STANDARD OPERATING PROCEDURES

FOR INTEGRATION OF MENTAL HEALTH AND HIV SERVICES IN ZIMBABWE

“THERE IS NO HEALTH WITHOUT MENTAL HEALTH”
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AIDS Support and Technical Assistance Resources Project

AIDS Support and Technical Assistance Resources, Sector I, Task Order 1 (AIDSTAR-One) is funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID) under contract no. GHH-I-00-07-00059-00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with BroadReach Healthcare, EnCompass LLC, International Center for Research on Women, MAP International, mothers2mothers, Social & Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in knowledge management, technical leadership, program sustainability, strategic planning, and program implementation support.

Recommended Citation


Acknowledgments

The authors would like to acknowledge Dorcas Sithole, Deputy Director of Mental Health Department, Ministry of Health and Child Welfare, and other key Ministry staff for their support and collaboration throughout the entire activity. The authors are grateful for all of the staff and community partners who participated in the pilot activity and assessment visits. The authors also thank Vuwelya Chitimbire, Executive Director of the Zimbabwe Association of Church-Related Hospitals, and Bernadette Sobuthana, AIDSTAR-One consultant, for their support and logistical guidance locally. Thanks to Tom Kresina, Liaison to the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) Division of Pharmacologic Therapies (SAMHSA), for his participation in the assessment and expert knowledge on harmful substance use. Finally, thanks to the USG team in Zimbabwe, in particular Ruth Bulaya-Tembo, Reena Shukla, and Panganai Dhilwayo; the PEPFAR Care and Support Technical Working Group led by Ilana Lapidos Salaiz; and the PEPFAR Treatment Technical Working Group led by Tom Minior for their vision, technical insight, and financial support.
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<tbody>
<tr>
<td>CBO</td>
<td>community-based organization</td>
</tr>
<tr>
<td>MH</td>
<td>mental health</td>
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<tr>
<td>MOHCW</td>
<td>Ministry of Health and Child Welfare</td>
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<tr>
<td>PEPFAR</td>
<td>U.S. President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PLHIV</td>
<td>people living with HIV</td>
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<tr>
<td>SOP</td>
<td>standard operating procedure</td>
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<tr>
<td>SSQ</td>
<td>Shona Symptom Questionnaire</td>
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<tr>
<td>TMP</td>
<td>traditional medical practitioner</td>
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<tr>
<td>USG</td>
<td>U.S. Government</td>
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<tr>
<td>WRAP</td>
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EXECUTIVE SUMMARY

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

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

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

PROGRAM PLANNING

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

1. Identify a coordinating body that will oversee integration efforts and develop a workplan for planning and oversight of integration efforts. Wherever possible, integration efforts on the ground should be led at the highest level possible in order to provide a means to establish the scope of the MH/HIV integration program and to oversee implementation, referral networks, monitoring, and reporting.

2. Carry out community sensitization with community leaders. Explain the objective and scope of mental health and HIV integration efforts within the community and at health facilities; seek support for the program to disseminate information and support for availability and uptake of services to the HIV community.


4. Build a referral network within the community and at health facilities. Identify a referral point person to oversee the referral network. Identify clinical health workers, CBOs, and TMPs within the community who may provide mental health screenings and interventions and psychosocial services, while keeping in mind that the referral network should also include organizations that meet the social and spiritual needs of clients. Identify a referral hospital that can provide more intensive mental health services as needed. Meet with representatives from facilities and organizations to agree on referral procedures. Wherever feasible, seek out already existing MH/HIV referral directories. See Annex G on page 21 of this document to complete the MH/HIV Integration Referral Directory.

5. Create a bi-directional referral system between health facilities and CBOs. Ensure that a solid referral system is in place such that when a referral is made, organizations are acquainted with the referral protocols. If referring to private institutions that have no relationships with the public institutions, be sure to make certain the client is well informed. Identify barriers to completing referrals, including transportation and costs, and brainstorm mechanisms to overcome them with CBOs and family members where appropriate. When completing the Client Referral Form, the top half should be completed by the provider making the referral. The provider should give the Client Referral Form to the client to bring to the appointment for which he or she has been referred. The provider at that organization should complete the bottom half of the form and give the entire form back to the client, who brings it back to his or her next appointment where the original referral was made from. This allows for communication
between providers and agencies regarding a client. Record all referrals made and received in the Referral Log. See Annex H (page 23) for a Client Referral Form, Annex I (page 25) for the Register of Referrals – OUT Form, and Annex J (page 27) for the Register of Referrals – IN Form.

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


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

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

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

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

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

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

8. Review the Stepped-Care Model. Identify who will be responsible for (at each site and within the community):

a. Carrying out screening tools and basic counseling interventions
b. Providing more intensive counseling therapy

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

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

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

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

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

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

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

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

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

1. **Provide routine supportive supervision.** Following the training, supportive supervision should be provided to each staff person carrying out mental health and HIV integrated service provision and should occur within one month of beginning integration activities and then routinely thereafter. Identify opportunities for ongoing mentoring based on results of supportive supervision visits.

2. **Monitor the referral system routinely.** Referrals should be routinely monitored by the established community referral point person at all organizations within the network to ensure that patients are completing referrals and that the correct referral procedures are being followed. Consider creating a community forum to identify and solve issues surrounding retention and other ongoing problems within the referral system.

3. **Ensure continual availability of integration materials.** Identify and correct any issues surrounding availability of screening tools and referral forms.

4. **Provide continuous training opportunities to increase the number of staff trained and to train new staff.** Carry out training needs assessments every six months to identify training needs and provide as necessary follow-up training and mentoring to ensure that the information was correctly understood and is effectively implemented during service delivery.

5. **Provide and ensure availability of updated job aids.** Integration Leaders should make necessary arrangements with facility heads to ensure these job aids are available and submit formal requests for the materials when they are not available. Job aids should be visible in areas where integration services are offered. See Annex C (page 13) for the Health Facility Job Aid. See Annex D (page 15) for the CBO and TMP Job Aid. See Annex B (page 11) for the Mental Health and HIV Integration Protocol.

6. **Employ motivational strategies for staff.** Provision of integrated services may offer additional challenges to staff; identify motivators such as ongoing training opportunities or staff recognition to keep staff engaged to follow the protocols for the integrated program and to continually provide high-quality care.

7. **Ensure ongoing functionality and quality of supply chain management.** Carry out routine monitoring to ensure that sufficient supplies of medications are available for integrated services.

**PROGRAM MONITORING AND EVALUATION**

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

1. **Routinely monitor the accuracy of data collection and reporting forms.** Ensure that integrated data are correctly reported and routinely utilized.

2. **Carry out quality improvement practices.** Quality improvement activities can help identify and correct any gaps in integrated service provision.
3. **Identify any monitoring and evaluation training needs due to the integrated program.** Training needs may be identified through data monitoring, quality improvement activities, and speaking with staff.

4. **Utilize the data for planning purposes.** This will serve to further inform integration efforts and increase collaboration, particularly at the community and district levels.

5. **Share data, promising practices and lessons learned with community partners.** Advocate for strengthening MH services for PLHIV to ensure that a strong support system is available when required.

6. **Conduct health outcome assessments.** Health outcome assessments can measure the effect of integrating MH and HIV services.
REFERENCES


ANNEX A. THE STEPPED-CARE MODEL

The Stepped-Care Model

Clients with suicidal ideation and alcohol and substance use emergencies require immediate SAME DAY care.

Health Facility: A client with a positive SSQ (28) or CAGE-AID (21)

CBO or TMP: Positive Abbreviated Community Screen (7 or greater) to sad or worry questions or a “yes” to alcohol and substance use question

Simple counseling intervention, referral to CBO, health provider for further management

More intensive counseling therapy

Medication Therapy

Intensive psychotherapy, medication therapy and potential hospitalization for stabilization

Increasing treatment intensity

If mental health symptoms are suspected despite a negative screen, the client should enter the Stepped-Care Model and receive services
ANNEX B. MENTAL HEALTH AND HIV INTEGRATION PROTOCOL

Screening Guidelines:
Screen all adult clients at each visit.

Documentation:
Place completed screen in client record.
When a referral is made, complete the following:
- Top half of Referral Form (give to client to bring to next appointment)
- Referral – OUT Register
When a referral is received, complete the following:
- Bottom half of Referral Form (give to client to bring to provider who made original referral)
- Referral – IN Register

Hospitalization
Action:
- a) Stabilize client with counseling therapy and/or medication
- b) Refer back to health facility and CBO/TMP once stable

CBO and/or TMPs
Action:
- a) Psychosocial services, spiritual services
- b) Further counseling
- c) Refer to hospital when a client is a danger to self or others

Health Facility
Action:
- a) In-depth counseling (may include family members/trusted friends)
- b) Medication management
- c) Further counseling

Community Organization (CBO)/Traditional Medicine Practitioners (TMPs)
Entry Point: Clients visit the CBO or TMP
Tool: Abbreviated Community Screen
Positive Screen: A) Score of 7 or greater to the sad or worry B) "yes" to the alcohol and substance use question; or C) Suspicion of health problems/substance use despite negative screen
Action: 1) Therapeutic counseling; 2) Refer to health facility for a full SSQ or CAGE-AID; and 3) Continue psychosocial services

Clients with acute suicidal ideation and/or alcohol withdrawal should be immediately referred the SAME DAY to the health facility.
ANNEX C. HEALTH FACILITY JOB AID

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

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

A Positive SSQ (score 8 or greater)
1. Determine if the client is suicidal by asking:
   - Are you thinking of hurting yourself?
   - Have you ever attempted suicide in the past?
   - Do you have a plan? If yes, what is it?

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

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

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

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

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

6. Record the referral in the Referral Register.

A Positive CAGE-AID (score 1 or greater)
1. Assess for Acute Alcohol Withdrawal symptoms through determining if the client is tremulous, sweating, nauseous, vomiting, has a headache, is irritable and smells of alcohol.

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

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

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

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

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

6. Record the referral in the Referral Register.

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

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

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

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

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

A “yes” to the alcohol and substance use question:
1. Assess for Acute Alcohol Withdrawal symptoms through determining if the client is tremulous, sweating, nauseous, vomiting, has a headache, is irritable and smells of alcohol.
   If Acute Alcohol Withdrawal is suspected the client should receive immediate SAME DAY medical attention per alcohol withdrawal guidelines.
2. Refer the client to a health facility for a full assessment.
3. Continue CBO services and link the client into additional supplementary CBO services.

A score of 7 or greater on the sad or worry questions:
1. Determine if the client is suicidal by asking:
   - Are you thinking of hurting yourself?
     - If the client answers yes, then ask:
   - Have you ever attempted suicide in the past?
   - Do you have a plan? If yes, what is it?
   If the client is actively suicidal seek Immediate SAME DAY medical attention per suicidal ideation guidelines.
2. Refer the client to the health facility for a full assessment.
3. Continue CBO services and link the client into additional social and spiritual services.

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

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

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

Clients who are suspected of mental health problems or alcohol and substance use, but have a negative screen should be treated as if they had a positive screen and receive the above services.
ANNEX E. MOHCW GUIDELINES FOR SUICIDAL IDEATION

RISK FACTORS

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

ASSESSING SUICIDAL RISK

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

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

MANAGEMENT OF THE SUICIDAL PATIENT

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

LEVEL I OBSERVATION

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

LEVEL II OBSERVATION

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

LEVEL III OBSERVATION

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

The current condition must be treated accordingly.
# ANNEX F. MOHCW GUIDELINES FOR ACUTE ALCOHOL WITHDRAWAL

## Acceptable Levels:
- Male: 21 units per week
- Female: 14 units per week

### 1 unit
- pint of beer
- small glass of wine
- a tot of whisky or vodka
- a tot of liquor and so on

Abuse of alcohol is drinking more than the accepted amount per week.

## Clinical Features:
- Drinking alcohol excessively
- Development of tolerance
- Drink seeking behavior over other activities
- Feeling guilty about drinking

The patient may develop the Alcohol Dependency Syndrome, which comprises:
1. Privacy of drinking seeking behavior
2. Developing of drinking routine
3. Tolerance
4. Repealing withdrawal symptoms
5. Reinstatement after a period of abstinence.

## Treatment:
### General:
- A careful appraisal of nutritional status
- Rehydration
- Vitamin supplements—particularly thiamine and nicotinamide.

Detoxification with diazepam in reducing doses e.g.
- Diazepam 20 mg tds x 2 days
- Diazepam 15 mg tds x 2 days
- Diazepam 10 mg tds x 2 days
- Diazepam 5 mg tds x 2 days
- Diazepam 5 mg bd x 2 days
- Diazepam 5 mg nocte x 2 days

Then stop if the patient has blackouts. You may want to prevent seizures by giving an antiepileptic. If the patient has psychotic symptoms, you may want to give an antipsychotic medication. Care needs to be observed in using CPZ, which may further precipitate a seizure.

## After Detoxification:
A thorough reappraisal of the drinking behavior:
- What has happened to cause the drinking behavior?
- How can drinking be substituted with something more profitable?
- Focus needs to be emphasized on behaviors that discourage drinking.
# ANNEX G. MENTAL HEALTH/HIV INTEGRATION REFERRAL DIRECTORY

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Type of Services Provided</th>
<th>Contact Person</th>
<th>Contact Information (Telephone and Address)</th>
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ANNEX H. CLIENT REFERRAL FORM

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

<table>
<thead>
<tr>
<th>Name of facility:</th>
<th>CLIENT REFERRAL FORM</th>
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<tbody>
<tr>
<td>Referred by:</td>
<td>Name:</td>
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<tr>
<td></td>
<td>Position:</td>
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<tr>
<td><strong>Initiating Facility</strong></td>
<td>Date of referral:</td>
</tr>
<tr>
<td>Name and Address:</td>
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</tr>
<tr>
<td>Telephone arrangements made:</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Referred to Facility</strong></td>
<td></td>
</tr>
<tr>
<td>Name and Address:</td>
<td></td>
</tr>
<tr>
<td>Client Name</td>
<td></td>
</tr>
<tr>
<td>Identity Number</td>
<td>Age:</td>
</tr>
<tr>
<td>Client address</td>
<td></td>
</tr>
<tr>
<td>Screening Scores</td>
<td>SSQ score (health facility only)</td>
</tr>
<tr>
<td>Reason for referral</td>
<td></td>
</tr>
<tr>
<td>Additional notes:</td>
<td></td>
</tr>
<tr>
<td>Print name, sign &amp; date</td>
<td>Name:</td>
</tr>
</tbody>
</table>

Note to receiving facility: On completion of client management please fill in and detach the referral back slip below and send with patient or send by fax or mail.

--->-------------------receiving facility - tear off when making **back referral**-----------------<---

<table>
<thead>
<tr>
<th>Back referral from Facility Name</th>
<th>Tel No.</th>
<th>Fax No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reply from (person completing form)</td>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Position:</td>
<td>Specialty:</td>
<td></td>
</tr>
<tr>
<td>To Initiating Facility: (enter name and address)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity Number</td>
<td>Age:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Client address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This client was seen by: (give name and specialty)</td>
<td>on date:</td>
<td></td>
</tr>
<tr>
<td>Services provided to client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer back to:</td>
<td>on date:</td>
<td></td>
</tr>
<tr>
<td>Print name, sign &amp; date</td>
<td>Name:</td>
<td>Signature:</td>
</tr>
</tbody>
</table>
## ANNEX I. REGISTER OF REFERRALS – OUT FORM

<table>
<thead>
<tr>
<th>Register of Referrals OUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date referral made</td>
</tr>
<tr>
<td>------------------------</td>
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<tr>
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</tbody>
</table>
ANNEX J. REGISTER OF REFERRALS – IN FORM

<table>
<thead>
<tr>
<th>Date referral received</th>
<th>Client identification number</th>
<th>Male or female (M/F)</th>
<th>Age</th>
<th>Referred from (name of facility / specialty)</th>
<th>Referred for</th>
<th>Summary of treatment provided</th>
<th>Date client back-referred</th>
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</tbody>
</table>
ANNEX K. SHONA SYMPTOM QUESTIONNAIRE

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

Client Name: __________________ Date: ___________________

Scoring Information

Total score 8 to 14: refer for further assessment.

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

Action Taken:

Referred: (circle one)  YES  NO

Referred to: ____________________________
ANNEX L. CAGE-AID SCREENING TOOL

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

<table>
<thead>
<tr>
<th>Pindurai ehe kana aiwa pane mibunzo inotevera:</th>
<th>Ehe</th>
<th>Aiwa</th>
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</thead>
<tbody>
<tr>
<td>Please answer yes or no to the following questions:</td>
<td></td>
<td></td>
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<tr>
<td>1. Unombonzwa here kuti unofaniwa kudzikisira manwiro unoiita doro, uye maputiro kana mashandisiro unoiita zvinodhaka? Have you ever felt you should cut down on your drinking or drug use?</td>
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<td></td>
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<tr>
<td>2. Pane munhu kana vanhu vanombokushatira sa here nekushoro podza kwavanoita manwiro ako edoro, uye maputiro kana mamwe mashandisiro unoiita zvinodhaka? Have people annoyed you by criticizing your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Unombonzwungesa here pamusoro pekunwa doro, kuputa kana kushandisa kwavanoita zvinodhaka? Have you ever felt bad or guilty about your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Wakambotanga nekumwadoro, kuputa kana kushandisa zvinodhaka uchangobva mukumuka mangwaneni kuti unzwe zvakakasa kana kuti upedze bhabhara? Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (an &quot;eye-opener&quot;)?</td>
<td></td>
<td></td>
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</tbody>
</table>

**Scoring Information**

**Score:**

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

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

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

**TOTAL SCORE:**

**Action Taken:**

Referred: (circle one)  YES  NO

Referred to: ____________________________

Additional notes: ________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

______________________________________________________________________________
ANNEX M. ABBREVIATED COMMUNITY SCREEN

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

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

1. Wakambonzwa kusuwa here musvondo rapfuura?
   
   Have you been feeling sad over the past 7 days?

2. Wakambonzwa kushushikana here musvondo rapfuura?
   
   Have you been worried over the past 7 days?

3. Wakambotanga nekumwa doro, kuputa kana kushandisa zvinodhaka uchangobva mukumuka mangwanani kuti unzwe zvakanaka kana kuti upedze bhabharasi?
   
   Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover (an "eye-opener")?

Action Taken:

Referred: (circle one) YES  NO

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

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

DAILY MAINTENANCE

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

WHEN THINGS ARE BREAKING DOWN OR GETTING WORSE

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

CRISIS PLANNING

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

MENTAL HEALTH TOOLKIT

- Talk to a friend or family member
- Take a walk
- Go to a religious service
- Speak with a spiritual healer
- Exercise
- Take a nap
- Take a bath or shower
- Practice deep breathing
- Sing
- Read a book
- Other _________________________
- Other _________________________
ANNEX P. THE READINESS TO CHANGE RULERS

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

<table>
<thead>
<tr>
<th>How important is this change for you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>NOT IMPORTANT</td>
</tr>
<tr>
<td>VERY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How confident are you about making the change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>NOT IMPORTANT</td>
</tr>
<tr>
<td>VERY</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Importance</th>
<th>Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If it is not important to change, how will you know when it is time to change?</td>
<td>• What prevents you from changing?</td>
</tr>
<tr>
<td>• What would be the benefits if you did consider changing?</td>
<td>• What could you do to increase your ability to change?</td>
</tr>
<tr>
<td>If the mark is on the left side</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Importance</th>
<th>Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Why did you put your mark here?</td>
<td>• Why did you put your mark here?</td>
</tr>
<tr>
<td>• What are the benefits that you are experiencing as you try to change?</td>
<td>• What may be some actions you take to try to change?</td>
</tr>
<tr>
<td>• What are the barriers to changing?</td>
<td>• When you made other changes in your life, how did you do it?</td>
</tr>
<tr>
<td>• How can you overcome these barriers?</td>
<td>• What are the barriers to changing?</td>
</tr>
<tr>
<td>If the mark is in the middle</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Importance</th>
<th>Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What will be different for you when you reach your goal?</td>
<td>• What will be different for you when you reach your goal?</td>
</tr>
<tr>
<td>• What people, places, or things do you still need to consult/go to, or what things do you still need to do to maintain your behavior?</td>
<td>• What people, places, or things do you still need to consult/go to, or what things do you still need to do to maintain your behavior?</td>
</tr>
<tr>
<td>If the mark is on the right side</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Importance</th>
<th>Confidence</th>
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</thead>
<tbody>
<tr>
<td>• What made you decide to take this step?</td>
<td>• What made you decide to take this step?</td>
</tr>
<tr>
<td>• What has helped you to be successful in taking this step?</td>
<td>• What has helped you to be successful in taking this step?</td>
</tr>
<tr>
<td>• What else will help?</td>
<td>• What else will help?</td>
</tr>
<tr>
<td>• What is your next step?</td>
<td>• What is your next step?</td>
</tr>
<tr>
<td>If the client has taken a serious step to make a change</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Importance</th>
<th>Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What worked for a while?</td>
<td>• What worked for a while?</td>
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<tr>
<td>• What did you learn from the experience?</td>
<td>• What did you learn from the experience?</td>
</tr>
<tr>
<td>• How will this help you give it another try?</td>
<td>• How will this help you give it another try?</td>
</tr>
<tr>
<td>If the client has had a relapse</td>
<td></td>
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</tbody>
</table>
ANNEX Q. EMERGENCY ACTION TEMPLATE

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

SUICIDAL IDEATION:

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

The most appropriate location for a client to receive this level of service is: ___________________
Name of facility: ______________________________________________________________
Contact information (telephone): ___________________________________________________
Additional notes: ____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

ACUTE ALCOHOL WITHDRAWAL:

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

The most appropriate location for a client to receive this level of service is: ________________
Name: ________________________________________________________________________
Contact information (telephone): ___________________________________________________
Additional notes: ____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
ANNEX R. INTEGRATION LEADER’S CHECKLIST

☑ Train colleagues on mental health and HIV integration pilot activity.

☑ Provide guidance to colleagues throughout pilot activity as needed.

☑ Check in with colleagues routinely to ensure correct screening protocol is carried out.

☑ Ensure that adequate screening tools are available throughout pilot.

☑ Monitor referral system to ensure that the correct protocol is carried out by reviewing Referral-Out and Referral-In forms and client referral forms.

☑ Ensure that clients’ confidentiality is maintained throughout pilot activity.
## ANNEX S. SAMPLE DATA COLLECTION SHEET FOR HEALTH FACILITIES

**Mental Health/HIV Integration Data Collection Sheet at the Health Facility Level**

<table>
<thead>
<tr>
<th>MR#</th>
<th>Gender (M or F)</th>
<th>Age</th>
<th>Date of assessment</th>
<th>SSQ score</th>
<th>CAGE-AID score</th>
<th>Referral (Y/N)</th>
<th>Client Given Referral Form (Y/N)</th>
<th>Referral Recorded in Referral Register (Y/N)</th>
<th>Comments</th>
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</thead>
<tbody>
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</table>
ANNEX T. SAMPLE DATA COLLECTION SHEET AT THE COMMUNITY AND TRADITIONAL PRACTITIONER LEVELS

<table>
<thead>
<tr>
<th>Mental Health/HIV Integration Data Collection Sheet at the Community and Traditional Practitioner Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client ID#</td>
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For more information, please visit aidstar-one.com.