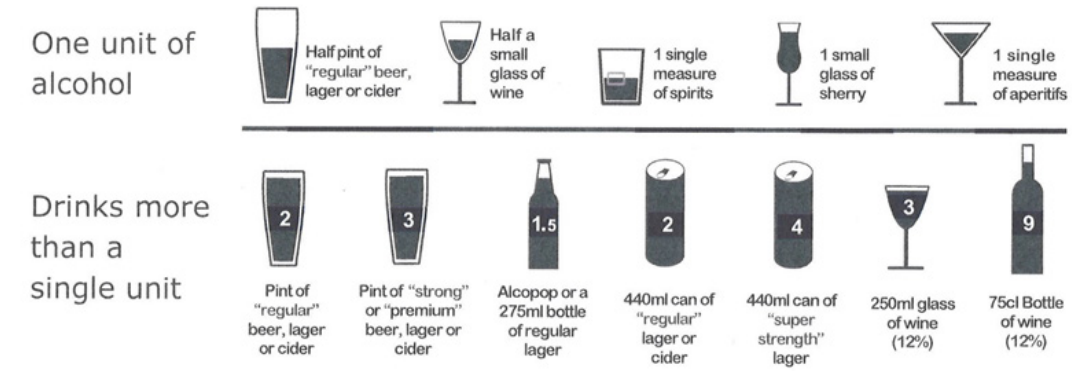
**Scoring**

- 0 to 7 indicates low risk
- 8 to 15 indicates increasing risk
- 16 to 19 indicates higher risk
- 20 or more indicates possible dependence

**Giving feedback and advice**

- If the score is lower than 8 provide feedback. No further action is needed.
- If the score is 8 or above, give brief advice to reduce risk for alcohol harm.
- If the score is 20 or above, consider referral to a specialist alcohol harm assessment.

**Alcohol unit reference**



## Annexure 3g: ASSIST tool (Modified for drug-use screening)

| Patient name: | Date of birth: |
|---|---|
| _____ | _____ |

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is designed to be administered by a health professional as part of a verbal interview with an adult patient. Alternatively, it can be self-administered electronically, applying automatic skip patterns based on patient answers.

The ASSIST can be modified according to the substances that are screened for and the language used to describe these substances. This version screens for non-medical drug use only, and uses language that defines misuse of three types of prescription drugs.

**Sample introductory text**
*"Thank you for taking part in this brief interview about recreational drug use. I'm going to ask some questions about your experience using these substances in your life and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills."*

**Question 1**

| | No | Yes |
|---|---|---|
| In your life, which of the following substances have you **ever** used? | | |
| 1. Cannabis (marijuana, pot, grass, hash, etc) | 0 | 3 |
| 2. Cocaine (coke, crack, etc) | 0 | 3 |
| 3. Prescription stimulants, more for the feeling than prescribed use, or ones that were not prescribed for you (Ritalin, Adderall, diet pills, etc) | 0 | 3 |
| 4. Methamphetamine (meth, crystal, speed, ecstasy, molly, etc) | 0 | 3 |
| 5. Inhalants (nitrous oxide, glue, paint thinner, poppers, whippets, etc) | 0 | 3 |
| 6. Sedatives, just for the feeling more than prescribed use, or ones that were not prescribed for you (sleeping pills, Valium, Xanax, tranquillisers, benzos, etc) | 0 | 3 |
| 7. Hallucinogens (LSD, acid, mushrooms, PCP, special K, ecstasy, etc) | 0 | 3 |
| 8. Street opioids (heroin, opium, etc) | 0 | 3 |
| 9. Prescription opioids, just for the feeling more than prescribed use, or those that were not prescribed for you (Fentanyl, Oxycodone, OxyContin, Percocet, Vicodin, methadone, Buprenorphine, etc) | 0 | 3 |
| 10. Any other drugs to get high. Specify | 0 | 3 |

*Patients who answer "no" to all questions, or who do not provide any answers, are done. Patients who answer "yes" to any question should proceed to Question 2.*

**Question 2**

| In the **past three months,** how often have you used the substances you mentioned? [FIRST DRUG, SECOND DRUG, ETC] | **Never** | **Once or twice** | **Monthly** | **Weekly** | **Daily or almost daily** |
|---|---|---|---|---|---|
| [FIRST DRUG] | 0 | 2 | 3 | 4 | 6 |
| [SECOND DRUG] | 0 | 2 | 3 | 4 | 6 |
| [THIRD DRUG] | 0 | 2 | 3 | 4 | 6 |
| [ETC] | 0 | 2 | 3 | 4 | 6 |

*Patients who answer "never" for all drugs on question 2, or who do not provide any answers, should skip to Question 6. All other patients proceed to Question 3.*

**Question 3**

| During the **past three months**, how often have you had a strong desire or urge to use [FIRST DRUG, SECOND DRUG, ETC]? | **Never** | **Once or twice** | **Monthly** | **Weekly** | **Daily or almost daily** |
|---|---|---|---|---|---|
| [FIRST DRUG] | 0 | 3 | 4 | 5 | 6 |
| [SECOND DRUG] | 0 | 3 | 4 | 5 | 6 |
| [THIRD DRUG] | 0 | 3 | 4 | 5 | 6 |
| [ETC] | 0 | 3 | 4 | 5 | 6 |

**Question 4**

| During the **past three months** how often has your use of [FIRST DRUG, SECOND DRUG, ETC] led to health, social, legal or financial problems? | **Never** | **Once or twice** | **Monthly** | **Weekly** | **Daily or almost daily** |
|---|---|---|---|---|---|
| [FIRST DRUG] | 0 | 4 | 5 | 6 | 7 |
| [SECOND DRUG] | 0 | 4 | 5 | 6 | 7 |
| [THIRD DRUG] | 0 | 4 | 5 | 6 | 7 |
| [ETC] | 0 | 4 | 5 | 6 | 7 |

**Question 5**

| During the **past three months** how often have you failed to do what was expected of you because of your use of [FIRST DRUG, SECOND DRUG, ETC] | **Never** | **Once or twice** | **Monthly** | **Weekly** | **Daily or almost daily** |
|---|---|---|---|---|---|
| [FIRST DRUG] | 0 | 5 | 6 | 7 | 8 |
| [SECOND DRUG] | 0 | 5 | 6 | 7 | 8 |
| [THIRD DRUG] | 0 | 5 | 6 | 7 | 8 |
| [ETC] | 0 | 5 | 6 | 7 | 8 |

**Question 6**

| Has a friend or relative or anyone else **ever** expressed concern about your use of [FIRST DRUG, SECOND DRUG, ETC.]? | **No, never** | **Yes, in the past three months** | **Yes, but not in the past three months** |
|---|---|---|---|
| [FIRST DRUG] | **0** | **6** | **3** |
| [SECOND DRUG] | **0** | **6** | **3** |
| [THIRD DRUG] | **0** | **6** | **3** |
| [ETC] | **0** | **6** | **3** |

**Question 7**

| Have you **ever** tried and failed to control, cut down or stop using [FIRST DRUG, SECOND DRUG, ETC.]? | **No, never** | **Yes, in the past three months** | **Yes, but not in the past three months** |
|---|---|---|---|
| [FIRST DRUG] | **0** | **6** | **3** |
| [SECOND DRUG] | **0** | **6** | **3** |
| [THIRD DRUG] | **0** | **6** | **3** |
| [ETC] | **0** | **6** | **3** |

**Question 8**

| Have you **ever** used any drug by injection? (Non-medical use only) | **No, never** | **Yes, in the past three months** | **Yes, but not in the past three months** |
|---|---|---|---|
| | | | |

*Patients who answer "Yes, in the past 3 months" for Question 8 should be asked the two extra drug injection questions below. All other patients are finished.*

**Extra drug injection questions**

| | | |
|---|---|---|
| During the **past three months**, how often have you injected drugs? | Once a week or less | More than once a week |
| During the **past three months**, have you ever injected drugs three or more days in a row? | Yes | No |

**Score sheet and indicated responses**

| **Substance** | **Total score on questions 1 - 7 for each substance** |
|---|---|
| Cannabis | |
| Cocaine | |
| Prescription stimulants | |
| Methamphetamine | |
| Inhalents | |
| Sedatives | |
| Hallucinogens | |
| Street opioids | |
| Prescription opioids | |
| Other drugs | |

**Indicated responses to scores**

| **Score** | **Indicated response** |
|---|---|
| 0 - 3<br>(0 - 4 for cannabis) | **Brief education** |
| 4 - 26<br>(5 - 26 for cannabis) | **Brief intervention** |
| 27+ | **Brief intervention (Offer other interventions that include treatment)** |

Note: Patients who have injected drugs (for non-medical use) in the last three months, but no more than once per week or never more than three days in a row, should receive a brief intervention. All other patients who have injected drugs in the last three months should receive a brief intervention that includes options for treatment.

**Brief education:** Inform patients about the risks of illicit drug use and signs of a substance use disorder.

**Brief intervention:** Patient-centered discussion that employs motivational interviewing concepts to raise a patient's awareness of his/her substance use and enhances motivation to change this use. Brief interventions are typically performed in 3 - 15 minutes, and the first should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention.

If a patient is ready to accept treatment, a referral is a proactive process that facilitates access to specialised care for individuals probably experiencing a substance use disorder. These patients are referred to alcohol and drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. Treatment may also include prescribing medication for substance use disorder as part of the patient's normal primary care.

Based on: Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V and Monteiro M (2010). The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Manual for Use in Primary Care. Geneva, World Healh Organization

More resources: www.sbirtoregon.org

## Annexures 3h-3i: Tools for self-use by healthcare providers

## Annexure 3h: Maslach Burnout Inventory (MBI)

The Maslach Burnout Inventory (MBI) is a tool to self-assess whether you might be at risk of burnout. The MBI explores three aspects of burnout: exhaustion, depersonalisation and personal achievement. While this tool may be useful, it must not be used as a scientific diagnostic technique, regardless of the results. The objective is simply to make you aware that you, like anyone, may be at risk of burnout.

For each question, indicate the score that corresponds to your response. Add up your score for each section and compare your results with the results interpretation at the bottom of this document.

| **Questions** | **Never** | **A few times a year** | **Once a month** | **A few times per month** | **Once a week** | **A few times per week** | **Every day** |
|---|---|---|---|---|---|---|---|
| | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| **SECTION A: EXHAUSTION** | | | | | | | |
| I feel emotionally drained by my work<br><br>Working with people all day long requires a great deal of effort<br><br>I feel like my work is breaking me down<br><br>I feel frustrated by my work<br><br>I feel I work too hard at my job<br><br>It stresses me too much to work in direct contact with people<br><br>I feel like I'm at the end of my rope | | | | | | | |
| **Total score – SECTION A** | | | | | | | |
| **SECTION B: DEPERSONALISATION** | | | | | | | |
| I feel I look after certain patients/ clients impersonally, as if they are objects<br><br>I feel tired when I get up in the morning and have to face another day at work<br><br>I have the impression that my patients/clients make me responsible for some of their problems<br><br>I am at the end of my patience at the end of my workday | | | | | | | |

| Questions | Never | A few times a year | Once a month | A few times per month | Once a week | A few times per week | Every day |
|---|---|---|---|---|---|---|---|
| I really don't care about what happens to some of my patients/ clients<br><br>I have become more insensitive to people since I've been working<br><br>I'm afraid that this job is making me uncaring | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| **Total score – SECTION B** | | | | | | | |
| **SECTION C: ACHIEVEMENT** | | | | | | | |
| I accomplish many worthwhile things in this job<br><br>I feel full of energy<br><br>I am easily able to understand what my patients/clients feel<br><br>I look after my patients'/clients' problems very effectively<br><br>In my work, I handle emotional problems very calmly<br><br>Through my work, I feel that I have a positive influence on people<br><br>I am easily able to create a relaxed atmosphere with my patients/clients<br><br>I feel refreshed when I have been close to my patients/clients at work | | | | | | | |
| **Total score – SECTION C** | | | | | | | |

**Interpretation of results**

**Section A: Exhaustion**
Burnout (or depressive anxiety syndrome) may be present if the individual testifies to fatigue at the very idea of work, chronic fatigue, trouble sleeping and physical problems.
For the MBI, exhaustion is a key component of the syndrome. Unlike depression, the problems disappear outside work.

A total score of 17 or less: Low-level burnout.
A total score between 18 and 29 inclusive: Moderate burnout.
A total score of 30 or greater: High-level burnout.

**Section B: Depersonalisation**
Depersonalisation or a loss of empathy can also be described as "dehumanisation" in interpersonal relations. The notion of detachment is excessive, leading to cynicism with negative attitudes to patients or colleagues, feelings of guilt, avoidance of social contacts, and withdrawing into oneself. The professional blocks the empathy s/he can show to patients and/or colleagues.

A total score of 5 or less: Low-level burnout.
A total score between 6 and 11 inclusive: Moderate burnout.
A total score of 12 and greater: High-level burnout.

**Section C: Personal achievement**
Burnout sees a reduction in a sense of personal achievement. The individual assesses himself or herself negatively and feels unable to move the situation forward. This component represents the demotivating effects of a difficult, repetitive situation leading to failure despite efforts. The person begins to doubt his or her genuine ability to accomplish things.

A total score of 33 or less: High-level burnout.
A total score between 34 and 39 inclusive: Moderate burnout.
A total score of 40 or greater: Low-level burnout.

In sum: A high score in the first two sections and a low score in the last section may indicate burnout.

**Note:** People react to stress and burnout differently. This test is not intended to be a scientific analysis or assessment. The information is not designed to diagnose or treat your stress or symptoms of burnout. Consult your medical doctor, counsellor or mental health professional if you feel that you need help regarding stress management or dealing with burnout.

## Annexure 3i: Stigma Attribution Questionnaire (AQ-27)

Please read the following statement about Harry

*Harry is a 30-year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He has been hospitalised six times because of his illness.*

Please answer each of the following questions about Harry. Circle the number that best matches your answer to each question.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| I would feel aggravated by Harry | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| I would feel unsafe around Harry | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| Harry would terrify me | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| How angry would you feel at Harry? | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| If I were in charge of Harry's treatment, I would require him to take his medication | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| I think Harry poses a risk to his neighbours unless he is hospitalised | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| If I were an employer, I would interview Harry for a job | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| I would be willing to talk to Harry about his problems | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| I would feel pity for Harry | 1<br>None at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| I would think it was Harry's own fault that he was in the present condition | 1<br>Not at all under personal control | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Completely under personal control |
| How controllable, do you think, is the cause of Harry's condition? | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| How irritated would you feel by Harry? | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| How dangerous would you feel Harry is? | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| How much do you agree that Harry should be forced into treatment with his doctor even if he doesn't want to? | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |
| I think it would be best for Harry's community if he were put away in a psychiatric hospital | 1<br>Not at all | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9<br>Very much |

| | |
|---|---|
| I would share a car pool with Harry every day | 1 2 3 4 5 6 7 8 9<br>Not likely Very likely |
| How much do you think an asylum, where Harry can be kept away from neighbours, is the best place for him? | 1 2 3 4 5 6 7 8 9<br>Not at all Very much |
| I would feel threatened by Harry | 1 2 3 4 5 6 7 8 9<br>Not at all Very much |
| How scared of Harry would you feel? | 1 2 3 4 5 6 7 8 9<br>Not at all Very much |
| How likely is it that you would help Harry? | 1 2 3 4 5 6 7 8 9<br>Definitely would not help Definitely would help |
| How certain would you feel that you would help Harry? | 1 2 3 4 5 6 7 8 9<br>Not certain at all Absolutely certain |
| How much sympathy would you feel for Harry? | 1 2 3 4 5 6 7 8 9<br>None at all Very much |
| How responsible, do you think, is Harry for his present condition? | 1 2 3 4 5 6 7 8 9<br>Not at all Very much |
| How frightened of Harry would you feel? | 1 2 3 4 5 6 7 8 9<br>Not at all Very much |
| If I were in charge of Harry's treatment, I would force him to live in a group house | 1 2 3 4 5 6 7 8 9<br>Not at all Very much |
| If I were a landlord, I probably would rent an apartment to Harry | 1 2 3 4 5 6 7 8 9<br>Not likely Very likely |
| How much concern would you feel for Harry? | 1 2 3 4 5 6 7 8 9<br>None at all Very much |

**Scoring the AQ-27**

The AQ consists of 9 factors, which are scored by summing the items as outlined below:

**Responsibility =** AQ10+ AQ11 +AQ23
**Pity =** AQ9 + AQ22 + AQ27
**Anger =** AQ1 + AQ4 + AQ12
**Dangerousness =** AQ2 + AQ13 + AQ18
**Fear =** AQ3 + AQ19 + AQ24
**Help =** AQ8 + AQ20 + AQ21
**Coercion =** AQ5 + AQ14 + AQ25
**Segregation =** AQ6 + AQ15 + AQ17
**Avoidance =** AQ7 + AQ16 + AQ26

The higher the score, the more that factor is endorsed by the subject. Note the reversals in scoring items AQ7, AQ16 and AQ26.

**Assessment by**
Patrick W. Corrigan, Psy.D. University of Chicago Center for Psychiatric Rehabilitation 7230 Arbor Drive. Tinley Park, IL 60447 www.StigmaResearch.org

**Publications**
Corrigan, P.W., Markowitz, F.E., Watson, A.C., Rowan, D., & Kubiak, M.A. (2003). Attribution and Dangerousness Models of Public Discrimination Towards People With Mental Illness. Journal of Health and Social Behavior,44, 162-179.

Corrigan, PW, Watson, AC, Gracia, G. & Warpinski, AC (2003) Ethnic Differences in Stigmatizing Attitudes about Mental Illness. Manuscript submitted to Journal of Social and Clinical Psychology.

Corrigan, PW, Watson, AC, Warpinski, AC & Gracia, G. (2003). Stigmatizing Attitudes about Mental Illness and Allocation of Resources to Mental Health Services. Manuscript submitted to Community Mental Health Journal.

Corrigan, PW, Watson, AC, Warpinski, AC & Gracia, G. (2003) Mental Illness, Violence, and Stigma: Implications for Educating the Public. Manuscript submitted to Psychiatric Services.

*This research was supported by a research infrastructure support program grant from the National Institute of Mental Health (5 R24 MH62198) to Patrick Corrigan.*

**Attribution questionnaire vignettes**

*Condition #1 – no danger.* Harry is a 30-year-old single man with schizophrenia. Although he sometimes hears voices and becomes upset, Harry has never been violent. Like most people with schizophrenia, Harry is no more dangerous than the average person. He lives in an apartment and works as a clerk in a large law firm. His symptoms are usually well managed with the appropriate medication.

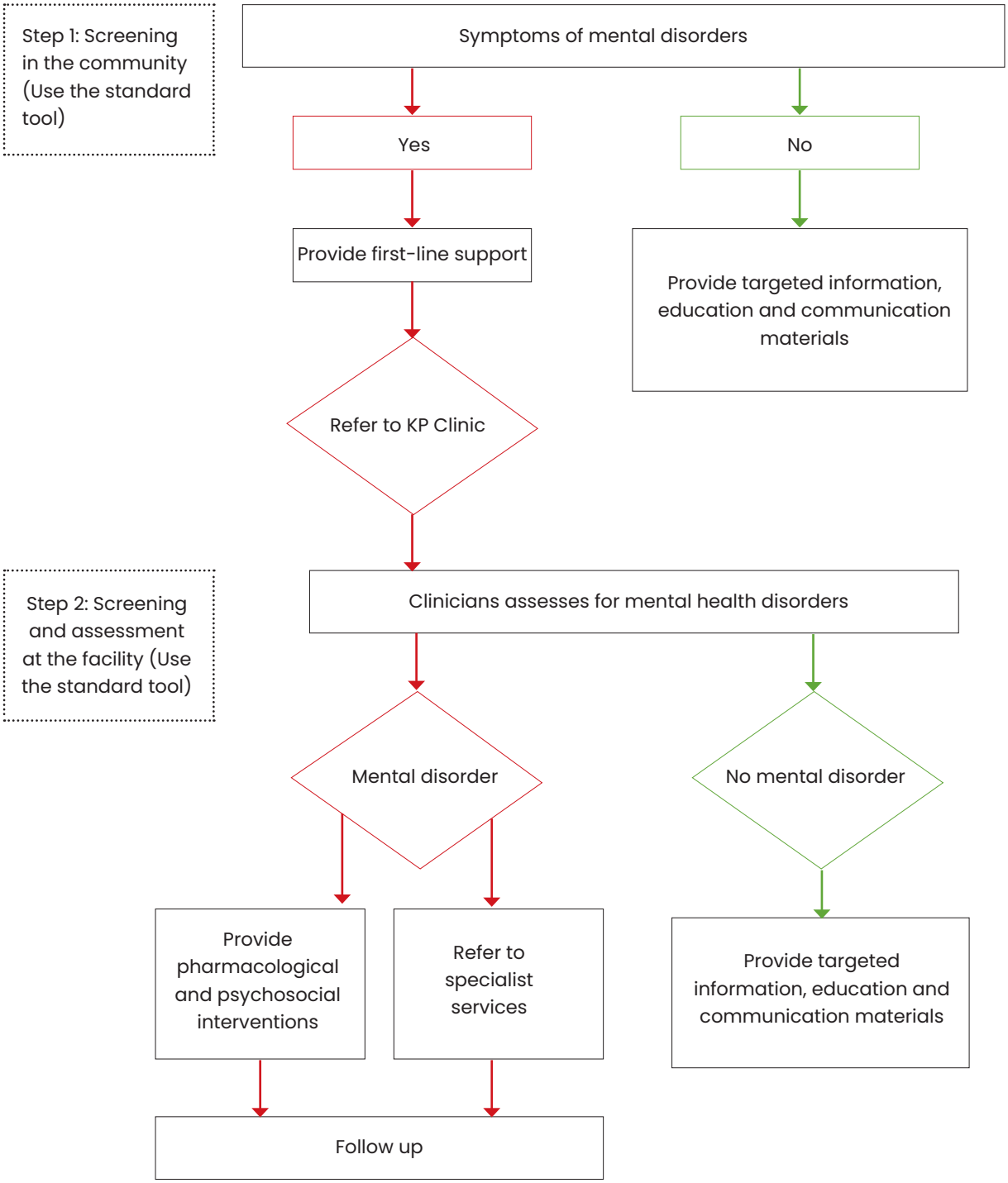
*Condition #2 – danger.* Harry is a 30-year-old single man with schizophrenia. The last time his symptoms got worse, he heard voices and believed his neighbours were planning to hurt him. He attacked his landlady in the belief that she was in on the plot. When the police escorted him to the hospital, he tried to grab the officer's gun. He attacked an orderly in the emergency room and had to be put into restraints. He only quietened down after he was given large doses of medication.

*Condition #3 – danger without controllability of cause.* Harry is a 30-year-old single man with schizophrenia. The last time his symptoms got worse, he heard voices and believed his neighbours were planning to hurt him. He attacked his landlady in the belief that she was in on the plot. When the police escorted him to the hospital, he tried to grab the officer's gun. He attacked an orderly in the emergency room and had to be put into restraints. Harry's mental illness was originally caused by a severe head injury suffered during a car accident when he was 22. The mental illness leads to violence whenever he suffers from migraines, also caused by the accident.

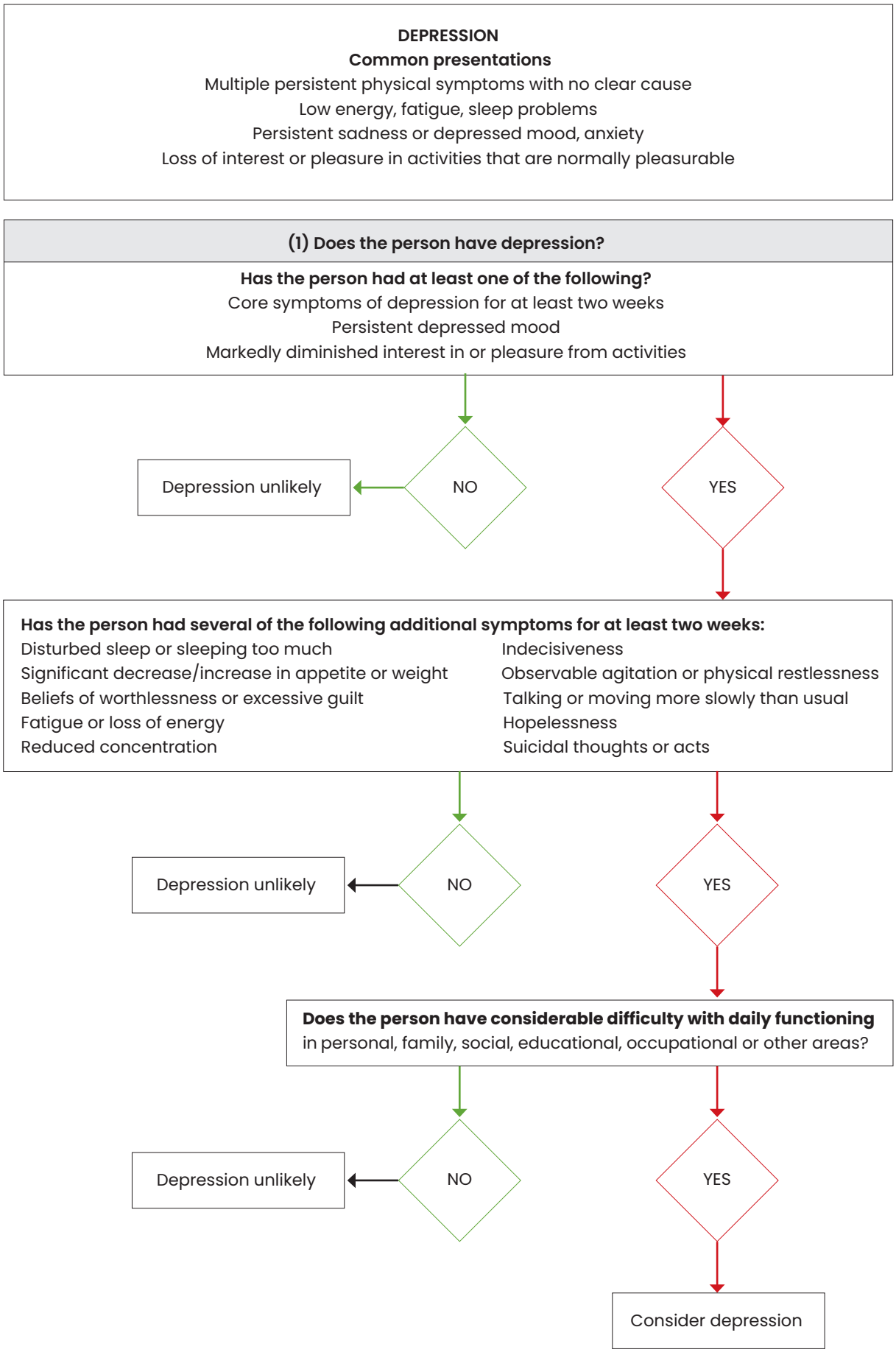
*Condition #4 – danger with controllability of cause.* Harry is a 30-year-old single man with schizophrenia. The last time his symptoms got worse, he heard voices and believed his neighbours were planning to hurt him. He attacked his landlady in the belief that she was in on the plot. When the police escorted him to the hospital, he tried to grab the officer's gun. He attacked an orderly in the emergency room and had to be put into restraints. Harry's mental illness was originally caused by eight years of abusing illegal drugs. The mental illness leads to violence whenever he snorts cocaine.

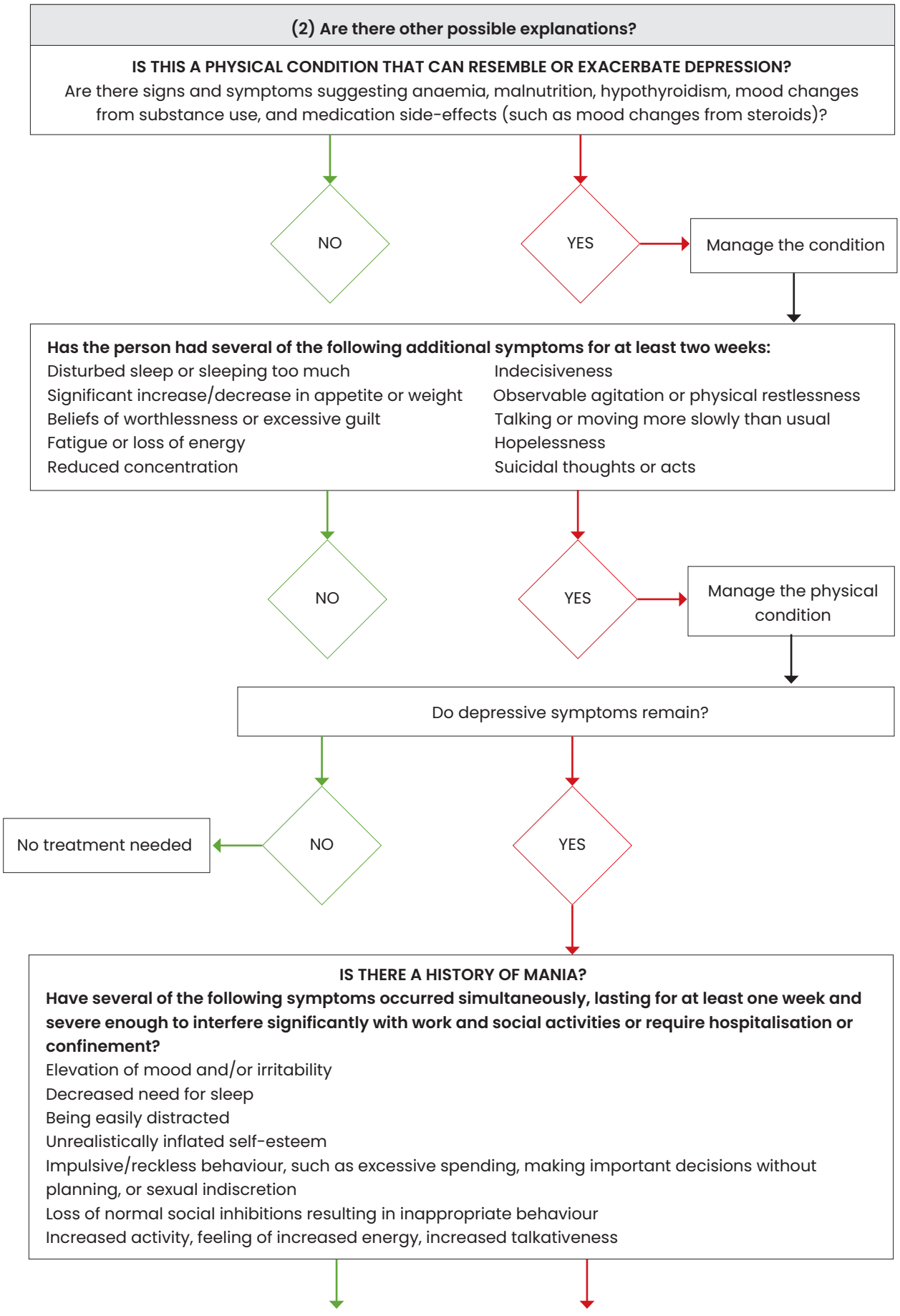
## Annexure 4
## Screening and Assessment Algorithms

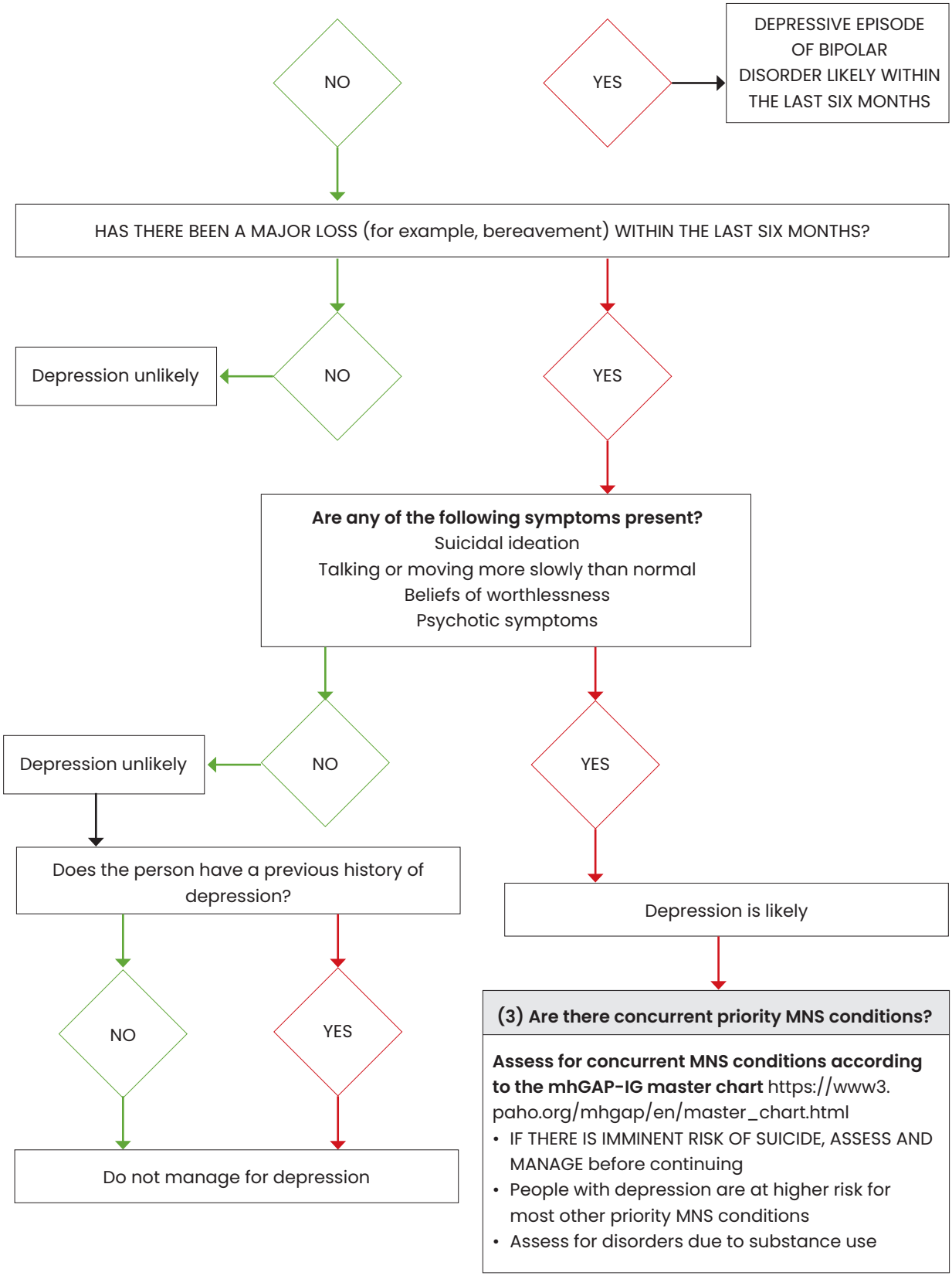
### Annexure 4a: General screening and assessment algorithm for mental disorders



## Annexure 4b: Algorithm for depression




(2) Are there other possible explanations?
IS THIS A PHYSICAL CONDITION THAT CAN RESEMBLE OR EXACERBATE DEPRESSION?
Are there signs and symptoms suggesting anaemia, malnutrition, hypothyroidism, mood changes from substance use, and medication side-effects (such as mood changes from steroids)?
NO
YES
Manage the condition
Has the person had several of the following additional symptoms for at least two weeks:
Disturbed sleep or sleeping too much
Significant increase/decrease in appetite or weight
Beliefs of worthlessness or excessive guilt
Fatigue or loss of energy
Reduced concentration
Indecisiveness
Observable agitation or physical restlessness
Talking or moving more slowly than usual
Hopelessness
Suicidal thoughts or acts
NO
YES
Manage the physical condition
Do depressive symptoms remain?
No treatment needed
NO
YES
IS THERE A HISTORY OF MANIA?
Have several of the following symptoms occurred simultaneously, lasting for at least one week and severe enough to interfere significantly with work and social activities or require hospitalisation or confinement?
Elevation of mood and/or irritability
Decreased need for sleep
Being easily distracted
Unrealistically inflated self-esteem
Impulsive/reckless behaviour, such as excessive spending, making important decisions without planning, or sexual indiscretion
Loss of normal social inhibitions resulting in inappropriate behaviour
Increased activity, feeling of increased energy, increased talkativeness


NO
YES
DEPRESSIVE EPISODE OF BIPOLAR DISORDER LIKELY WITHIN THE LAST SIX MONTHS
HAS THERE BEEN A MAJOR LOSS (for example, bereavement) WITHIN THE LAST SIX MONTHS?
Depression unlikely
NO
YES
Are any of the following symptoms present?
Suicidal ideation
Talking or moving more slowly than normal
Beliefs of worthlessness
Psychotic symptoms
Depression unlikely
NO
YES
Does the person have a previous history of depression?
Depression is likely
NO
YES
(3) Are there concurrent priority MNS conditions?
Assess for concurrent MNS conditions according to the mhGAP-IG master chart https://www3.paho.org/mhgap/en/master_chart.html
• IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing
• People with depression are at higher risk for most other priority MNS conditions
• Assess for disorders due to substance use
Do not manage for depression

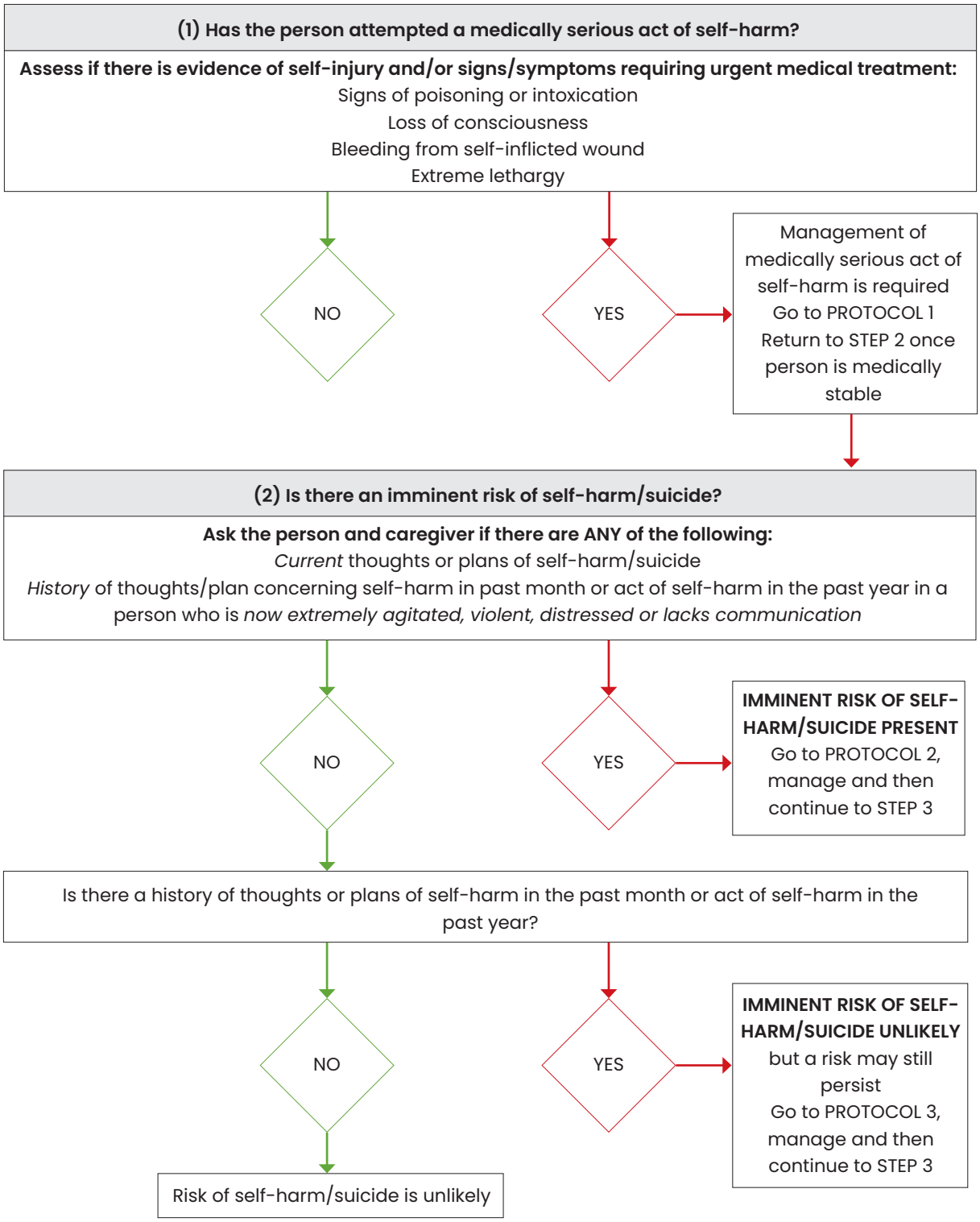
## Appendix 4c: Algorithm for suicide/self-harm

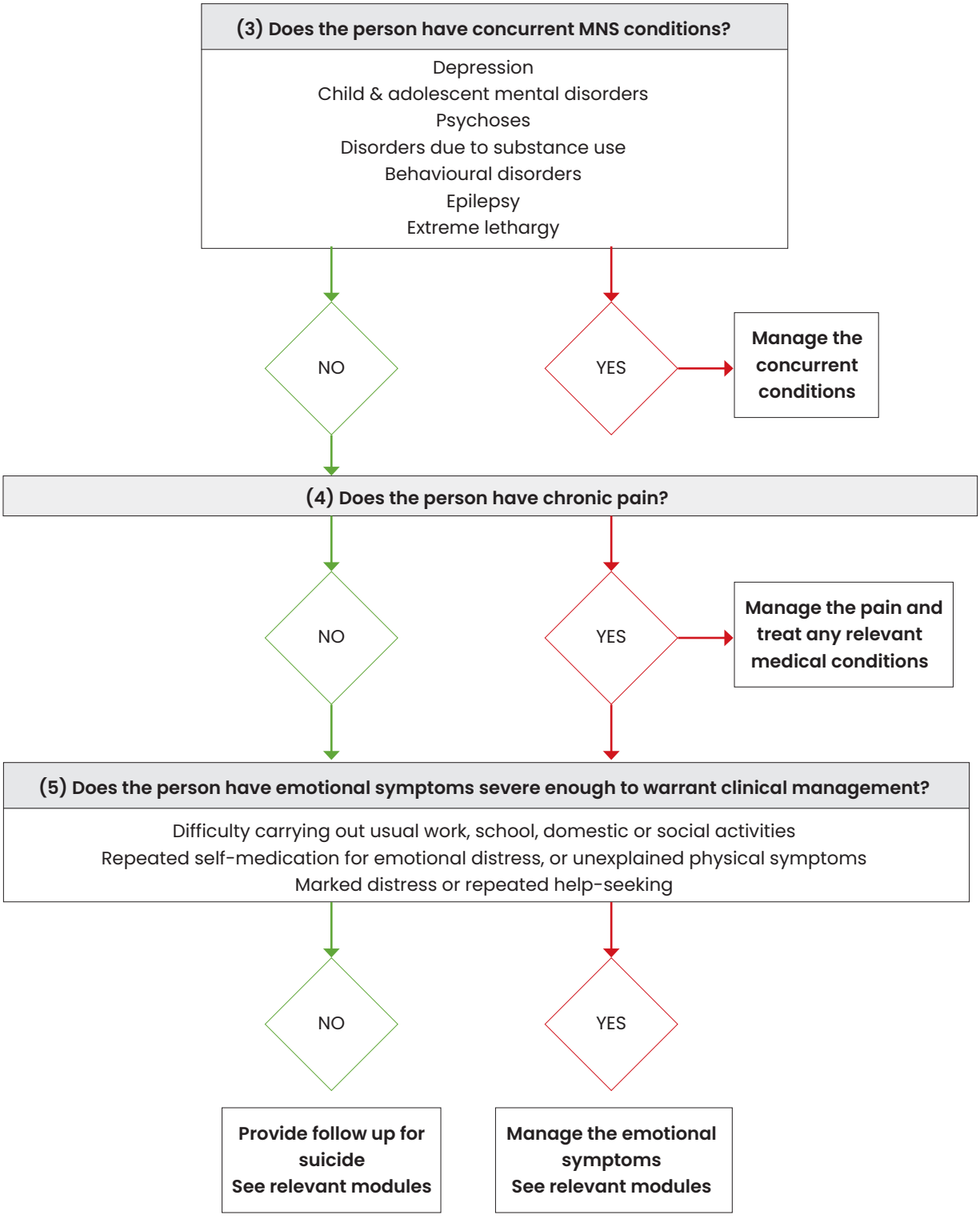
**ASSESS FOR SELF-HARM/SUICIDE IF THE PERSON PRESENTS WITH EITHER:**

Extreme hopelessness and despair, current thoughts/plan/act of self-harm or suicide or history thereof, act of self-harm with signs of poisoning/intoxication, bleeding from self-inflicted wound, loss of consciousness and/or extreme lethargy

OR

Any of the priority MNS conditions, chronic pain or extreme emotional distress




(3) Does the person have concurrent MNS conditions?
Depression
Child & adolescent mental disorders
Psychoses
Disorders due to substance use
Behavioural disorders
Epilepsy
Extreme lethargy
NO
YES
Manage the concurrent conditions
(4) Does the person have chronic pain?
NO
YES
Manage the pain and treat any relevant medical conditions
(5) Does the person have emotional symptoms severe enough to warrant clinical management?
Difficulty carrying out usual work, school, domestic or social activities
Repeated self-medication for emotional distress, or unexplained physical symptoms
Marked distress or repeated help-seeking
NO
YES
Provide follow up for suicide
See relevant modules
Manage the emotional symptoms
See relevant modules

## Protocols for suicide management

| Protocol 1 | Protocol 2 | Protocol 3 |
|---|---|---|
| **Medically serious act of self-harm** | **Imminent risk of self-harm/ suicide** | **Risk of self-harm/suicide** |
| For all cases: Place the person in a secure and supportive environment at a health facility<br><br>DO NOT leave the person alone<br><br>Medically treat injury or poisoning<br><br>If there is acute pesticide intoxication, follow Management of pesticide intoxication https://www.who.int/mental_health/prevention/suicide/pesticides_intoxication.pdf<br><br>If hospitalisation is needed, continue to monitor the person closely to prevent suicide<br><br>Care for the person with self-harm<br><br>Offer and activate psychosocial support<br><br>Offer support to caregiver(s)<br><br>Consult a mental health specialist, if available | Remove means of inflicting self-harm or committing suicide<br><br>Create a secure and supportive environment. If possible, offer a separate, quiet room while waiting for treatment<br><br>DO NOT leave the person alone<br><br>Supervise and assign a named staff or family member to ensure person's safety at all times<br><br>Attend to mental state and emotional distress<br><br>Provide psychoeducation to the person and caregiver(s)<br><br>Offer and activate psychosocial support<br><br>Offer support to caregiver(s)<br><br>Consult a mental health specialist, if available<br><br>Maintain regular contact and follow-up | Offer and activate psychosocial support<br><br>Consult a mental health specialist, if available<br><br>Maintain regular contact and follow-up |

## Appendix 4d: Algorithm for acute stress

**(1) Has the person recently experienced a potentially traumatic event?**

Ask if the person has experienced a potentially traumatic event – that is, any threatening or horrific event such as physical or sexual violence (including domestic violence), witnessing an atrocity, or major accidents or injuries. Consider asking:
What major stress have you experienced?
Has your life been in danger?
Have you experienced something that was very frightening or horrific or has made you feel very bad?
(If yes) ask how much time has passed since the event(s)
Do you feel safe at home?

NO

YES

Go to assessment question 2 if a potentially traumatic event has occurred within last month

If a potentially traumatic event has occurred more than one month ago, then consider PTSD

**(2) If a potentially traumatic event has occurred within the last month, does the person have significant symptoms of acute stress?**

**Check for:**
Anxiety about threats related to the traumatic event(s)
Sleep problems
Concentration problems
Recurring frightening dreams, flashbacks or intrusive memories of the events, accompanied by intense fear or horror
Deliberate avoidance of thoughts, memories, activities or situations that remind the person of the events (such as avoiding talking about issues that are reminders, or avoiding returning to places where the events happened)
Being "jumpy" or "on edge", excessive concern and alertness to danger, or reacting strongly to loud noises or unexpected movements
Feeling shocked, dazed or numb, or unable to feel anything
Any disturbing emotions (such as frequent tearfulness or anger) or thoughts
Changes of behaviour such as: aggression, social isolation and withdrawal, risk-taking behaviours in adolescents, regressive behaviour in children such as bedwetting, clinginess or tearfulness
Hyperventilation (for example, rapid breathing or shortness of breath)
Medically unexplained physical complaints such as: palpitations, dizziness, headaches, generalised aches and pains, dissociative symptoms relating to the body (for example, medically unexplained paralysis, inability to speak or see, "pseudoseizures")

NO

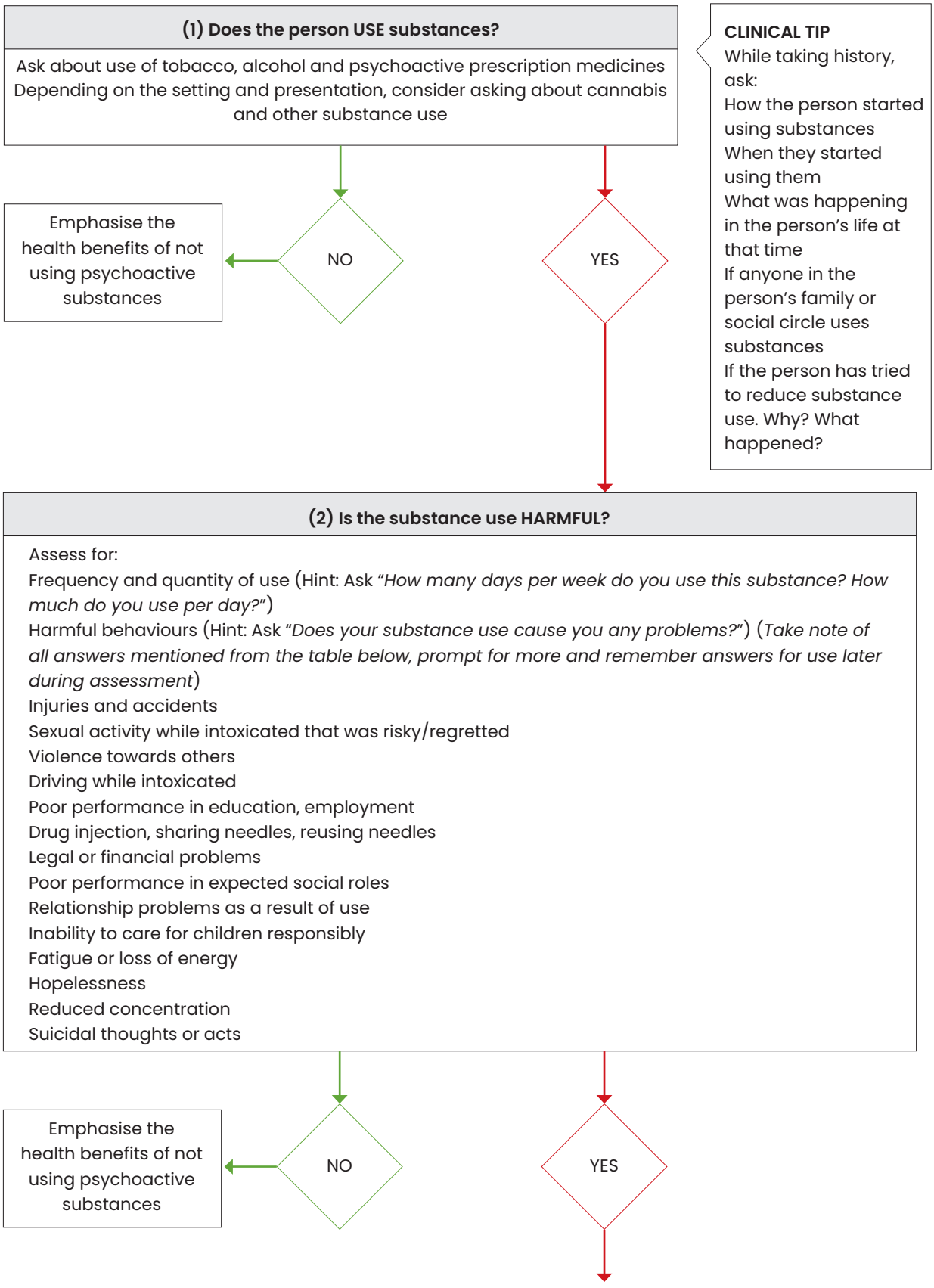
YES

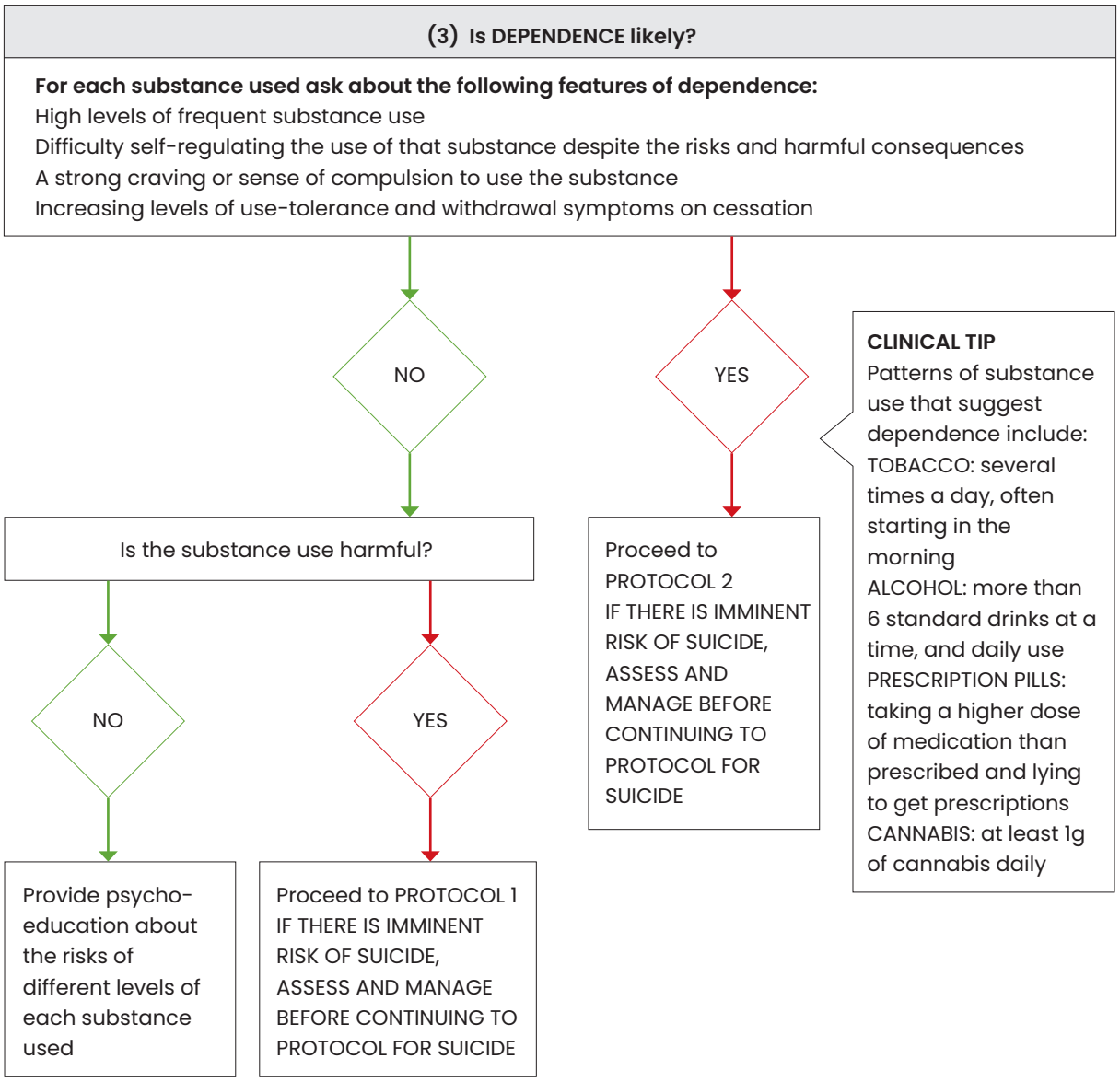
Significant symptoms of acute stress are likely if the person meets ALL of the following criteria:

- A potentially traumatic event has occurred within about one month
- The symptoms started after the event
- There is considerable difficulty with daily functioning because of the symptoms or with seeking help for the symptoms

| (3) Is there a concurrent condition? |
| --- |
| Check for any physical conditions that may explain the symptoms, and manage accordingly if found<br>Check for any other MNS condition covered in this guide that may explain the symptoms – including depression – and manage accordingly if found |

## Appendix 4e: Algorithm for disorders due to substance use




(3) Is DEPENDENCE likely?
For each substance used ask about the following features of dependence:
High levels of frequent substance use
Difficulty self-regulating the use of that substance despite the risks and harmful consequences
A strong craving or sense of compulsion to use the substance
Increasing levels of use-tolerance and withdrawal symptoms on cessation
NO
YES
CLINICAL TIP
Patterns of substance use that suggest dependence include:
TOBACCO: several times a day, often starting in the morning
ALCOHOL: more than 6 standard drinks at a time, and daily use
PRESCRIPTION PILLS: taking a higher dose of medication than prescribed and lying to get prescriptions
CANNABIS: at least 1g of cannabis daily
Is the substance use harmful?
Proceed to PROTOCOL 2 IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE BEFORE CONTINUING TO PROTOCOL FOR SUICIDE
NO
YES
Provide psycho-education about the risks of different levels of each substance used
Proceed to PROTOCOL 1 IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE BEFORE CONTINUING TO PROTOCOL FOR SUICIDE

| Management: Protocol 1 |
| --- |
| **HARMFUL USE** |
| • Provide psychoeducation and emphasise that the level/pattern of substance use is causing harm to health<br>• Explore the person's motivations for substance use. Conduct motivational interviewing<br>• Advise halting use of the substance completely or consuming it at a non-harmful level, if that is possible<br>• Verbalise your intention to support the person in doing this. Ask them if they are ready to make this change<br>• Explore strategies for reducing or stopping use and strategies for reducing harm<br>• Address food, housing, and employment needs<br>• Follow up<br>• If the person is an adolescent or a woman who is of child-bearing age, pregnant or breastfeeding, see Special Populations (Page 69) |

| Management: Protocol 2 | |
|---|---|
| **DEPENDENCE** | |
| IF THE PERSON IS DEPENDENT ON OPIOIDS:<br>• Maintenance treatment is generally more effective than detoxification<br>• Assess the severity of dependence and, if appropriate, provide or refer the person for opioid agonist maintenance treatment, also known as opioid substitution therapy (OST). Go to PROTOCOL 5 (Opioid Agonist Maintenance Treatment)<br>• In the remainder of cases arrange planned detoxification, if necessary. Go to PROTOCOL 4 (Opioid Withdrawal)<br><br>IF THE PERSON IS DEPENDENT ON BENZODIAZEPINES:<br>• Sudden cessation can lead to seizures and delirium. Consider gradually reducing the dose of benzodiazepine with supervised dispensing or a more rapid reduction in an inpatient setting. Go to PROTOCOL 6 (Benzodiazepine Withdrawal)<br><br>IF THE PERSON IS DEPENDENT ON ALCOHOL:<br>• Sudden alcohol cessation can lead to seizures and delirium. However, if the person is willing to stop using alcohol, facilitate this. Determine the appropriate setting to cease alcohol use, and arrange inpatient detoxification, if necessary. Go to PROTOCOL 3 (Alcohol Withdrawal)<br>• Advise oral administration of thiamine at a dose of 100 mg/day po<br>• Consider pharmacological intervention to prevent relapse into alcohol dependence. Medications include acamprosate, naltrexone and disulfiram. Baclofen can also be used – however, its sedating effects and risk of abuse make it best reserved for specialist settings. With these medications, an effective response may include a reduction in the quantity and frequency of alcohol consumption, if not complete abstinence | FOR ALL OTHER SUBSTANCES:<br>• Advise stopping use of the substance completely and verbalise your intention to support the person in doing so. Ask person if s/he is ready to do this<br>• Explore strategies for reducing or stopping use and strategies for reducing harm<br>• Consider referral to peer help-groups or rehabilitation/residential therapeutic communities, if available<br>• Address food, housing, and employment needs<br>• Assess and treat any physical or mental health co-morbidity, ideally after 2 - 3 weeks of abstinence as some problems will resolve with abstinence<br><br>IN ALL CASES:<br>• Provide psychoeducation<br>• Arrange for detoxification services, if necessary, or treatment in an inpatient facility where available. Treat withdrawal symptoms as needed<br>• Provide a brief intervention using motivational interviewing to encourage the person to engage in treatment of substance dependence<br>• Consider longer-term psychosocial treatment for persons with ongoing problems related to their substance use if they do not respond to the initial brief interventions. Evidence-based psychological therapies for disorders due to substance use include structured individual and group programmes that are run over 6 - 12 weeks or more and use techniques such as cognitive behavioural therapy, motivational enhancement therapy, contingency management therapy, the community reinforcement approach and family therapy. Evidence-based social support approaches include employment and accommodation support<br>• Address food, housing, and employment needs<br>• Follow up<br>• If the person is an adolescent or a woman who is of child-bearing age, pregnant or breastfeeding, see Special Populations (Page 69) |

| Management: Protocol 3 | |
|---|---|
| **ALCOHOL WITHDRAWAL** | |
| Provide an environment that is as quiet and unstimulating as possible. It should be well-lit during the day and lit enough at night to prevent falls if the person wakes up<br><br>Ensure adequate fluid intake and that electrolyte requirements, such as potassium and magnesium, are met<br><br>**Address dehydration**<br>Maintaining adequate hydration may include intravenous hydration<br>If needed, encourage oral fluid intake. Be sure to give thiamine before glucose to avoid precipitating Wernicke's encephalopathy<br><br>**Pharmacological interventions**<br>When appropriate, treat alcohol withdrawal symptoms. In the case of planned detoxification, prevent withdrawal symptoms using diazepam. The dose and duration of diazepam treatment varies according to the severity of the withdrawal<br><br>Administer diazepam at an initial dose of up to 40mg daily (10mg four times a day by mouth or 20mg twice a day) for 3 - 7 days. Gradually decrease the dose and/or frequency as soon as symptoms improve. Monitor the person frequently, as individuals respond differently to this medication<br><br>In the hospital setting, diazepam can be given hourly and at higher daily doses, up to 120mg by mouth daily for the first 3 days, if necessary. The dose and frequency are based on frequent assessment of the person's withdrawal symptoms and mental state<br><br>In persons with impaired hepatic metabolism (that is, with signs of liver disease or the elderly), initially use a single low dose of 5 - 10 mg diazepam by mouth, as duration of action may be longer in these populations. Alternatively, a shorter-acting benzodiazepine, such as oxazepam, may be used | **CAUTION**<br>Be cautious when initiating or increasing the dose of benzodiazepines, as these medicines can cause respiratory depression. Be especially careful with persons with respiratory disease and/or hepatic encephalopathy<br><br>**CLINICAL TIP**<br>For planned alcohol cessation, assess the person's risk for severe withdrawal. Ask:<br>• Have there been past episodes of severe withdrawal symptoms, including seizures or delirium?<br>• Are there other significant medical or psychiatric issues?<br>• Have significant withdrawal features developed within 6 hours of the person's last drink?<br>• Have outpatient cessation attempts failed in the past?<br>• Is the person homeless or without any social support?<br>• If risk is high, inpatient detoxification is preferable to outpatient detoxification<br><br>**PREVENTING AND TREATING WERNICKE'S ENCEPHALOPATHY**<br>Chronic heavy users of alcohol are at risk of Wernicke's encephalopathy, a thiamine deficiency syndrome characterised by confusion, nystagmus, ophthalmoplegia (trouble with eye movements) and ataxia (uncoordinated movements)<br><br>To prevent this syndrome, all persons with a history of chronic alcohol use should be given 100mg thiamine a day by mouth<br><br>Give thiamine prior to administering glucose to avoid precipitating Wernicke's encephalopathy |

| Protocol 4 | Protocol 5 | Protocol 6 |
|---|---|---|
| **OPIOID WITHDRAWAL** | **OPIOID AGONIST MAINTENANCE TREATMENT** | **BENZODIAZEPINE WITHDRAWAL** |
| **Buprenorphine:** Buprenorphine is given sublingually at a dose range of 4 - 16mg per day for 3 - 14 days for withdrawal management. Before initiating buprenorphine treatment, it is important to wait until signs and symptoms of opioid withdrawal become evident. This is in order to avoid the risk of buprenorphine precipitating a withdrawal syndrome. This period will be at least 8 hours after the last dose of heroin and 24 - 48 hours after the last dose of methadone<br><br>**Methadone:** Methadone is given orally at an initial daily dose of 15 - 20mg, increasing to 30mg a day, if necessary. Then gradually decrease the dose over 3 - 10 days until tapered off completely. As with buprenorphine, special care should be taken with individuals taking other sedating medications.<br><br>**Clonidine or lofexidine:** If opioid substitution medications are not available, clonidine or lofexidine can be used to manage some opioid withdrawal symptoms, namely hyperarousal. They are given orally at a dose range of 0.1 - 0.15mg three times daily and are dosed according to body weight. Light-headedness and sedation may result. Monitor blood pressure closely. Other symptoms of withdrawal should also be treated: nausea with anti-emetics, pain with simple analgesics, and insomnia with light sedatives | Opioid agonist maintenance treatment requires the presence of an established and regulated national framework. It is characterised by the prescription of long-acting opioid agonists (or partial agonists), such as methadone or buprenorphine, generally on a daily, supervised basis. There is strong evidence that agonist maintenance treatment with methadone or buprenorphine effectively reduces illicit drug use, the spread of HIV, mortality and criminality, as well as improving physical health, mental health and social functioning<br><br>Monitoring: Medications used for opioid agonist maintenance treatment are open to misuse and diversion. Therefore, programmes should take measures to limit the risk of diversion, including supervised consumption | Benzodiazepine withdrawal can be managed by switching to a long-acting benzodiazepine and gradually decreasing the dose over 8 -12 weeks and combining this approach with psychosocial support. More rapid tapering is possible only if the person is in an inpatient setting in a hospital or detoxification facility<br><br>If severe, uncontrolled benzodiazepine withdrawal develops or occurs due to a sudden or unplanned cessation, consult a specialist or other available resource person immediately to start a high-dose benzodiazepine sedation regime and hospitalise the person. Be cautious about unsupervised dispensing of benzodiazepines to unknown patients |

# Special populations

## Adolescents

**Assessing the adolescent**

- Clarify the confidential nature of the healthcare discussion and in what circumstances the individual's parents or caregivers will be given information.
- Ask what else is going on in the adolescent's life to establish important underlying issues. Bear in mind that adolescents may not be able to describe fully what is bothering them.
- Ask open-ended questions to elicit information in the following areas: home, education and employment, eating, activities, drugs and alcohol, sexuality, safety and depression/suicide. Allow sufficient time for discussion. Also assess for other priority mental health conditions.

**Psychoeducation for the adolescent**

- Provide the adolescent and the parents with information on the effects of alcohol and other substances on individual health and social functioning.
- Encourage a change in the adolescent's environment and activities rather than focusing on the adolescent's behaviour as a "problem". Encourage participation in activities that interest the individual, particularly:
  - School or work or activities that would occupy the adolescent's time.
  - Group activities that are safe and enable the adolescent to build skills and contribute to the community.
  -

Encourage parents and/or caregivers to know where the adolescent is, who s/he is with, what they are doing and when they will be home, and expect the adolescent to be accountable for his/her activities.

## Women who are of child-bearing age, pregnant or breastfeeding

**Alcohol use**

- Advise women who are pregnant or considering becoming pregnant to avoid alcohol completely.
- Inform women that consuming even small amounts of alcohol early in pregnancy can harm the developing foetus. Larger amounts of alcohol can result in severe developmental problems, known as Foetal Alcohol Syndrome.
- Advise women who are breastfeeding to avoid alcohol completely.
- Given the benefits of exclusive breastfeeding, especially in the infant's first six months, where mothers continue to drink alcohol, advise them to limit their intake and minimise alcohol content in the breastmilk by:
  - Breastfeeding before drinking alcohol.
  - Not breastfeeding again till alcohol blood levels fall to zero. This takes about two hours for each alcoholic drink consumed.
  - Expressing milk before drinking for later use.

**Drug use**

- Ask about the woman's menstrual cycle and inform her that substance use can interfere with the menstrual cycle and sometimes give a false impression that pregnancy is not possible.
- Discuss the harmful effect of drugs on foetal development and ensure the woman has access to effective contraception.
- Advise women who are pregnant to stop using all illicit drugs and provide support to them. Pregnant opioid-dependent women should generally be advised to take an opioid agonist such as methadone.
- Screen babies of mothers with drug use disorders for withdrawal symptoms (neonatal abstinence syndrome) due to maternal opioid use. Where this exists, treat the baby with low doses of opioids

(such as morphine) or barbiturates. For more details refer to *Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy*: http://apps.who.int/iris/bitstream/10665/107130/1/9789241548731_eng.pdf

- Advise and support breastfeeding mothers not to use any illicit drugs.
- Advise and support mothers with disorders due to substance use to breastfeed exclusively for at least the first six months unless there is special advice not to breastfeed.

**CAUTION**

All mothers with harmful substance use and young children should be offered available social support services, including additional postnatal visits, parenting training and childcare during medical visits.

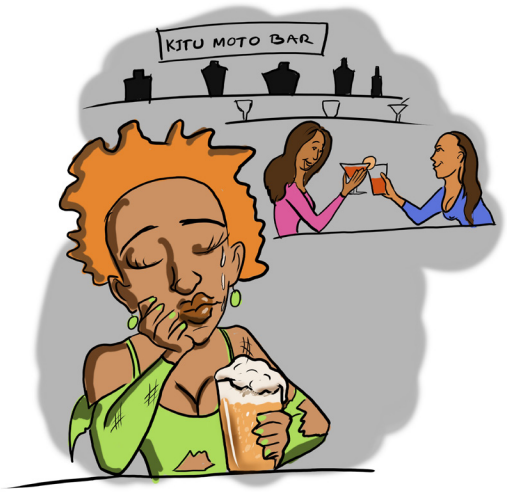
# References

1. National AIDS and STI Control Programme (2014) National Guidelines for HIV and STI Programming with Key Populations. Nairobi; NASCOP Kenya. https://www.icop.or.ke/wp-content/uploads/2016/10/KP-National-Guidelines-2014-NASCOP.pdf
2. World Health Organization (2016). WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva; WHO. https://www.who.int/publications/i/item/9789241549790
3. World Health Organization (2016). WHO mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders. Geneva; WHO. https://www.who.int/publications/i/item/978924154970
4. Kenya Ministry of Health (2015). Kenya Mental Health Policy 2015 - 2030. Nairobi; Kenya Ministry of Health. https://publications.universalhealth2030.org/uploads/Keny-Mental-Health-Policy.pdf
5. Kenya Ministry of Health (2021). Kenya Mental Health Action Plan 2021 - 2025. Nairobi; Kenya Ministry of Health. https://mental.health.go.ke/download/kenya-mental-health-action-plan-2021-2025/
6. Kenya Ministry of Health (2017). National Protocol for Treatment of Substance Use Disorders in Kenya. Nairobi; Ministry of Health. https://www.afro.who.int/publications/national-protocol-treatment-substance-use-disorders-kenya
7. Kenya Ministry of Health (2020). National Implementation Guide for HIV and STI Programming among Transgender People. Nairobi; Kenya Ministry of Health.
8. World Health Organization (2003). Mental Health Context: Mental Health Policy and Service Guide Package. Geneva; WHO. http://www.who.int/mental_health/resources/en/context
9. World Health Organization (Undated). Fact Sheet. Geneva; WHO. https://www.who.int/news-room/fact-sheets/detail/mental-disorders
10. World Health Organization (2001). World Health Report 2001. Geneva; WHO. https://who.int/news/item/29-09-2001-the-world-health-report-2001-mental-disorders-affect-one-in-four
11. Whiteford H, Ferrari A and Degenhardt L. Global Burden of Disease Studies: Implications for mental and substance use disorders. Health Affairs Studies. 2016; 35(6). https://doi.org/10.1377/hlthaff.2016.0082
12. World Health Organization (2014). Mental Health Atlas. Geneva; WHO. https://apps.who.int/iris/bitstream/handle/10665/178879/9789241565011_eng
13. Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN and Mellins CA. Mental Health and HIV/AIDS: The Need for an Integrated Response. AIDS 2019; 33:1411-1420. https://www.natap.org/2019/HIV/090919_05.htm
14. Joska JA, Obayemi A Jr, Cararra H and Sorsdahl K. Severe Mental Illness and Retention in Antiretroviral Care: a Retrospective Study. AIDS Behaviour Journal 2014. DOI: 10.1007/s10461-014-0709-z https://docksci.com/severe-mental-illness-and-retention-in-anti-retroviral-care-a-retrospective-stud_.5b01f368d64ab25d97e171ef html
15. Substance Abuse and Mental Health Services Administration (2020). Key Substance Use and Mental Health Indicators: Results from the 2016 National Survey on Drug Use and Health. Rockville, Maryland; SAMHSA. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf
16. Remien R. The Impact of Mental Health across the HIV Care Continuum. Psychology and AIDS Exchange Newsletter, January 2019. https://www.apa.org/pi/aids/resources/exchange/2019/01/continuum
17. Viswasam N, Schwartz S and Baral S. Characterising the Role of Intersecting Stigmas and Sustained Inequities in Driving HIV Syndemics across Low and Middle-Income Settings. Currrent Opinion in HIV and AIDS, 15 (4): 243 -249, July 2020. DOI: 10.1097/COH.0000000000000630.
18. Kenya National Commission of Human Rights (2011). Silenced Minds: The Systemic Neglect of Mental Health in Kenya. Nairobi; Kenya National Commission of Human Rights. https://www.knchr.org/Portals/0/EcosocReports/THE_%20MENTAL_HEALTH_REPORT.pdf
19. Scott G, Beauchamp-Lebron A, Rosa-Jimenez AA, Hernandez-Justiniano J, Ramos A, Asencio-Toro G et al. Commonly Diagnosed Mental Disorders in a General Hospital System. International Journal of Mental Health Systems,2021; 15 (61): 2021. DOI: 10.21203/rs-10602/v1 https://www.researchgate.net/publication/346878920_Commonly_Diagnosed_Mental_Disorders_in_a_General_Hospital_System
20. Jenkins R, Njenga F, Okonji M, Kigamwa P, Baraza M, Ayuyo J et al. Psychotic Symptoms in Kenya: Prevalence, Risk Factors and Relationship with Common Mental Disorders. International Journal of Environmental Research and Public Health, 2021; 9(5): 1748-56. 2012. DOI: 10.3390/ijerph905/748. https://www.researchgate.net/publication/228106241_Psychotic_Symptoms_in_Kenya_-_Prevalence_Risk_Factors_and_Relationship_with_Common_Mental_Disorders
21. Musyimi CW, Mutiso VN, Ndetei DM et al. Mental Health Treatment in Kenya: Task-Sharing Challenges and Opportunities among Informal Health Providers. International Journal of Mental Health systems, 2017; 11(45). DOI: 10.1186/s13033-017-0152-4. https://www.researchgate.net/publication/318841092_Mental_health_treatment_in_Kenya_Task-sharing_challenges_and_opportunities_among_informal_health_providers
22. British Broadcasting Corporation. Mental health in Kenya: 'I was accused of bewitching my husband.' 10 February

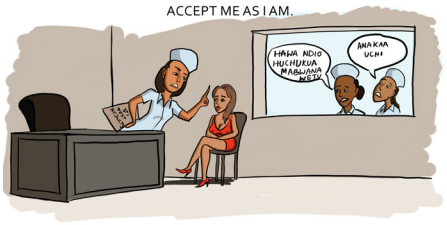
2020. https://www.bbc.com/news/world/world-africa-51222194
23. National Academies of Sciences, Engineering and Medicine (2016). Providing Sustainable Mental and Neurological Health Care in Ghana and Kenya. Workshop Summary. Washington DC; NASEM. https://www.nationalacademies.org/event/01-13-2015/providing-sustainable-mental-health-care-in-kenya#sectionEventPublications
24. Bhana A, Kerniske P, Pather A, Abas MA and Mellins CA. Interventions to Address the Mental Health of Adolescents and Young Adults Living with or Affected by HIV: State of the Evidence. Journal of the International AIDS Society, 2021; 24 (Suppl 2): e25713, June. DOI:10.1002/jia2.25713. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8222850/
25. Nakimulu-Mpungu E, Musisi S, Smith C, Von Isenburg M, Akimana B, Shakarishvili A et al. Health Interventions for People Living with HIV in Low and Middle-Income Countries: a Systematic Review. Journal of the International AIDS Society, 2021; 24 (Suppl 2): e 251722. DOI: 10/1002/jia2.25722. https://www.researchgate.net/publication/352707456_Mental_health_interventions_for_persons_living_with_HIV_in_low-and_middle-income_countries_a_systematic_review
26. Pan American Health Organisation. Undated. https://www.paho.org/hq/index.php?option=_content&view=article&id=14833:mental-health-and-hiv&itemid=40682&lang=en
27. Elliot I (2016). Poverty and Mental Health: a Review to Inform the Joseph Rowntree Foundation's Anti-Poverty Strategy. London; Mental Health Foundation. https://www.mentalhealth.org.uk/sites/default/files/Poverty%20and%20Mental%20Health.pdf
28. Beattie TS, Smilenova B, Krishnaratne S and Mazzuca A. Mental Health Problems among Female Sex Workers in Low and Middle-Income countries: a Systematic Review and Meta-Analysis. PLoS Medicine 2020, 17(9): e1003297. DOI: 10.1371/journal.pmed.1003297 https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003297
29. Chege MN, Kabiru EW, Mbithi JN and Bwayo JJ. Childcare Practices of Commercial Sex Workers. East African Medical Journal, 2002; 79(7): 382-389. DOI: 10.4314/eamj.v79i7.844 https://www.ajol.info/index.php/eamj/article/view/8844
30. Li Q, Li X, and Stanton B (2010). Alcohol Use among Female Sex Workers and Male Clients: an Integrative Review of Global Literature. Alcohol and Alcoholism, 2010; 45(2) 188-199. DOI10.1093/alcalc/agp095 https://pubmed.ncbi.nlm.nih.gov/20089544/
31. Roberts ST, Flaherty BP, Deya R, Masese L, Ngina J, McLelland RS et al. Patterns of Gender-based Violence and Association with Mental Health and HIV Risk Behaviour Among Female Sex Workers in Mobasa, Kenya: A Latent Class Analysis. AIDS and Behavior, 2018; 22(10): 3273-3286. DOI: 10.1007/s10461-018-2107-4. https://pubmed.ncbi.nlm.nih.gov/29603110/
32. Kimani J et al, Partners for Health and Development in Africa, Nairobi, Kenya (2021). Presentation at the key population pre conference, NACC, Nairobi, 2021. http://www.phdaf.org/resource-center/
33. Gilman SE, Cochran SD, Mays VM, Hughes M, Ostrow D and Kessler RC. Risk of Psychiatric Disorders among Individuals Reporting Same-Sex Sexual Partners in the National Comorbidity Survey. American Journal of Public Health, 2001; 91(6): 933-939. DOI: 10.2105/AJPH.91.6.933. https://pubmed.ncbi.nlm.nih.gov/11392937/
34. Miranda-Mendizábal A, Castellvi P, Parés-Badell O, Almenara J Alonso I, Blasco M et al. Sexual Orientation and Suicidal Behaviour in Adolescents and Young Adults: Systematic Review and Meta-Analysis. British Journal of Psychiatry, 2017; 211(2): 77-87. DOI: 10.1192/bjp.116.196345 https://pubmed.ncbi.nlm.nih.gov/28254960/
35. Korhonen C, Kimani M, Wahome F, Otieno F, Okall D, Dailey RC et al. Depressive Symptoms and Problematic Alcohol and Other Substance Use in 1 476 Gay, Bisexual and other MSM at Three Research Sites in Kenya. AIDS, 201; 32(11): 1507-15. DOI:1097/QAD0000000000001847. https://pubmed.ncbi.nlm.nih.gov/29734218/
36. Secor AM et al. Depression, substance abuse and stigma among men who have sex with men in coastal Kenya Andrew M. AIDS. 2015; 29(0 3): S251–S259. DOI:10.1097/QAD.0000000000000846.
37. Professionals in Pride Kenya (Undated). Mental Health Assessment Toolkit: An Assessment Toolkit for Community Organisations and Health Care Workers Working for and with LGBT Communities. No title. No publisher. https://icop.or.ke/wp-content/uploads/2018/10/Final-Mental-Health-Toolkit.pdf World Health Organization (2013). Comprehensive Mental Health Action Plan 2013-2020. Geneva; WHO. https://www.who.int/mental_health/action_plan_2013/bw_version.pdf
38. Castel S, Rush B, Urbanoski K and Toneatto T. Overlap of Clusters of Psychiatric Symptoms among Clients of a Comprehensive Addiction Service. Psychology of Addictive Behaviours, 2006; 20(1): 28-35. DOI: 10.1037/0893-164X.20.1.28. https://pubmed.ncbi.nlm.nih.gov/16536662/
39. Mathari Medically Assisted Therapy Clinic, Ministry of Health, Nairobi, Kenya (2018). Presentation at the national sharing meeting on mental health and key populations, June 2021.
40. Muslim Education and Welfare Association, Mombasa Kenya (2021). Presentation at the national sharing meeting on mental health and key populations, June 2021.
41. Ngara Medically Assisted Therapy Clinic, Ministry of Health, Nairobi, Kenya (2021) Presentation at the national sharing meeting on mental health and key populations, June 2021.

42. Anderssen N, Sivertsen B, Lønning KJ and Malterud K. 2020. Life satisfaction and mental health among transgender students in Norway. BMC Public Health, 138 (2020). http://bmcpublichealth.biomedicalcentral.com/articles/10.1186/s12889-020-8228-5)
43. Garg G, Elshimy G and Marwaha R (2021). Gender Dysphoria. Stat Pearls Publishing. PMID: 30335346. https://www.ncbi.nim.nih.gov/books/NBK532313
44. Muller A, Daskilewicz K and the Southern and East African Research Collective on Health (2019). Are we doing alright? Realities of violence, mental health and access to healthcare related to sexual orientation and gender identity and expression in Kenya. Amsterdam; COC Netherlands.
45. Trans*Alliance, Nduta S, Smith LG and Okeyo N (2020). NTDS – A Baseline Study of Transgender Persons in Kenya: Life Experiences and Access to Health Services. Nairobi; Epilson Publishers.
46. International Labour Organization (2004). Danger at sea – Working in the Fishing Sector. https://www.ilo.org/global/about-the-ilo/mission-and-objectives/feature/wcms-075579/leang-en/index.htm
47. Food and Agricultural Organization (Undated). Fisheries and Aquaculture: Health. https://www.fao.org/fishery/en/topic/16607/ru
48. Michalopoulos LTM, Baca-Atlas SN, Simona SJ et al. "Life at the River is a Living Hell": a Qualitative Study of Trauma, Mental Health, Substance Use and HIV Risk Behaviour among Female Fish Traders from the Kafue Flatlands in Zambia. BMC Women's Health, 2017; 17(15). DOI:10.1186/s12905-017-0369-z. https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-017-0369-z
49. World Health Organization (Undated). Information Sheet: Mental Health in Prisons. Geneva, WHO. https://www.euro.who.int/_data/assets/pdf_file/0007/98989/WHO_ICRC_InfoSht_MNH_Prisons.pdf
50. Fazel S, Ramesh T and Hawton K. Suicide in Prisons: An International Study of Prevalence and contributory factors. The Lancet Psychiatry, 2017; 4: 946-952. https://www.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(17)30430-3.pdf
51. Lamb HR and Weinberg LE. Persons with Severe Mental Illness in jails and prisons: A Review. Psychiatric Services, 1998; 49(4): 483-92. DOI: 10.1176/ps.49.4.483. https://ps.psychiatryonline.org/doi/10.1176/ps.49.4.483?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed
52. Shattell M, Agostolopoulos Y, Collins C, Sonmez S and Fehrenbacher C. Trucking Organisation and Mental Health Disorders of Truck Drivers. Issues in Mental Health Nursing, 2021; 33(7). DOI: 10.3109/01612840.2012.665156. https://pubmed.ncbi.nlm.nih.gov/22757596/
53. Rispel LC, Cloete A and Metcalf CA. "We Keep her Status to Ourselves": Experiences of Stigma and Discrimination among HIV-Discordant Couples in South Africa, Tanzania and Ukraine. Journal of Social Aspects of HIV/AIDS, 2015; 12(1), 10-17. DOI: 10.1080/17290376.2015.1014403.
54. Greeff M, Phetlhu R, Makoae LN, Dlamini PS, Holzeme WI, Naidoo JR et al. Disclosure of HIV Status: Experiences and Perceptions of Persons Living with HIV/AIDS and Nurses Involved in their Care in Africa. Qualitative Health Research, 2018; 18(3), 311-324. DOI: 10.1177/1049732307311118.
55. Mwakalapuka A, Mwampagatwa I, Bali T, Mwashambwa M, Kibusi S and Mwansisya T. Emotional and Relationships Dynamics between HIV Sero-Discordant and -Concordant Couples: A Narrative Literature Review and Theoretical Framework. ABC Journal of Public Health and Community Medicine, 2017; 2(2), 1-14.
56. Partners for Health and Development in Africa. Presentation to National Sharing Workshop, Nairobi, June 2021.
57. World Health Organization (2017). mhGAP Training Manuals for the mhGAP Internvention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialised Health Settings (Version2). Geneva, WHO. https://apps.who.int/iris/bitstream/handle/10665/259161/WHO-MSD-MER-17.6-eng.pdf
58. Health Options for Young Men with HIV, TB and STI. Presentation to National Sharing Workshop, Nairobi, June 2021.
59. TransAlliance, Kisumu, Kenya (2021). Presentation at the national sharing meeting on mental health and key populations, June 2021.
60. Patel V et al. The Lancet Commission on Global Mental Health and Sustainable Development. The Lancet, 2018; 392(10157). https://www.thelancet.com/commissions/global-mental-health
61. United Nations. Convention on the Rights of Persons with Disabilities. New York, United Nations. https://www.un.org/development/desa/disabilities/convention -on-the-rights-of-persons-with-disabilities.html
62. Baingana FK, Alem A and Jenkins R. 2006. Mental Health and the Abuse of Alcohol and Controlled Substances. In Jamison DT, Feacham RG, Makgoba MW et al. Disease and Mortality in Sub-Saharan Africa. Washington DC, World Bank. https://www.ncbi.nlm.nih.gov/books/NBK2305/

BE AWARE OF MENTAL HEALTH SYMPTOMS.



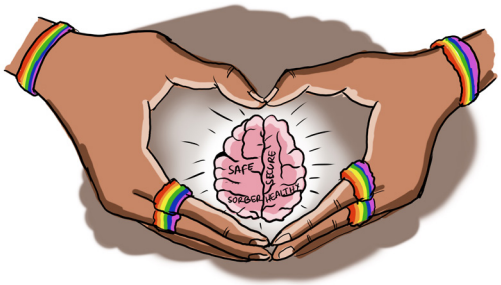

ACCEPT ME AS I AM.



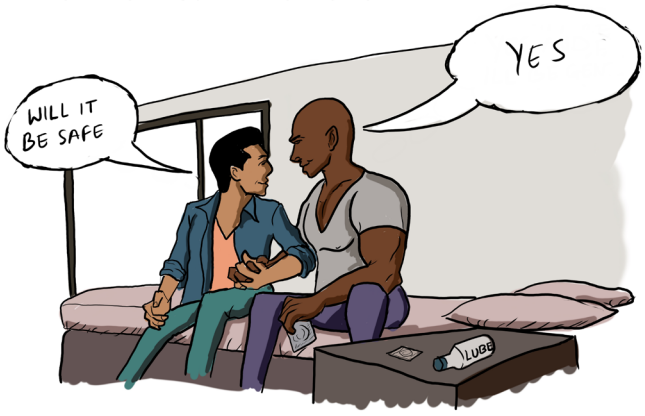

YOU ARE NOT ALONE, ANYONE CAN BE A VICTIM OF MENTAL HEALTH.

PROTECT ME, DON'T VIOLATE ME! MY MENTAL HEALTH MATTERS.

YOUR MENTAL HEALTH SECURITY STARTS WITH YOU.




SAFE SEX CONTRIBUTES TO MENTAL HEALTH.



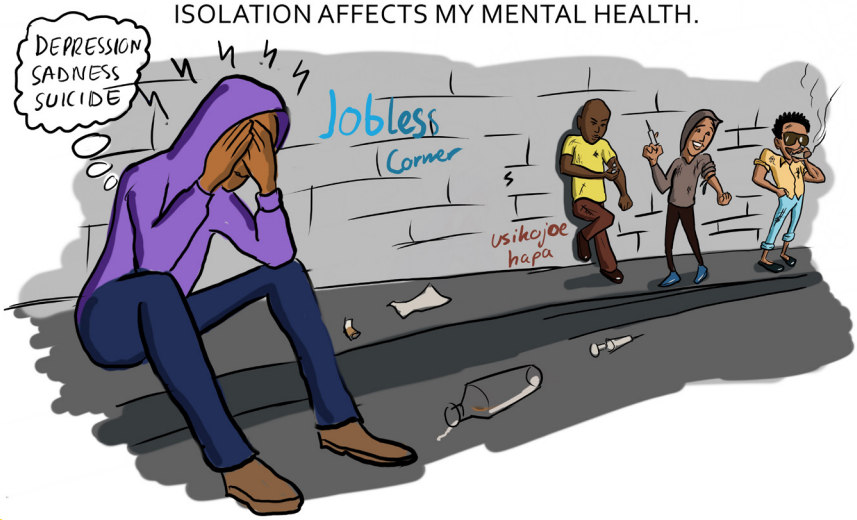

~~PEPSI~~ SOLUTION YA STRESS.

YOUR MENTAL HEALTH IS YOUR WEALTH.

A STIGMA FREE SOCIETY = MENTAL WELLNESS.

STOP BLACKMAIL SAVE MY MENTAL WELLBEING.

ISOLATION AFFECTS MY MENTAL HEALTH.




YOUR NEGATIVE ACTIONS AFFECT MY MENTAL HEALTH

YOUR NEGATIVE ACTIONS AFFECT MY MENTAL HEALTH.

National AIDS and STI Control Programme
Kenyatta National Hospital (KNH Grounds)
P. O. BOX: 19361- (00202), Nairobi, Kenya

Email: Info@nascop.or.ke
Website: www.nascop.or.ke