

HIV Nursing matters

A Magazine of the Southern African HIV Clinicians Society



Gender based violence
Supporting healthcare professionals
Management of depression in HIV

September 2012 Volume 3. No 3.





Adding value to life.

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**HIV
Nursing
matters**
focus on
Mental Health

on cover

Gender based violence
Supporting healthcare professionals
Management of depression in HIV

guest editorial



Dr Greg Jonsson

Integrating Mental Health and HIV care: A call to action

It is relatively well known that people living with HIV/AIDS (PLWHA) are more at risk of developing mental health disorders.¹ On the other hand people living with mental health disorders (PLWMHD) are more at risk of contracting and transmitting HIV due to the ill effects of the mental health disorder. It therefore makes sense that we integrate care. The world health organization (WHO) called for integrating mental health services in global initiatives for HIV/AIDS, stating that, as there is a severe shortage of mental health practitioners and a substantial resource base in the primary health sector that it would then make sense that services are integrated.²

The question posed today is therefore: Why hasn't this call for integration translated into practical existence? Task shifting has been suggested as a possible mechanism for integration but this is also fraught with difficulties. Staff are overworked, overburdened and the majority insufficiently trained in mental health. In an article by Mall et al¹, one of the reasons posited was that staff were concerned about their safety. A further problem with increased screening for mental health

disorders is: what then does one do with all these patients identified with mental health disorders when there are no specific services to refer them to?

We know that patients with serious mental illness and HIV are a doubly or even triply stigmatized population. There are multiple barriers to access care faced by patients with a double or triple diagnosis. Once care is accessed, adherence and monitoring of side effects and drug-drug interactions is difficult with so few staff trained in this type of care. While patients with acute mental health disorders may be non-adherent to their treatment regimen, patients with treated mental health disorders are as likely to take their treatment as patients without mental health disorders.³

Whether integrated care is partial or fully inclusive, it is vital to try in any way possible to achieve some sort of integrated care. Just identifying common mental disorders, speaking to a fellow clinician and trying to coordinate care are added advantages for the patient. This not only adds to the convenience for the patient but improves health outcomes and may prove cost effective in the long run. Mental Health matters because when this is identified as a problem and adequately treated, adherence, prognosis, morbidity and the quality of life of the patient is improved.

Patients with serious mental illness are a doubly or even triply stigmatized population

This edition of HIV Nursing Matters is dedicated to Mental Health and HIV. It is vital that we improve our knowledge on these matters, communicate with fellow clinicians and identify any way possible to try to integrate care. The publication is divided into 2 major parts, one comprising current issues in mental health and HIV and the other on clinical updates.

Kirsten Thomson tackles the very important topic of supporting health workers in self care and debriefing. All too often we forget about the mental health of staff and this in turn impacts on our patients. Nataly Woollett is an experienced psychologist at the Wits Reproductive Health and HIV Institute (WRHI) and highlights gender based violence and its impact on health care providers. The clinical update section is packed full of clinical tips in terms of screening, managing and treating HIV Associated Neurocognitive disorders and Depression. Algorithms and case studies are put forward for your perusal and learning. A wonderful piece, superbly written by Ethelwyn Rebello on her interactions and experiences with patients in a creative writing group ends the journal.

We can only achieve change and integrated care if we prescribe it, advocate for it, expect it and demand it!

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References:

1. Mall S, Sorsdahl K, Swartz L, Joska J. "I understand just a little..." Perspectives of HIV/AIDS service providers in South Africa of providing mental health care for people living with HIV/AIDS. *AIDS Care* 2012; 24(3):319-23.
2. Freeman M, Patel V, Collins P, Bertolote JM. Integrating mental health in global initiatives for HIV/AIDS. *British Journal of Psychiatry* 2005; 187:1-3
3. Himeloch S, Brown CH, Wlakup J, Chander G, Korthuis PT, Afful J. HIV patients with psychiatric disorders are less likely to discontinue HAART. *Ais* 2009; 23(13):1735-42.

Message from the president

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Dr Francesca Conradie:
President Southern African
Clinicians Society

Any health care worker who treats HIV infected patients knows that the easy part is initiating therapy. Our National program gives access to the highest quality antiretroviral therapy to all who live within our borders and need it. The difficult part is to help our patients to take their medication for the rest of their lives. We know that long term adherence is difficult. But also know that patients who adhere to therapy do very well. There is no doubt that the most frustrating thing that I have to deal with on a day to day basis when a patient who was very ill, took ART and got better and then stops taking their medications at a later date. The reasons for this are often very difficult to understand. I am sure most of us have heard "God healed me" or "My partner told me to stop". What I do know is that I need more counselling skills and a better understanding of mental health. We hope that this edition will give that to all of us.

We live in a region with a very high prevalence of HIV. So it stands to



reason, that we will have patients who have mental illness as well as HIV infection. When is a person depressed and when are they just sad because they have found out about their status? Efavirenz psychosis rears its ugly head every now and then. What should we do? Then there are a range of neuropsychiatric manifestations of HIV. And finally our patients may have had intracranial infections like tuberculous meningitis. These often have sequelae. This edition is aimed at helping you deal with these.

Finally, please do not forget that we are hosting a conference at the end of the year from the 25th to 28th November. I hope you have pencilled the dates into your calendar already. [®]

**Remember
the HIV
Clinicians**

society Conference
in November 2012



The Mental Health Summit

April, 2012, St George's Hotel, Pretoria, Gauteng

The Mental Health Summit was opened by the Minister of Health, who motivated why he thought this summit was important, quoting a study which indicates that only 1 out of 8 people with severe mental illness in South Africa receive treatment. Most impressive during the opening ceremony was a session of music therapy by the staff and seriously disabled residents from Little Eden Home in Gauteng. The obvious dedication of the staff and the affirming interaction between them and the residents, were inspiring.

The first day was spent on messages of support, and then contributions from different sectors, such as The Judicial system and Higher Education. It was interesting to hear the Ministry of Correctional Services describe a study they did to establish to what extent mental patients in their system received appropriate treatment. Lastly, introductory plenary presentations were done to set the scene for the discussions. Most important was the recent epide-

miological studies done that illustrated the very high incidence of mental health problems in South Africa, and the presentation on substance abuse which underlined the importance of this issue in our communities. A lack of intervention studies was also reported.

The second day was spent on 10 commissions, each of which was introduced by two speakers. The commissions had to contribute to the strengthening of the new National Mental Health Policy Framework for South Africa (Draft 1, April 2010), which formed the basis of the discussions in the commissions:

- Mental health promotion and prevention of mental disorders;
- Mental Health Research and Innovation including systems and surveillance (A nurse, Ms Jennifer Chipps, was the lead speaker in this session);
- Strengthening mental health systems (including re-engineering PHC system);

- Mental health physical infrastructure requirements and human resource issues;
- Mental health and other health conditions;
- Mental Health Care Act No 17 of 2002;
- Child and adolescent mental health;
- Culture, faith-based practices and indigenous mental health practices;
- Suicide prevention;
- Advocacy, social mobilization, user and community participation.

A large number of nurses took part in the discussions, which took about three hours, and resulted in additions to the Policy, and also a "Declaration on Mental Health". One sometimes gets the impression that the DOH already knows what they want in these declarations that emanate from summits. Nevertheless, from each commission one proposal was added to the declaration to capture the major intentions of the group in order to improve mental health in the country.

AIDS Mortality Higher in woman with Depression

In HIV positive women, chronic depressive symptoms appear to increase the risk of AIDS-related death; researchers report in the July issue of the American Journal of Public Health. Dr. Judith A Cook of the University of Illinois at Chicago and colleagues note that previous studies have shown an association between depression and immune system suppression and other negative health outcomes. However the relationship between depression and HIV disease progression is not well understood. To investigate further, the researchers examined data on 1716 HIV seropositive women who, over a 7.5 year period, paid semi-annual visits to clinics at one of 6 sites. In all, 147 (9%) died from AIDS-related causes

over the course of the study. Other causes, including accidents and non HIV - related diseases accounted for the deaths of another 147 women. Woman who had chronic depressive symptoms were more than twice as likely to die of AIDS related causes than were woman who had few or no such symptoms. These findings are in line with those of another large multi-centre study. Moreover, AIDS mortality was less likely in woman who reported mental health services use. Among other factors that reduced mortality were being on a HAART regimen or on non-HAART combination therapy. Thus, Dr. Cook told Reuters Health, "we now have substantial evidence from two large, multi-site cohorts of

HIV-positive woman that depression treatment must be part of the best-practice standard of care for woman with HIV." "Antiretroviral treatment alone," she added, "will not address the needs of the significant number of woman with HIV". Such therapy, the researchers conclude, "must be augmented by appropriate and sensitive mental health treatment, particularly as HIV disease progress." *Am J Public Health* 2004,94:1133-1140.

*By David Douglas
Reuters Health Information, July 21.
New York
Article from www.sadag.org under
local and international news.*

Anxiety and Panic Attacks

According to the Press release during Panic Awareness Day on the 10th of July 2012, 16% of South Africans will experience Anxiety and Panic Attacks. Two thirds will not seek help due to stigma.

Panic disorder is a very misunderstood illness and according to the SASH study of 4351 adults conducted by Professor Dan Stein, in all parts of South Africa, two thirds of the 15.8% of South Africans with the disorder will never seek help due to stigma and fear (Professor Srein.UCT, SASH study)

Panic is more common in woman than men, the average age of onset for woman during early 20's and for men in their early 40's. Recent research shows that there's a strong genetic or hereditary component that predisposes people to panic. Attacks can be trig-

gered by stressful life events but can also occur "out of the blue".

The average length of a panic attack is 4-6 minutes, sometimes longer. Untreated, Panic can have severe consequences-up to 30% of people with panic disorder abuse alcohol, 17% abuse drugs, and up to 20% attempt to commit suicide. It is important to note that caffeine, cold and flu medications, anti-Malaria medications, appetite suppressants and local anaesthetics with adrenalin may trigger panic attacks in some people.

Most of us feel some amount of stress and anxiety in our lives which is normal, even helpful. But when the anxiety becomes overwhelming, persistent, or interferes with your daily activities, this may indicate a problem and it is advisable to talk to a doc-

tor or a psychologist. SADAG (The South African Depression and Anxiety Group) offers telephonic counselling 7 days a week from 08h00 am-8pm on 0800205026 or 011262 6396, or visit their website www.sadag.co.za

SADAG can refer patients to a specialist in their area, and they also hold workshops where they explain the dynamics of a panic attack, the concept and aims of CBT (Cognitive Behavioural Therapy), self-help techniques that work, the workshops are hosted in Cape Town, Durban, Pretoria and Johannesburg. For more information or to register for the workshop, contact SADAG at 011 262 6396.

From SADAG (The South African Depression & Anxiety Group) www.sadag.co.za

The South African Nursing Council and Africa Health Placements sign cooperation agreement

Africa Health Placements (AHP) recently signed a memorandum of understanding with the South African Nursing Council (SANC) to assist the council to bring more nurses to South Africa.

Through this agreement AHP will support SANC and the Department of Health to address the country's shortage of nurses, which is especially severe in our rural areas. Almost half of South Africa's population lives in these areas, but they are served by only 19% of the country's nurses.

Saul Kornik, AHP's CEO, says the memorandum is an important milestone. "We all need to work together to attract nurses to come to South Africa. We are excited to assist SANC by facilitating the registration process and increasing their capacity to bring even more foreign-qualified nurses to our country".

"We have already facilitated the recruitment of more than 1400 foreign doctors through working with the Department and the Health Professions Council of South Africa (HPCSA). We expect our partnership with SANC to be just as fruitful," Kornik says.

"South Africa does not have enough local health care workers. We need

foreign-qualified nurses to provide quality care to patients," he says. The aim of the agreement is to contribute to improving nurse staffing in rural areas, while maintaining the standard of nursing and midwifery care which SANC is mandated to uphold. AHP will assist SANC and the Department to bring more nurses to South Africa and to place these resources where they are needed the most.

AHP will provide a full-time administrative staff member to SANC's foreign-qualified nurse registration department to assist in the processing of registration applications. AHP will pre-screen its applicants to ensure only complete documentation is submitted to SANC.

Tendani Mabunda, SANC's Registrar, said that "through the cooperation agreement, SANC and AHP will work together to make the registration process efficient and on par with other countries to attract scarce and skilled personnel without compromising quality and nursing standards".

SANC will ensure no special preference is given to applications received from AHP over applications received directly by SANC. Applications will be dealt with on the principle of "first in, first out".

SANC and AHP will also form a management task team, comprising of two representatives from each party, to co-manage the implementation of the agreement.

The South African Nursing Council protects the public by setting education, practice and research standards, monitors nursing and midwifery practice, formulates and ensures the implementation of nursing and midwifery legislation and policies in response to social needs, and collaborates with relevant partners for holistic healthcare.

Africa Health Placements is a non-profit organisation recruiting foreign and local healthcare professionals for the country's public health care facilities in rural and underserved areas. Since AHP's inception in 2005 the organisation has placed 2 500 healthcare workers.

<http://www.ahp.org.za/news-detail/355/press-release-sanc-and-ahp-sign-cooperation-agreement>

Toll-Free National HIV & TB Health Care Worker Hotline

Are you a doctor, nurse or pharmacist?

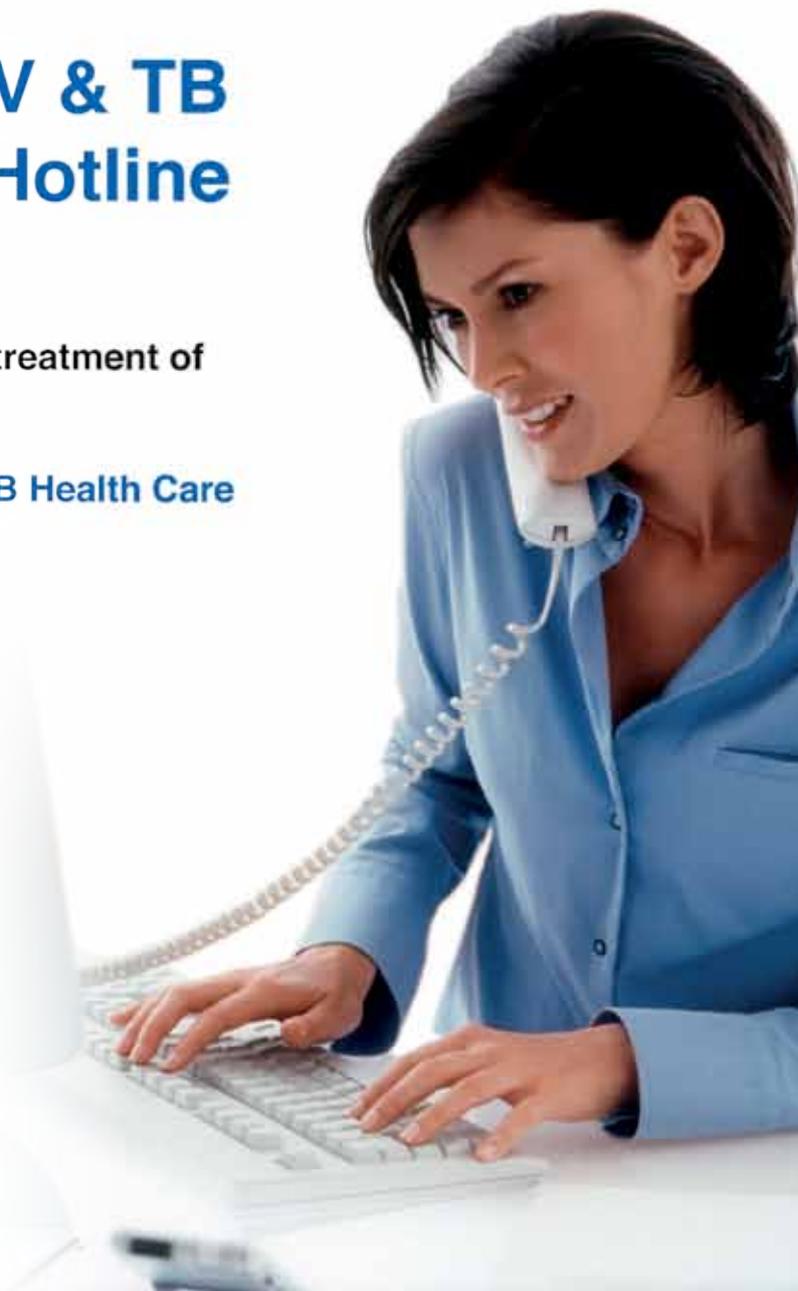
Do you need clinical assistance with the treatment of your HIV or TB patients?

Contact the TOLL-FREE National HIV & TB Health Care Worker Hotline



**0800 212 506 /
021 406 6782**

Alternatively send an SMS or
"Please Call Me" to 071 840 1572
www.hivhotline.uct.ac.za



The Medicines Information Centre (MIC) situated within the Division of Clinical Pharmacology, Department of Medicine at the University of Cape Town is the largest and only clinically-based medicine information centre in South Africa.

In collaboration with the Foundation for Professional Development and USAID/PEPFAR, the MIC provides a toll-free national HIV & TB hotline to all health care workers in South Africa for patient treatment related enquiries.

What questions can you ask?

The toll-free national HIV & TB health care worker hotline provides information on queries relating to:

- HIV testing
- Post exposure prophylaxis: health care workers and sexual assault victims
- Management of HIV in pregnancy, and prevention of mother-to-child transmission
- Antiretroviral Therapy
 - When to initiate
 - Treatment selection
 - Recommendations for laboratory and clinical monitoring
 - How to interpret and respond to laboratory results
 - Management of adverse events
- Drug interactions
- Treatment and prophylaxis of opportunistic infections

- Drug availability
- Adherence support
- Management of tuberculosis and its problems

When is this free service available?

The hotline operates from Mondays to Fridays 8.30am – 4.30pm.

Who answers the questions?

The centre is staffed by specially-trained drug information pharmacists who share 50 years of drug information experience between them. They have direct access to:

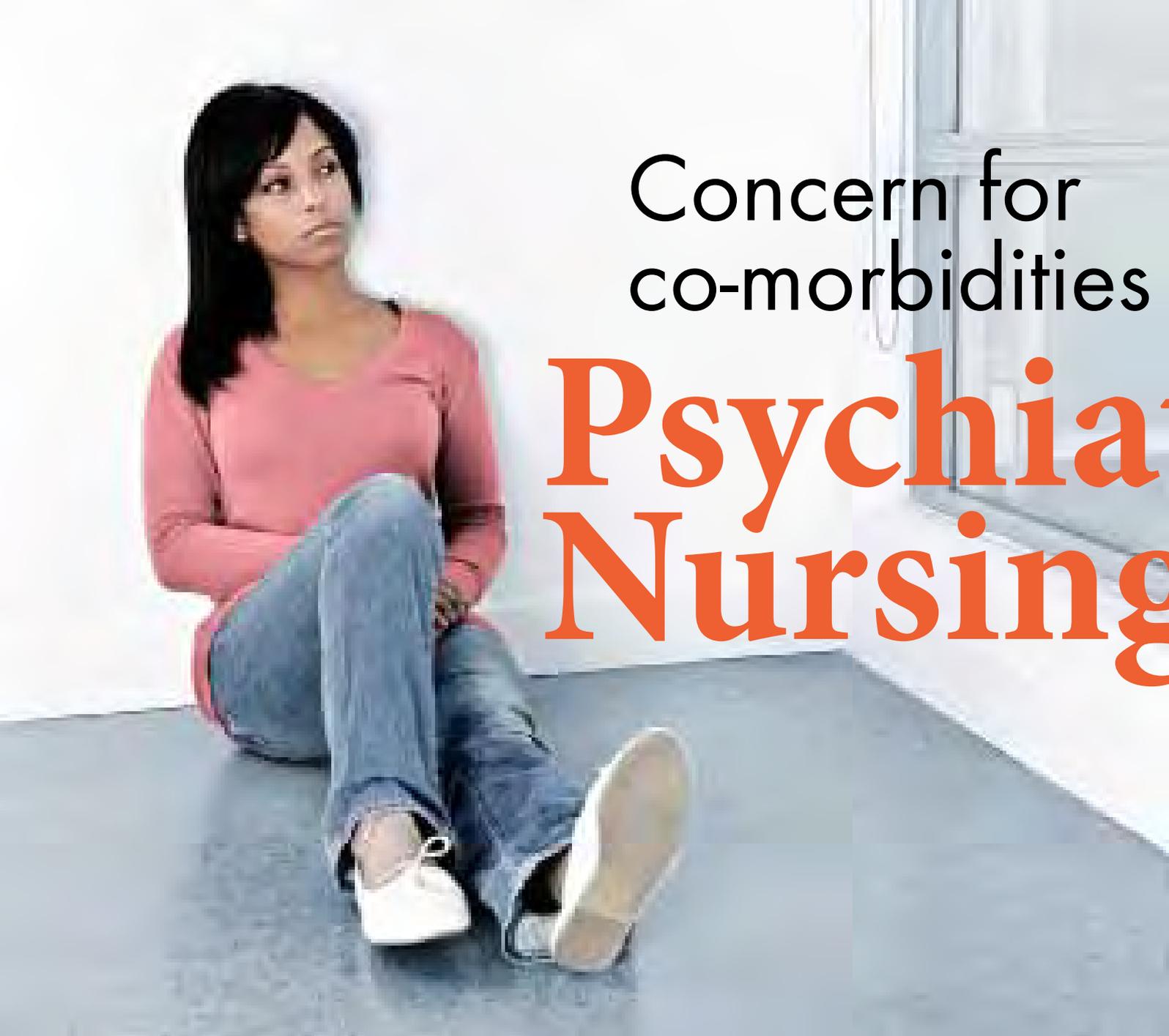
- The latest information databases and reference sources
- The clinical expertise of consultants at the University of Cape Town's Faculty of Health Sciences, Groote Schuur Hospital and the Red Cross War Memorial Children's Hospital



**MEDICINES
INFORMATION
CENTRE**



Call us - we will gladly assist you! This service is free.



Concern for
co-morbidities

Psychiatric Nursing

Blott WA (RN, DPN, DNAD, BA)

Assistant Director, Psychiatric Services, Chris Hani Baragwanath Academic Hospital

Never has the concept of total patient care been as relevant as it is in the practice of contemporary Psychiatric Nursing. The reason for this assertion being that whilst a small percentage of the Mental Health Care Users (MHCUs) have had co-morbid medical conditions, this percentage has risen considerably with the advent of the HIV/AIDS pandemic.

in Psychiatric

a “back to basics” approach becomes equally important.

With MHCUs who may have low CD4 counts and high viral loads, the need for total nursing care is highly probable. Assistance with bathing and general grooming may be needed, as well as mouth care (especially where the patient has oral candidiasis). As these MHCUs are immuno-compromised and prone to varied opportunistic diseases, careful monitoring of their vital signs and physical integrity is of importance. Once antiretroviral (ARV's) are commenced, the nurse needs to be vigilant for possible side effects such as nausea, diarrhea, increased fatigue, headaches, rashes, sleep disturbances and Depression, to name but some, and be available to render appropriate nursing interventions, support and encouragement.

HIV/AIDS and Mental Illness

One also cannot ignore the dynamic interplay that exists between HIV/AIDS and Mental Illness. Mental Health Care Practitioners have to be constantly aware that both HIV, and certain ARV's, can elicit symptoms of Mental Illness, and thus it is standard practice to exclude a physiological cause for the symptomatology before a diagnosis of a Primary Mental Illness is made.

Importance of health education

With the increase in the prevalence of co-morbid mental illness and HIV/AIDS, the nurse's role with regard to health education cannot be understated.

According to a study by Ngwena² it was alarming to note that doctors and nurses were the least source of information regarding HIV and AIDS to

Patients. With that being said, perhaps the South African nurses' perception of health education needs to broaden to include information regarding high risk practices that could result in MHCUs contracting HIV/AIDS. The efficacy of the health education according to Collins¹ will, however, be influenced by the attitude of the health care provider towards sexual relations and HIV among people with serious mental illnesses.

Nurses' advocacy role

As advocates for the MHCU, Psychiatric nurses must also be mindful of their duty to protect those in their care whose judgment may be impaired, and who may be hypersexual, thus exposing them to greater risk of acquiring sexually transmitted diseases.

Although the above is acknowledged, South African Nurses should remember their pledge of service and their commitment to providing the best possible care to all their patients.

References:

1. Collins PY. Challenges to HIV prevention on psychiatric settings: Perceptions of South African mental health care providers. *SocSci Med* 2006; 63(4):979-90.
2. Ngwena J. HIV/AIDS awareness in those diagnosed with mental illness. *Journal of psychiatric and mental health nursing* 2011; 18:213-220.

According to Collins et al¹, at around the time of publication of her article, recent studies had shown that the prevalence of HIV/AIDS amongst mental health care users varied from 9% in one state psychiatric hospital to 29% in an acute psychiatric admissions ward in a large tertiary care hospital.

The need for “back-to-basics”

With the increase in co-morbid medical conditions amongst the Mental Health Care Users in psychiatric wards, although specialist Psychiatric Nursing skills will still be needed, the need for

Psychiatric Nurses

must be mindful of their duty to protect those in their care whose judgment may be impaired

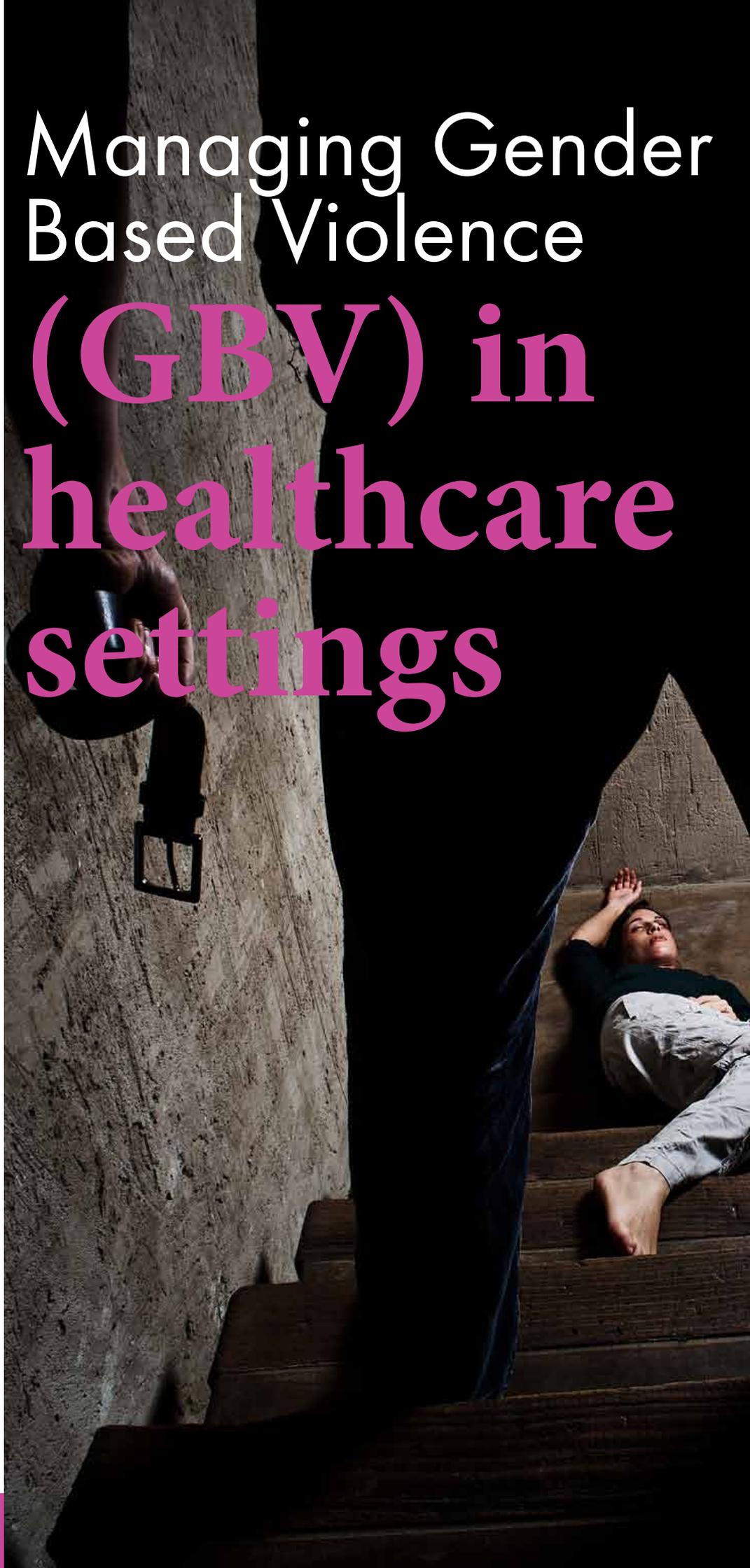
Managing Gender Based Violence (GBV) in healthcare settings

GBV

is both a cause and consequence of HIV and AIDS

Nataly Woollett
Technical Head Counselling and Prevention, Wits Reproductive Health and HIV Institute (WrHI)

Violence is both a cause and consequence of HIV and AIDS. It limits victims' ability to protect themselves from infection and those who are HIV-positive are often targeted for stigma and abuse upon disclosure of their status. (Maman, S. et al., 2004)



Definition:

Gender Based Violence (GBV) is often used synonymously with "violence against women"; however, the term "GBV" encompasses sexual violence against both men and women, boys and girls, and includes a broad range of human rights violations, including rape, domestic violence, intimate partner violence, sexual harassment, sexual abuse of children, human trafficking and harmful traditional practices (UNFPA, 2011).

The scale of the problem

South Africa has **one** of the world's highest rates of rape and sexual assault outside of countries in conflict (where rape is often used as a cheap and effective weapon of war). By some estimates, a woman or child/adolescent in South Africa is raped every 26 seconds (US Department of State, 2011 website); and rates of reported rape in South Africa is 4 times the global average (Jewkes et al, 2002).

In addition, after HIV/AIDS, violence is the leading cause of death for people living in South Africa, reports are 5 to 8 times higher than the global average (Seedat et al, 2009; Jewkes et al, 2002). When speaking of violence, this includes: community violence, sexual assault, intimate partner violence (IPV), domestic violence and child abuse. With the latter 3 categories, the incidents of violence are typically recurrent and committed by a known (and often trusted) perpetrator. With rates of violence so high, statistically, there is a great risk of one being a victim of violence in our communities, at schools and in the home.

Violence is both a cause and consequence of HIV and AIDS. It limits victims' (and in our context this is typically women and children) ability to protect themselves from infection and those who are HIV-positive are often targeted for stigma and abuse upon disclosure of their status (Maman, S. et

al, 2004).

There is a conscious push to end intimate partner violence both in its own right as well as to reduce women and girls vulnerability to HIV/AIDS (recognised in the most recent National Strategic Plan on HIV, STIs and TB 2012-2016). The evidence on the association between violence against women and HIV/AIDS highlights that there are direct and indirect mechanisms by which the two interact. Coercive sex poses a direct biological risk for HIV infection resulting from vaginal and anal trauma and lacerations; intimate partner violence poses indirect risk for HIV infection in several ways:

- Women or girls with a history of violence may not be able to negotiate condom use;
- Childhood sexual abuse, coerced sexual initiation and current partner violence may increase sexual risk taking (e.g. having multiple partners, engaging in transactional sex);
- Women and girls who experience violence may be in partnerships with older/riskier men who have a higher likelihood of being infected with an STI and HIV.

Also, violence or fear of violence may deter women and girls from seeking HIV testing, prevent disclosure of their status, and delay their access to HIV/AIDS treatment and other services (WHO, 2004).

One of the goals of the National Strategic Plan for HIV and AIDS, STIs and TB (2012-2016) is to address gender equity in healthcare. Key strategic objectives include addressing social and structural barriers that increase vulnerability to HIV, STI and TB infection; preventing new HIV, TB and STI infections; sustaining health and wellness increasing protection of human rights and improving access to justice. Managing GBV then becomes part of healthcare professionals' responsibilities.

What are healthcare providers

faced with in healthcare settings

Health services, including those focusing on HIV/AIDS care, provide an important and potential entry point for identifying and responding to victims who experience violence. Cross-training those working on HIV counselling and those working on GBV may be an effective strategy to sensitize providers on the dynamics of both epidemics. For example, healthcare providers can facilitate victims to receive care for their physical injuries, treatment for sexual and reproductive health problems that are associated with violence (e.g. STI, pelvic pain, unwanted pregnancies), and get referrals to other services that they may need. In HIV counselling and testing (HCT) clinics, identification of victims experiencing violence may enable doctors, nurses and counsellors to offer appropriate advice on disclosure if HIV positive and ensure referral for other services and support as appropriate. One strategy for addressing violence during HCT is couple testing and counselling, followed by mediated disclosure as a potential way of reducing tensions between partners, as well as adverse consequences for victims. Healthcare professionals must be very careful not to increase risk through disclosure that is not mediated. Professionals need to acknowledge their limitations in these contexts and refer patients for expert help, while they undergo training to master these skills. It is important that health services develop context specific responses to violence against women based on existing resources, level of staff training, referral options, and availability of other services (WHO, 2004).

Healthcare professionals need to be sensitive to patients, especially with those where GBV is recognised. There has been some research conducted in the nursing sector in South Africa on what victims who access care would like from healthcare professionals and nurses in particular: the resounding findings are... "to be kind!" (Joyner et

al, 2004). Most victims, when entering the healthcare system, already feel overwhelmed, ashamed, confused, unsafe, sad and angry. When anyone feels like that, they simply want to be treated with compassion, kindness, respect and without judgment. This doesn't seem to be a great deal to ask, but we are failing victims as we don't appear to be offering on this human element of service delivery. Most victims will be able to navigate complex systems when received with kindness.

Note too that, victims are in a state of shock and sometimes experiencing post-traumatic stress disorder (PTSD) when healthcare professionals encounter them. They have a strong need to feel safe. It is crucial to increase feelings of safety by asking victims what would help them to feel safe and how health care professionals can assist them. It may be sense of privacy and confidentiality, a kind demeanour, and especially for children/adolescents, this is having a known 'safe person' near them etc. Communication with the patient is important.

In cases of GBV or IPV, it is NOT helpful to tell victims they should leave the perpetrator or get out of dangerous situations; victims know this and are the experts of their own relationships (as we all are!). Health care service providers are there to educate and support. Incidentally, victims are at most risk for serious physical harm at two points in their relationship: during pregnancy and when they leave – so they know the danger of their situation and this should be respected. Also, avoiding victims, having a disbelieving or blaming attitude or making victims feel like something is wrong with them is also not helpful.

It should also be acknowledged that healthcare providers are mandated by law to report abuse against children and adolescents to the police, a social worker, child welfare or Child Line (Children's Act, 2010, section 110). This is to protect children and adoles-

cents and ensure systems are in place to take care of them.

Recommendations

Although many may think that it is 'traumatizing to victims' to be asked about violence, research indicates quite the opposite (De Prince et al, 2004 & Griffin et al, 2003); victims are relieved somebody has asked and is concerned. Of course with asking goes the assumption that the person can handle the response to the question. Really, this is why many of us DON'T ask...we don't know what to do with a 'yes' response.

Healthcare providers can be very helpful: firstly, respond appropriately (empathically and respectfully); ask what you can do to assist (surprisingly, victims sometimes don't want intervention other than someone to listen); if acceptable, refer to appropriate Care Centres. The police and Department of Social Development, Child Welfare/Child Line should be informed according to policy, especially if children and adolescents are involved.

Sexual assault victims have the right to proper post exposure prophylaxis (PEP), which MUST be obtained within 72hrs of the assault for it to be effective. Health care providers should keep a list of facilities mandated to administer PEP in their area so that victims can be referred on time.

According to statistics 1 in 3 women worldwide are victim to GBV (Seedat et al, 2009). This may include even the healthcare providers. Managers need to be aware that their staff might also be victims and therefore have first-hand experi-

ence of the issues they are trying to treat in patients. Adequate resources need to be made available to support professionals as well.

Healthcare providers need to be cognizant of the effects of working in the field of GBV and with victims and realise that the work can be tough! There are typically few reliable referral sources; the victims form a bond with the first responder (the healthcare professional one first tells about a GBV incident) and first responders resultantly can feel enormous responsibility in taking care of people so vulnerable and who have experienced such horror. This is all very hard to do and needs to be recognized and managed appropriately. Debriefing and using one's colleagues to talk about difficult cases and leave 'work at work' is an important part of remaining resilient to the effects of vicarious trauma and burnout and remaining hopeful for ourselves and our patients.

Things to remember

- Most perpetrators are known to their victims – this is especially the case with child and adolescent victims.
- Victims typically have highly ambivalent feelings towards their perpetrator if known, i.e. they love them and hate them at the same time. Just because you as the healthcare provider are very certain of how you feel about the perpetrator does not mean the victim feels the same way. The victim's feeling must trump yours at this time!
- Oftentimes, perpetrators will accompany victims to healthcare services to keep an eye on them and what they divulge to others – Healthcare practitioners should make sure that interviews are held in isolation and victims are asked if they feel safe talking in private.
- Witnessing violence in the home is the single most significant predic-

tor

of being a perpetrator or victim later in life – HCPs are missing out on prevention efforts if they are not working with younger victims.

- Most victims never report the crimes against them – it is important to ask.
- We all need to take a stand against violence in our society!!! Notions of 'what happens at home stays at home' need to be challenged so that we collectively increase safety for victims. **We all perpetuate norms by omission if we don't jointly stand up against GBV[®]**

References:

- De Prince AP and Freyd JJ, (2004). Costs and benefits of being asked about trauma history. *Journal of Trauma Practice*, 3(4):23-35.
- Griffin MG, Resick PA, Waldrop AE, Mechanic MB, (2003). Participation in trauma research: is there evidence of harm? *Journal of Traumatic Stress*, 16(3): 221 – 227.
- Jewkes, R. (2002). Intimate partner violence: causes and prevention. *The Lancet*, 359: 1423 – 29.
- Joynner, K., Theunissen, L., De Villiers, L., Suliman, S., Hardcastle, T., Seedat, S. (2007). Emergency care provision for, and psychological distress in, survivors of domestic violence. *South African Family Practice*, 49(3): 15
- Maman S, Campbell J, Sweat M D and Gielen A. (2000). The intersections of HIV and violence: directions for future research and interventions. *Social Science and Medicine*. 50: 459-478.
- National Department of Justice, Children's Act (2010). <http://www.justice.gov.za/legislation/acts/2005-038%20childrensact.pdf>
- National Strategic Plan for HIV and AIDS, STIs and TB (2012-2016). http://www.sanac.org.za/files/uploaded/519_NSP%20Draft%20Zero%20110808%20pdf%20%20final.pdf
- Seedat, M., van Niekerk, A., Jewkes, R., Suffla, S., Ratele, A. (2009). Violence and injuries in South Africa: prioritizing an agenda for prevention. *The Lancet*, 374 (9694): 1011 – 1022.
- UNFPA (2011). Ending Widespread Violence against Women. <http://www.unfpa.org/gender/violence.html>
- WHO (2004). Violence against women and HIV/AIDS: critical intersections. Information Bulletin Series, volume 1. <http://www.who.int/hac/techguidance/pht/InfoBulletinIntimatePartnerViolenceFinal.pdf>



Supporting Health Care Professionals **in Self-care and Debriefing**

Farhana Goga and Kirsten Thomson, WRHI

People working in health care, are naturally caring individuals, inspired to make a difference. However, the stresses and demands of the work context can leave professionals feeling disengaged and less motivated.

What makes the Health Care Team vulnerable to stress and demands?

Vulnerability is not a word that gets talked about within health care systems. Rather, there is a stoicism of being available and getting the job done. This is not all bad, when working with people who are sick and dying, there needs to be focus and intention at work. However, when frustrations and demands are high, divisions, conflicts and complaints become the focus which impact negatively on service delivery. Increased workload and lack of staff are realities but they are not the whole reality. Health care workers are trained to work in demanding and busy systems, so what else is happening?

Vulnerability links to connection and relationship¹. A key aspect of any health care worker's job is working with people: colleagues and patients. In terms of colleagues, it is important to be aware of the dynamics of teams and how this is assisting or hindering the service being delivered. In terms of patients, it is important to be aware that when questions are asked about illness, adherence, medication and/or symptoms, patients are being asked to be vulnerable. An explanation of illness and physical pain comes with a personal story. Within the context of South Africa, which has some of the highest rates of violence in the world^{2,3}, these stories often have challenges of poverty and trauma. Health care workers are from the same South African context and thereby at equal risk of being exposed to violence and hence reactive to their and others' stories. Hearing the heart-wrenching stories, recognizing the severity of mental health concerns in patients and navigating team dynamics without clear communication can leave the health care worker feeling overworked,

under-appreciated, burnt out, avoidant and dismissive.

What are the possible effects with long term exposure to the health care system for health care workers?

The effects of working within a stressful healthcare environment can negatively impact a person and can be seen in the form of stress, burnout or vicarious trauma.

Simply put, stress occurs when the external demands placed on the individual outweigh the internal and external resources of the person to cope⁴. Types of stressors include: life changing events; environmental stressors (eg. unsafe neighbourhood); family and relationship stressors (eg. marital disagreement; rebellious teens); work stressors (eg. job dissatisfaction; exhaustive workload; lack of resources; lack of medication) and social stressors (eg. poverty; unemployment; lack of social support). Work stress can compound home stress and vice versa.

When stress continues without action being taken, it may lead to burnout. Burnout is a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situation⁵. It could also be described as giving too much of yourself, caring too much for others and having little focus or time for self care. Some causes for burnout could include: setting unrealistic goals for yourself or having them imposed on you; being expected to be too many things to too many people; working under rules that seem unreasonably coercive or punitive; doing work that frequently causes you to violate your personal values; feeling trapped for economic reasons by a job that fits any of the above scenarios and being blamed and criticized for matters that

are beyond your control. Burnout has 3 dimensions: emotional exhaustion; depersonalization (negative attitude towards patients) and reduced personal accomplishment and commitment^{6,7}.

Vicarious trauma is the experience of being repeatedly exposed to the traumatic stories of the patients that we support^{8,9}. This does not include our own or our families or neighbours' experiences of trauma, it is the impact of hearing the trauma stories of the patients. The impact on the health worker could be a challenged world view, intrusive imagery with avoidance and hyper arousal, symptoms similar to that of the patients' trauma response (eg. confusion, tearfulness, isolation, anger, irritability, a sense of powerlessness, hopelessness), increased vulnerability and survivor guilt.

To manage these effects it is important to implement strategies of support:

1. Empower health care professionals with information; referral sources and skills
2. Teach staff what mental health is, and create an ethos of self-care, and care for each other (colleagues) and patients
3. Assist people in recognizing their limitations and respecting them
4. Provide structures to manage the work impact (ie. debriefing)

Understanding Debriefing

Debriefing focuses on supporting the individual in managing the challenges and demands within the context of the work. It has a specific emphasis on how the cases and working experiences are affecting the individual. The intention is to share what the issue is, the content of the cases and its impact on the individual. It is not to provide specific information and intervention on the cases (which is considered



supervision) nor is it to provide individual counseling. Debriefing could be facilitated within a group or with an individual.

The process of effective debriefing

Experience suggests that an **external** facilitator is ideal. When the facilitator is internal to the organization other dynamics may emerge, including blurry power dynamics, and support/management role confusion. Furthermore, there needs to be a good relationship with the external facilitator and the manager of programme for which the debriefing group falls under. All this needs to be done while ensuring that it does not violate issues of trust and confidentiality, which are central to the process of debriefing.

Essential to this trust and confidentiality, is commitment from within the organisation, that this is a process that is supported. The facilitator needs to develop confidence with the participants and the participants need to develop reliance with each other. This occurs when the team knows that what is said within the sessions is kept within the sessions and any stepping

out of confidentiality occurs with the acknowledgement and agreement of the group. Further, as trust is developed, the underlying dynamics of the team will emerge and will need to be addressed. This could become conflictual, but it is a healthy space if handled correctly.

If people have not experienced this type of support before, it can take up to two years to facilitate the level of trust and support that one needs to build an effective debriefing group. It is likely that if the participants do not feel contained (safe to speak, helped, empowered), they will stop coming to sessions. It is often the reason that groups fail. Participants feel that they express their struggles, and are left feeling more vulnerable than when they arrived for the session. During that time, patience is required. The group will go through many challenges and changes as vulnerability and ways of working differently in the work place is shared. Ongoing skills development of the group is essential. It makes members feel empowered in their work and builds cohesion in the group. Good debriefing support results in the improvement of staff attitude and service delivery.

Why is self-care important?

Self-care is the performance or practice of activities that individuals initiate and perform on their own behalf to maintain life, health and well-being.¹⁰ Self-care is important to mitigate the impact of the three effects of long term exposure to working within the health care sector. Self-care could literally be doing something for oneself or it could mean accessing other support and resources to help the individual, team or patients through a difficult and/or challenging time.

The benefits of self-care include: creating positivity and confidence in the caring role; creating more support and thereby decreasing isolation; voicing concerns and putting strategies into place to manage situations; asking for and receiving assistance; allowing time to reflect and develop self-awareness and to reconnect to the meaning of the work.

Some suggestions on creating a work culture of self-care

Caring is a value, an attitude and way of being. It is not a lack of professional standards and does not devalue a



strong work ethic. A strong work ethic is upheld by the support of the team and the recognition of the difficulty of the job. If the work culture does not support or create a space for reflection on the frustrations, losses and challenges of the work, then the staff will be disempowered and ill-equipped to be able to deal with the content of their work.

Here are some suggestions to create the support:

- Listen to those around you. Share with colleagues or talk through at work
- Take regular breaks
- Have a culture of openness about difficulties experienced at work. When we share with others at work, make it about finding the solution, rather than just about venting. Learn to voice your needs
- Time-management and shift management must be clear and arranged for the well-being of staff
- Consider formal talk therapy and counselling outside of work
- Support from managers; work-load management; clear reporting strategies; fairness at work
- Laugh

- Physical exercise: walking, going to a soccer field; dancing and singing; bike riding
- Activities such as going out with friends; cooking; listening to and playing music.
- Work/life balance and having a variety of things that fill your life
- Making realistic demands on yourself & others
- Attend debriefing sessions
- Match your expectations with your resources
- Vary your job and activities
- Define your job, your role & your goals clearly
- Learn to bring yourself back into your body through breathing and relaxation exercises so you can be fully present with each person you interact with.

References:

- ¹Brown, B. (2010). *The gifts of imperfection: let go of who you think you are suppose to be and embrace who you are*. Hazelden
- ²Seedat, M., van Niekerk, A., Jewkes, R., Suffla, S., Ratele, A. (2009). Violence and injuries in South Africa: prioritizing an agenda for prevention. *The Lancet*, 374 (9694): 1011 - 1022.
- ³Miller, K & Ramussen, A. (2010) War Exposure, daily stressors and mental health in

conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Social Science and Medicine* 70: 7-16

⁴Lazarus, R.S. (1976). *Patterns of Adjustment* (3rd ed). New York: McGraw

⁵Pines, A. M.& Aronson, E. (1988). *Career Burnout: Causes and Cures*. New York: Free Press

⁶Maslach, C. & Leiter, M. (1997). *The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It*. San Francisco: Jossey-Bass Publishers.

⁷Perlman, B. & Hartman, E.A. (1982). Summary and Future Research. *Human Relations*, 25 (4): 283-305

⁸McCann, I.L. & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131-149.

⁹Sexton, L. (1999). Vicarious traumatization of counsellors and effects on their workplaces. *British Journal of Guidance and Counselling*, 27(3), 393-403.

¹⁰Orem, Dorothea E. (1991). *Nursing: Concepts of practice* (4th Ed.) St. Louis: Mosby

The diagnosis and management of depression in HIV positive patients:

A practical approach for the primary health care or HIV nurse.

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In South Africa, not enough is being done to integrate mental health and HIV care.⁵ As Antiretroviral drugs are rolled out, staff are faced with many health priorities and tend to neglect mental health.



Not only do HIV + individuals have a higher prevalence of depression than HIV - individuals, but depression can lead to a greater risk of contracting HIV. This may be due to the negative effects depression has on behaviour, impulsivity, judgment and insight. Similarly, antiretroviral and opportunistic infection medication as well as the psychosocial effects of HIV, may lead to depressive disorders. Depression is debilitating as it has severe effects on quality of life, adherence to medication and disease progression.¹⁴ Untreated Depression has been associated with substance abuse and alone or together increases risky sexual behaviour, which adds to increased transmission of the pandemic. Studies from first world countries quote prevalence rates of depression among HIV + patients to be between 12 and 71%, depending on the study, cohort and measures (e.g. BDI, CES-D, HAM-D) used.¹ South African studies quote prevalence rates of depression amongst HIV + individuals as high as between 25 and 37.6%.^{2,3}

In South Africa, not enough is being done to integrate mental health and HIV care.⁵ As Antiretroviral drugs are rolled out, staff is faced with many health priorities and tends to neglect

mental health. It is vital to identify depression and treat it appropriately and innovative ways of screening for, diagnosing and treating depression in our population is required

Assessment and Diagnosis

Diagnosing depression may present some difficulties as symptoms of severe disease progression (fatigue, loss of weight, poor concentration) overlap with the neuro-vegetative features of depression. A complete history and physical examination are thus needed as screening tools are only useful to alert you to a possible disorder, which requires further evaluation.

Screening Tools

A number of depression screening tools are available. These may be patient initiated / self reporting tools [e.g. Beck depression inventory (BDI-II), Kessler 10 scale (K10) and patient Health Questionnaire 9 (PHQ 9)] or clinician-initiated tools [e.g. Hamilton depression scale for depression (HAM-D), Diagnostic and statistical manual IV (DSM IV structured interview)]. Some screening tools have been adapted for chronic medical illnesses like HIV (e.g.

BDI-II) specifically.⁶ The Substance abuse and mental illness symptoms screener (SAMISS) is an inclusive tool that screens for a range of mental illnesses including depression, anxiety and substance abuse.⁷ Screening tools may not have high specificity and sensitivity, but are short, easy to use and aim to highlight potential problems warranting a more in depth interview.

A good example of a screening tool for use in a busy clinical setting is the patient initiated PHQ 9 tool. It can also be clinician initiated if need be. It not only uses criteria based on DSM IV criteria for depression, but also gives an indication of severity of depression. Challenges in using this tool may be the language barrier (as it is written in English), or the cultural acceptability of some of the terms used. The PHQ 9 requires that the patient completes, on a Likert type scale, how they rate 9 items relating to their mood in the past 2 weeks. A further question is then asked if they checked any of the boxes, to determine its impact on functioning. The score is then added up to give an initial diagnosis and may also be used to measure the severity of the depression, on an ongoing basis.⁸

Figure 1: The PHQ 9:

Over the past 2 weeks how often have you been bothered by any of 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 are 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 TV	0	1	2	3
8. Moving or speaking so slowly that others could have noticed. Or the opposite - being so fidgety and restless that you have been moving around a lot more than usual	0	1	2	3

Over the past 2 weeks how often have you been bothered by any of the following problems	Not at All	Several days	More than half the days	Nearly every day
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Add columns				
Total:				
0-4: No depression				
5-9: Mild depression				
10-14: moderate depression				
15-19: moderately severe				
20-27: Severe				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you checked any of the problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people				

Score:

For the initial diagnosis:

If there are at least 4 checked boxes in the highlighted section one should consider a depressive disorder. If there are 5 checked boxes in the highlighted section consider Major depressive disorder, if there are 2-4 checked boxes consider a depressive disorder.⁸

The numerical values of each box is then added up to determine severity:

Total score:

Total score	Depression Severity
0-4	None
5-9	Mild Depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Diagnosis of a depressive

disorder is the first step in appropriately treating your patient

Differential diagnosis

Figure 2 delineates an approach to the differential diagnosis of mood symptoms in the HIV positive patient. It is important to divide the differential diagnosis into primary mood disorders,

secondary mood disorders and other: life stressors and psychosocial issues.⁹ It is important to construct a differential diagnosis and exclude a general medical condition as the cause for the altered mental state.

Figure 2: Differential Diagnosis

Primary Mood Disorders	Secondary mood disorders	Psychosocial and life stressors	Other
Major depressive disorder	Mood d/o d.t General Medical Condition (HIV)	Bereavement	Medication effects Efavirenz (EFV) TB Hepatitis C (interferon) Other OI drugs
Bipolar Mood disorder	HIV Associated neurocognitive Disorder (HAND)	Relationship issues	Substance abuse
Adjustment disorder with depressed mood	Opportunistic Infections (OI) - Hepatitis C, Tuberculosis.	Adjustment issues due to stigma, disclosure, rejection, change in body shape	
Anxiety disorders			
Post traumatic stress disorder			

A full examination is not complete without the assessment of risk including suicide risk. Asking about sui-

cidal thoughts, plans or intent will not increase suicidal behaviour. There are specific times in a patient's life when

these questions are vital; e.g just after a diagnosis is given, recent losses, anniversary of a partner's death, uncontrolled pain, worsening of a patient's physical condition, loss of a job and where there is poor social support. One of the biggest predictors of suicide risk is a history of a past suicide

attempt. A useful scale to adopt in your clinical practice would be the sad person's scale that assesses risk of suicide.¹⁰ This scale, although just a guide could also help in terms of guiding your management. A point is given for each item and then added up to help in terms of the required action.

Figure 3: The SAD PERSONS scale

S	Sex: Male is at higher risk
A	Age: extremes of age are at higher risk
D	Depression or other psychiatric comorbidity are at higher risk
P	Previous attempts: those with a past history of attempts are at higher risk
E	Ethanol/Alcohol or other substance use/abuse
R	Rational thinking loss; e.g. psychosis with command hallucinations
S	Social support: no social support confers a higher risk
O	Organized plan
N	No spouse
S	Sickness: Medical or psychiatric illness may confer a higher risk

Figure 4: Score card for the SAD PERSONS scale

0-2 points	The patient may be sent home but one needs to ensure follow up in the future
3-4 points	Close follow up needs to be ensured and hospitalization considered
5-6 points	Hospitalization is strongly considered
7-10 points	Ensure hospitalization and consider involuntary admission if necessary

Management

Making a diagnosis of a depressive disorder is the first step in appropriately treating your patient. While a holistic, bio-psychosocial model is best followed; but may not be feasible in rural areas due to the lack of multidisciplinary team members. The treatment of depressive disorders is best divided into Non-Pharmacological and Pharmacological interventions.

Non-Pharmacological treatment

Many primary health care nurses can't prescribe schedule 5 medications; making non pharmacological management the mainstay of community treatment services.

Community based initiatives

Friendship bench

A novel innovative model to help deal with problems and stressors is to be found in the "friendship bench" project, from Zimbabwe.¹¹ Lay workers were trained to lead peer support groups and in problem solving therapy. A task shifting primary mental health care intervention was piloted. A bench was placed in the clinic grounds and identified as the bench where to go to if one had problems of an emotional nature. A nurse trained in counseling provides weekly group supervision to the lay workers. A clinical psychologist provides fort nightly supervision and a psychiatrist provides monthly supervision. A problem solving approach is

followed and a structured 6 session programme is followed by the facilitators.

Support groups and food security

Food insecurity is a very real problem in resource-limited South Africa. The uncertainty it causes is often a precipitator of depression and the lack of food impacts on adherence to ART as many people feel they "can't take their meds on an empty stomach". A study in Uganda found that food insecurity was associated with depression symptom severity among women and that social support helped alleviate the effects of food insecurity on depression.¹² It is therefore recommended that patients are referred to

1. Support groups led by a trained facilitator (preferably a nurse facilitator)
2. Food security groups which are often community or clinic based and if available
3. Interpersonal psychotherapy adapted for the group setting (IPT-G)

Social and familial support is equally important. This however often relies on disclosure of ones status and stigma may preclude this. It has nevertheless been shown that peer led support groups for PLWHA are helpful in terms of adherence, disease outcomes and the alleviation of depression in some patients.² Identification of substance related issues and referral to groups like AA and NA are useful if available.

Psychological interventions

A recent systematic review found psychological interventions to be effective in the management of depression. Interventions that incorporate a cognitive behavioural component also appear to be particularly effective in a first world setting.¹

Group therapy is an important process and cost effective way of increasing coverage and decreasing costs. Further, highly trained mental health

professionals; who are scarce in South Africa, are not necessarily needed.¹⁴

A study of the effects of group interpersonal psychotherapy, conducted in the community in rural Uganda, showed that 6 months after the intervention versus treatment as usual showed that the 16 week intervention it continued to confer a mental health benefit.¹⁵ This may be important for patients with HIV and Mental Health issues, where many receive treatment at community clinics or from various Non Governmental Organizations (NGO's). In a setting where regular stock outs of antidepressants, limited mental health staff and psychiatrists, where NIMART trained sisters and primary health care sisters are unable to prescribe schedule 5 drugs, facilitator based groups (professional or lay) may be a healthy alternative to antidepressant therapy. This may also help alleviate one of the biggest concerns nurses in the community have with poor support in terms of monitoring side effects and drug interactions of the various medications. Interpersonal psychotherapy, focusing on relationships as the basis for problem solving has been shown to reduce symptoms of depression. This may also be more culturally appropriate in our setting as opposed to cognitive therapy as pointed out by Bass et al¹⁵.

HIV treatment related interventions – adherence and prevention interventions

A number of other lay or peer run groups that deal with adherence and various prevention issues may be useful for the patient as an adjunct to other interventions. Psycho-education and other medically based education initiatives are important for patients to gain insight into their illness.

Pharmacological treatment- Choosing the right treatment for the right patient

It is often very difficult to prescribe a general treatment algorithm for HIV positive patients with depression, as there are such vast diversities of

comorbid medical and other conditions. There are generally three worries that the clinician has to consider when prescribing antidepressants in the HIV positive population; efficacy, the side effect profile and drug-drug interactions.

While most antidepressants are equally efficacious, the tolerability and side effect profile is often the deciding factor when choosing an antidepressant. Side effects of antidepressants often impact on adherence to medication and thereby alter prognosis of both illnesses. One such example is the tricyclic antidepressant (TCA) class of medications. The side effect profile of this class of medication includes; anticholinergic side effects, sedation, weight gain and cardiac side effects. Toxicity in overdose is one further particular worry. This however does not mean that they are not used. One may take advantage of the side effect profile for example in the patient with diarrhea, insomnia or weight loss. Generally one prefers to prescribe the Selective Serotonin Reuptake Inhibitors (SSRI's) as this group of antidepressants has fewer side effects and is less toxic in overdose. One negative side effect commonly described by patients on this class of medication is the sexual side effects of anorgasmia and decreased libido. Co-morbid pain disorders may benefit from prescribing antidepressants that have an effect on chronic pain like some of the tricyclic agents, duloxetine and venlafaxine. While there are theoretical drug interactions between antidepressants and some antiretroviral drugs, many do not require dose adjustments, however there are some that do. TCA's and the protease inhibitors show some significant drug interactions. The SSRI fluoxetine has some drug interactions with nevirapine (NVP) and efavirenz (EFV), and it is unclear whether these necessitate clinical dose adjustments. It is generally felt that there are very few interactions with citalopram and sertraline, and that these are safe and effective agents to use. There are however



concerns in a South African setting of stock shortages and limited access to these agents. Clinicians should have a low threshold for treatment initiation in the HIV positive population with depression, as it may have beneficial effects on adherence, morbidity and prognosis. It is generally considered that an effective trial of medication is 4 to 6 weeks at an adequate dose before switching or augmentation is required.¹⁶

Further treatment strategies include augmentation of various agents and substituting agents, however these should be reserved for the more experienced clinician and are beyond the scope of this article.

Generally interventions that include both psychological and pharmacological approaches are more effective than either intervention alone.¹ It is important that the care of the patient is coordinated in such a way that the patient receives the best possible care. Clinicians therefore have to communicate effectively with each other at all times.

An Algorithm of care

Figure 2 depicts an algorithm and management decision tree in the HIV + Patient presenting with depression. Exclusion of physical causes of altered mental state is important and identifying the cause of delirium, if present, is critical as one needs to initiate treatment of the underlying cause urgently. It is further important to distinguish between the presence of a pre-existing mood disorder or if the symptoms have developed subsequently to the HIV infection.

HINT BOX 2:

Compile a list of support services and numbers to give to patients. E.G. SADAG suicide helpline 0800567567 sms 31393

When to refer

One needs to always remember to refer to a more experienced clinician

should you feel ill equipped to deal with the presenting problem.

HINT BOX 2: When to refer a patient to a specialist?

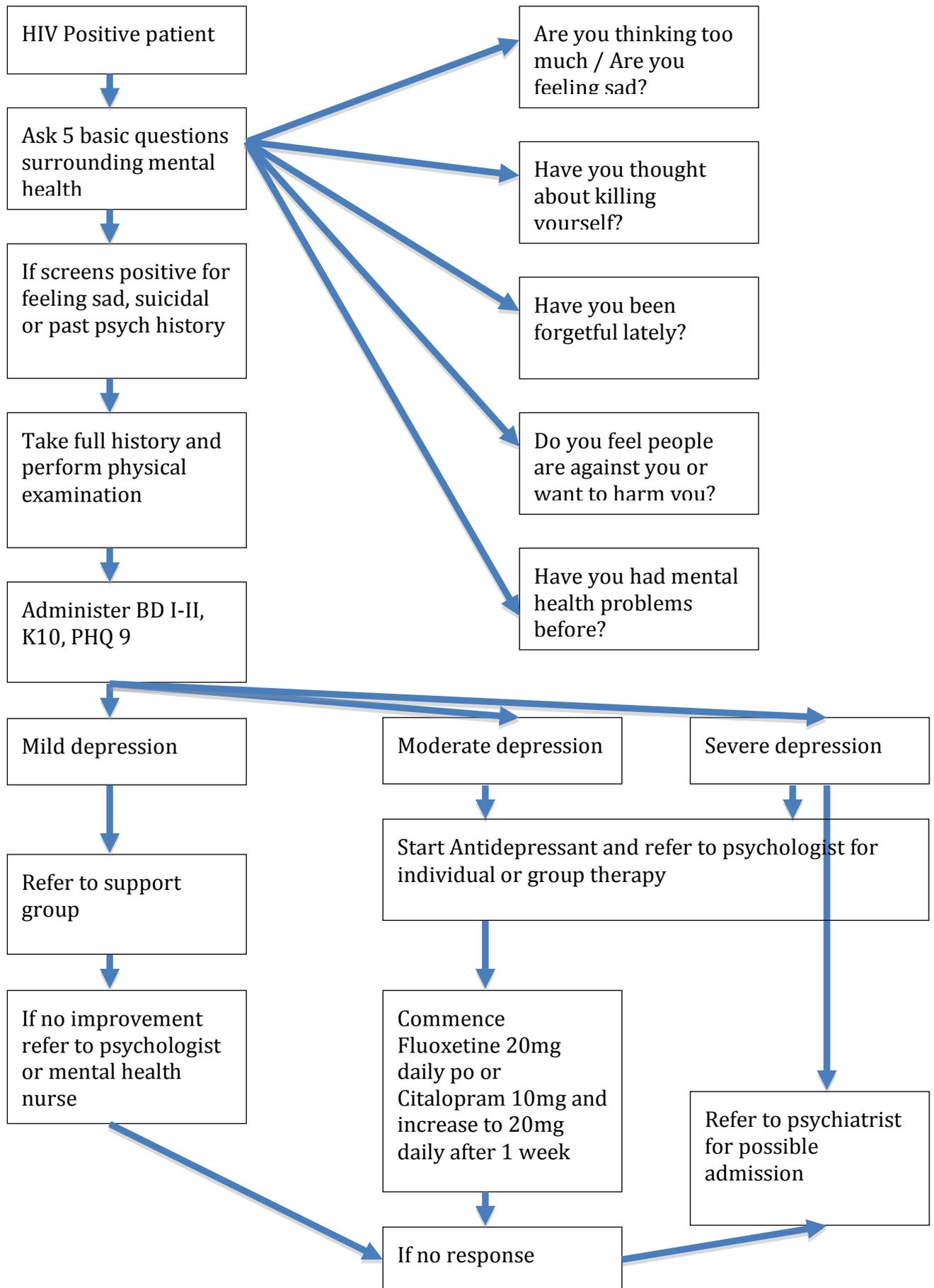
- No response to first line antidepressant therapy
- Presence of psychotic symptoms or suspected bipolar disorder
- Suicidal ideation / intent
- Severe hopelessness, agitation or negativism
- Co-morbid substance abuse/dependence
- Complicated drug regimens or suspected drug-drug interactions

Case study

The following case study depicts some of the more common issues encountered:

Simphiwe is a 29-year-old mother of 2 children; 4 and 2 years old respectively. She was diagnosed with HIV during her pregnancy with her oldest child. Her CD4 count had always been around 550 cells/mm³ but she has recently been physically quite ill. She presented to her local clinic with complaints of fatigue, listlessness, no appetite and loss of weight. She complained about bilateral peripheral neuropathy, chronic cough for the past 2 weeks, night sweats and not coping with caring for her 2 children, something she felt terribly guilty about. She was also anhedonic. She was tearful and reported being sad most of the day all day for the past 2 weeks. She has not thought of ending her life. You examine her and request her to produce some sputum for acid fast bacilli as you think she may have tuberculosis. Her AFB returns as positive and you start her on the intensive phase of antituberculosis therapy and pyridoxine 25mg po daily. Her CD4 count is 100 cells/mm³ and her viral load is 150 000 copies/ml. 2 weeks later you commence her on antiretroviral therapy (ART); lamivudine (3TC), tenofovir (TDF) and efavirenz (EFV). She follows up a month later and still complains of a low mood and scores 37 on the BDI-II. You then decide to start her on an antidepressant.

Figure 5: General Assessment and treatment Algorithm for Depressed HIV + Patients



The recognition of HIV-associated neurocognitive disorders:

A short guide for nursing practitioners

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Nursing practitioners occupy the front lines and spend the greatest degree of time with patients in psychiatric facilities; therefore they need to know how to manage these disorders.

The world's largest population of people living with HIV resides in South Africa¹. The neuropsychological signs and symptoms resulting from HIV infection, commonly referred to as HIV-associated neurocognitive disorders (HAND) will most likely remain a public health concern for South Africa; especially the milder incarnations of this disease. While South Africa actively practices in multidisciplinary frameworks, it is arguably the nursing practitioners who occupy the front lines and spend the greatest degree of time with patients in psychiatric facilities. These professionals would therefore greatly benefit from familiarity with the diagnostic signs of HAND such that their unique position might facilitate early recognition of these problematic but manageable disorders.

How do I recognize and diagnose HAND?

There are 3 different syndromes resulting from HIV infection that can be diagnosed: 1) asymptomatic neurocognitive impairment (ANI); 2) HIV-associated mild neurocognitive disorder (MND); and 3) HAD. These syndromes are discussed in turn below.

Asymptomatic Neurocognitive Impairment (ANI): Patients with ANI present with mild slowing in mental acuity and some loss of concentration but their everyday functioning remains intact so these early deteriorations often go unnoticed by both patient and professional. So it is important, as part of routine care following a diagnosis of HIV infection, to monitor whether patients have experienced any difficulties concentrating – for example, not being able to concentrate on doing one thing like reading a book or sitting through a meeting for as long as they could before – or perhaps unexplained forgetfulness like not remembering where one put one's keys or mobile phone. Detection and diagnosis of these early symptoms is important as a means of pre-identifica-

tion of those patients at further risk for later and more significant decline.

Mild Neurocognitive Disorder (MND): A diagnosis of MND requires evidence of neurocognitive impairment and mild functional decline; this is experienced as more serious and distressing to the patient than the forgetfulness of ANI. Enquire about difficulties completing aspects of daily living independently such as bathing, dressing, or financial management. Often patients may have been “let go” from employment or have had their job responsibilities significantly reduced. If patients are still employed ask whether they have experienced any difficulties completing their work tasks as they did before – often patients who satisfy the criteria for this diagnosis make more errors at work, are less productive, or find that they need to put in more effort to complete tasks.

HIV-Associated Dementia (HAD): HAD represents the most severe form of HAND. Patients at this stage of the disease are most likely already unemployed due to the cognitive difficulties impairing their functioning at work, are most likely significantly or entirely dependent on others to perform tasks of daily living (bathing, dressing etc).

The Neurocognitive Profile of HAND

The cognitive deficits resulting from HAND can be global, however psycho-motor skills, speed of information processing, executive functions, episodic memory, attention/working memory, language, and sensory perception are most commonly affected by HIV infection. Below I outline practical bedside tasks that can be used to examine the cognitive deficits indicative of HAND:

Memory impairment

Can the patient repeat a series of

words or pictures; recall the information after a delay of several minutes and then recognise the words or pictures from a list of multiple others? Does the patient constantly lose valuables (e.g. wallets and keys) or forget food cooking on the stove? Can the patient remember important dates in her or his personal life? Can the patient sequence important events in history in the order that they occurred (e.g. the release of Nelson Mandela, World War 1 and the 9/11 bombing of the Twin Towers)?

Executive and cognitive disturbance

Can the patient draw a clock with all the numbers and set the time according to your instruction? Does the patient display the ability to plan and design well? Does the patient spontaneously initiate behaviour or is excessive prompting required? The patient's abstract or concrete thinking style is checked by asking the meaning of a metaphor (e.g. "People in glass houses shouldn't throw stones" or, in the case of patients with less exposure to formal education, "In which ways are cats and dogs similar?"). Can the patient count to 10, recite the alphabet or subtract serial 3s?

Deterioration of language function (aphasia)

Is the patient's speech vague or empty with excessive use of terms such as "thing" or "it"? Does the patient have difficulty producing the names of individuals or objects and pictures? Can the patient name objects in the room (e.g. desk, lamp or chair) or follow commands (e.g. "Point to the door and then at the table") and repeat phrases (e.g. "No ifs, ands or buts")?

Impaired motor activities (apraxia)

Deficits in cooking, dressing or drawing may be reported. The patient is therefore asked to pantomime an

The Mini-Mental State Exam		
Patient _____	Examiner _____	Date _____
Maximum	Score	
5	()	Orientation
5	()	What is the (year) (season) (date) (day) (month)?
		Where are we (state) (country) (town) (hospital) (floor)?
3	()	Registration
		Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _____
5	()	Attention and Calculation
		Serial 7's. 1 point for each correct answer. Stop after 5 answers. Alternatively spell "world" backward.
3	()	Recall
		Ask for the 3 objects repeated above. Give 1 point for each correct answer.
2	()	Language
1	()	Name a pencil and watch.
3	()	Repeat the following "No ifs, ands, or buts"
		Follow a 3-stage command:
		"Take a paper in your hand, fold it in half, and put it on the floor."
1	()	Read and obey the following: CLOSE YOUR EYES
1	()	Write a sentence.
1	()	Copy the design shown.
		
Total Score _____ ASSESS level of consciousness along a continuum _____ Alert Drowsy Stupor Coma		

activity (e.g. making a cup of tea or combing hair) or to execute a known motor act (e.g. waving goodbye). The patient may also be asked to demonstrate how to brush teeth, to assemble blocks into designs or to copy intersecting pentagons.

Impaired orientation

Does the patient know what day, month and year it is? Does the patient know where she or he is (e.g. the particular hospital, town or country)?

Emotional, personality and interpersonal changes

Do family members report a change in the patient's personality? Is she or he more volatile, aggressive, unpredictable, emotionally shallow or cold? Is there evidence of apathy or withdrawal?

Adaptive functioning

Can the patient carry out tasks encountered in daily living (e.g. bathing, toileting and grooming unaided or, if assisted, to what degree?)

Neuropsychological Screening Tools for HAND

There are a number of screening tools that can be used in the assessment of HIV-related cognitive disturbance for example the HIV Dementia Scale, the Montreal Cognitive Assessment, and the International HIV Dementia Scale. Most of these assessment tools would usually be employed by psychologists, psychiatrists, or neurologists, but it may be useful for nursing practitioners to possess a basic knowledge of the most commonly used assessment instrument for assessing dementia - the Mini-Mental State Examination² (see above).



This is probably familiar to many nurses in South African settings as it is readily available and relatively easy to administer. It is suggested that a score of about 17 and below is suggestive of severe cognitive deficit but naturally one would have to consider diagnostic information from a number sources and then in its totality make a judgement about diagnosis.

Management of HAND

It is preferable that the management of HAND be multidisciplinary in nature. Practitioners should contain and alleviate the family's grief and anxiety by providing education on the patient's diagnosis and an attentive and supportive space within which to voice concerns and fears. They will furthermore most likely be responsible for engaging the family in conversations around care-giving arrangements or possible institutionalisation and for coordinating referrals to other disciplines. The following should also be borne in mind:

- It is preferable to delay institutionalisation as long as this is feasible and within the caregiver's capacity to do so, since patients with dementing diseases enjoy a longer life expectancy when not institutionalised.
- Encourage the performance of activities of daily living and the provision of opportunities for cognitive exercise in the patient, such as reading and writing, listening to the radio, watching television, listening to music, participating in conversations with others and perhaps doing puzzles and playing board-games if this is possible.
- Refer the family to a psychologist or specialist support group, such as Dementia SA (www.dementiasa.org; Toll-free Helpline: 0860636679), for psychotherapeutic intervention or counselling. Such intervention is beneficial in improving the caregiver's quality of life and greatly builds the caregiver's psycho-emotional resources, increasing the likelihood

of managing the challenges associated with caring for a patient with dementia. Psychologists may also be requested to conduct more elaborate and specialist neurocognitive testing to identify specific cognitive impairments.

- Refer the patient to a psychiatrist to exclude other underlying or co-morbid psychiatric disorders, such as depression, to determine which thinking and memory functions may be affected and to what degree and to provide ongoing management in the event that psychiatric symptoms have begun to emerge.

The development of effective treatments for HIV have improved worldwide survival rates but consequently raised prevalence rates as well as the commensurate adverse cognitive and functional impacts of the disease. These now represent a salient public health issue in South Africa. Our nursing practitioners are in a prime position to combat the impetus with which these diseases progress in Africa given their unique position as frontline workers in the mental health system. This can only be achieved through nurses developing a keen knowledge of the symptomology and instituting early remediation strategies via multidisciplinary collaboration. [®]

References

1. World Health Organization. Joint United Nations Programme on HIV/AIDS. Sub-Saharan Africa: Latest epidemiological trends. 2009.
2. Folstein MF, Folstein SE, McHugh PR. "Minimal state": a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 1975;12:189-198.

Nurses occupy

the frontlines and spend the greatest degree of time with patients - they must know how to manage these disorders

Using Creativity:

Description of a writing group
at Luthando Neuropsychiatric HIV
clinic, Chris Hani Baragwanath
Academic hospital



By Ethelwyn Rebelo
MA Clin Psych (UNISA), MA Writing (WITS)
Department of Psychiatry,
University of the Witwatersrand.

The psychological benefits of a writing group based at a neuropsychiatric HIV and mental illness clinic in Chris Hani Baragwanath Academic Hospital is described. Challenges are identified and useful exercises for such groups are noted.

Support groups are a useful vehicle for emotional healing as a consequence of trauma, loss, disability, and many more conditions. Davison et al (2000) found that in the United States, patients with diseases viewed as stigmatizing, such as HIV, were particularly likely to benefit. However the list of the positive functions of support groups is a lengthy one. Their power lies in their capacity to allow members to share their pain and sorrow with others, it lies in their facilitation of the flow of information and advice, and it lies in their capacity to make people feel less alone in their suffering (Randall, 2010).

This paper, however, presents our experience of a different sort of gathering: namely we would like to describe a creative and supportive group in which members are encouraged to express aspects of their lives and predicaments through writing. It was started in March 2011 and convenes every Friday at our Luthando Clinic. 'Luthando', which means 'love' in Xhosa, was formed to assist individuals with both HIV and Mental Illness. It is situated in the grounds of Chris Hani Baragwanath Academic Hospital's Department of Psychiatry.

Group Selection

As regards selection for the group, the only absolute exclusions would be patients who are psychotic and those who are illiterate. However it is recommended that caution and deliberation be exercised when considering the inclusion of those who have personality disorders characterised by aggression and a difficulty with regulating emotions. If sufficiently disturbed on an emotional level, such individuals may interfere with other group members' capacity to think and write. While the focus and function of the group is the creative work, relationships between group members and between members and the facilitator should function to

enhance thoughtfulness and healing in each person's respective response to the creative work. Hence it is important that members are all able to listen and to respond to each other's work in a therapeutic manner. Individuals with poor relationship skills can therefore affect the smooth functioning of the group.

In order to ensure a sufficient degree of attention and focus on each group member and their work, it is suggested that the optimal size for the group is six or seven people.

Our group meeting at Luthando lasts for two hours. Refreshments are offered and creative work and interpretation takes place together with emotional sharing, offers of support and information as well as general conversation.

Challenges

Lack of money is a problem faced with regard to establishing any sort of group consisting of people who are poor and disempowered, as is the case with the patient population attending Luthando. If one wants the group to meet on a weekly basis, this will only happen if the institution is able to assist with transport fare.

Another surmountable challenge was the lack of familiarity of group members with various forms of writing. Members of our group watch television regularly and only occasionally read newspapers or magazines. It was therefore necessary to have sessions in which they were exposed to different types of text. So, for example, a poetry-writing session was preceded by sessions reading poetry.

A further challenge at Luthando has been the need to give interested patients an equal opportunity of joining such a group. Initially I considered letting the group run for a period of a

few months, closing it and then starting a new one. However, in the end, we opted to have open periods every six months in which the loss of one or two members to full-time employment or a loss of interest, could then allow us to obtain the equivalent number of replacements.

Group Exercises

In addition to introducing different types of writing and other creativity exercises, the therapist's role is to listen to people's stories and feelings, to be alert to transformative symbols and to guide members in terms of which form of writing might best suit the material he or she wishes to communicate. In other words, would a particular communication make a good story? Should it rather be moulded into a poem? Would it make a good prayer? And so on.

In addition to writing about incidents in their lives, group members may also write about traumatic experiences, love relationships and so forth. Useful exercises include the following:

- a) Each group members chooses a symbol which represents some aspect of how they see themselves, they then write a poem or story about themselves using this symbol.
- b) Each member gets a chance to have everyone in the group create a poem about how they are seen and/or experienced.
- c) The group listens to a piece of music or views a piece of art and then writes about what emotions and images are evoked for each of them.
- d) The group collaborates on a poem. This assists participants to learn to work together, thus helping to reinforce healthy patterns of mutual interdependence (Furman, 2002, p 151).
- e) Each member identifies an aspect

of themselves with which they are dissatisfied e.g. low self-esteem, an easy anger, a phobia or fear, to explore related emotions, memories and possibly healing thoughts and to write about it.

Reading other people's words assists a person's capacity to empathise. The ability to see another's thoughts makes us doubly aware of the other's consciousness and of our own (Wolf, 2008, p 219; Pinker, 2011, p 175). Hence, at Luthando, every few months, with the permission of respective group members, we choose a piece of writing from each person and type it out to produce what we call our 'Luthando Literary Papers'.

Having the products of their creativity reproduced and distributed helps to improve people's confidence with regard to their writing abilities. The experience of having others read and sympathise with their experiences also helps to validate their responses and to make them feel that they are part of a universal pool of human suffering. Most essentially, however, the very experience of being able to create a piece of writing about their experiences helps them to hold onto more healing emotions and perspectives that may have emerged as they put pen to paper.

Future Projects

The group has decided that the next issue of the 'Luthando Literary Papers' should contain personal memories and the memories of friends and relatives

of the events of June 16 1976 when a peaceful protest by school children was met by violence as the apartheid police shot at them. It is expected that this project will allow people to contemplate their respective social histories and how they are located in response to it.

Conclusion

In addition to being vehicles of supportive interaction between members, writing groups assist members to grow with regard to their communication and problem-solving skills. Through the various forms of writing that emerge, different dimensions of group members' personalities become highlighted so that they are able to embrace more complex and competent self-definitions. Finally, as each writer becomes the hero or heroine of his or her life's drama in the communication of it, new and more empowering meanings of life events and situations are constructed. R

REFERENCES

- Davison, K, P., Pennebaker, J, W., Dickerson, S, S, *Who Talks? The Social Psychology of Illness Support Groups. American Psychologist, 2000: 55(2) Pages 205-217.*
- Furman, R., Downey, E, P., Jackson, R, L., Bender, K, *Poetry Therapy as a Tool for Strengths-Based Practice. Advances In Social Work, 2002: 3(2) Pages 146-157.*
- Pinker, S. (2011). *The Better Angels of Our Nature, The Decline of Violence in History and Its Causes.* Allen Lane, London.
- Randall, M, C, *Support Groups. What they are and what they do. Fact sheet: www.genetichealth.com/resources/support_groups_what_they_are_and_what_they_do.shtml*
- South Africa: Stigma still rife in mental health. Fact sheet: allafrica.com/stories/201007130428.html.*
- Wolf, M. (2008). *Proust and The Squid, Icon Books, London.*

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The Luthando Neuropsychiatric HIV clinic, Chris Hani Baragwanath Academic Hospital

Profile written by Dr Nawab and Dr F Jeena



Staff from Luthando Neuropsychiatric HIV clinic are proud to serve a marginalized and vulnerable population, who often face double or triple stigma. They serve a growing population from Soweto and surrounding areas.



Dr Nawab

Luthando Neuropsychiatric HIV clinic was started in March 2008 by Dr Jonsson as mentally ill patients with HIV were not getting the life saving antiretroviral treatment they deserved. Many patients were being admitted to the psychiatric department and were found to be HIV positive. Not only were the general HIV treatment clinics reluctant to initiate treatment in these patients as they were "perceived" to be and/or "going to be" non adherent to ART but follow up care was not integrated in any way. Patients had to attend two different pharmacies to receive their medication, often standing in queues lasting many hours. Difficult treatment regimens were prescribed and generally very few providers had the time and patience to explain this to them.

We received some initial donation money from an NGO (Aurum Institute) and were able to renovate a disused ward at Chris Hani Baragwanath Academic Hospital. We were also able to finance a post for a nursing sister through this ongoing relationship and were able to employ a medical officer through the hospital. Dr Jonsson heads the clinic and Dr Nawab is the permanent medical officer at the clinic and has been present basically since its in-

ception. She is trained in both Psychiatry and HIV care and has a diploma in mental health and HIV management. The importance of having another trained consultant in the clinic was quickly realized and Dr Fatima Jeenah joined our clinic in 2011 as a specialist. A professional psychiatric nurse (Sr Shareen Boomgaard), currently completing her NIMART training heads up the clinic from a nursing perspective. She joined our clinic in January 2012. Due to the care offered by this expert team our clinic grew tremendously quickly and to date we have initiated over 800 patients on ART and continue to follow up the majority of them. Our lost to follow up rate is comparable to most other general HIV clinics in the region who do not exclusively treat mentally ill people with co-morbid HIV. We then were able to partner with Secure the Future and initiate a community based psychosocial programme based on their seven-step programme. We combined that with general psychiatric care and income generation activities. To date our adherence rate is improving due to this community based approach. We not only have support groups but also food security programmes and a beading income generation group that is facilitated by an Occupational Therapist. Mentally ill peer led groups were trained in TB and general HIV information and now provide peer led support to mentally ill patients with HIV.

Our clinic compliment consists of 2 psychiatrists, a medical officer, a nursing sister and 2 nursing auxiliaries. A data capturer, general admin clerk/counselor and ward assistant complete the programme. Many of the groups are patient run but supervised. Patients are referred to us from the psychiatric wards and we provide an in-patient and an out-patient integrated service including a "one stop shop" of psychiatric, ART initiation, HIV follow up care





Dr F Jeena

Acknowledgements-Dr G Jonsson, and all the Luthando Neuropsychiatric HIV clinic staff, not forgetting Anova Health Institute and Secure the Future for financial support.

and opportunistic infection screening and treatment. The majority of the nursing and support staff are funded through funding now received through the Anova Health Institute.

The majority of patients seen have psychiatric symptomatology due to HIV but approximately 40% have primary psychiatric disorders, including bipolar mood disorder, schizophrenia and major depressive disorder with psychotic features. HIV Neurocognitive disorders really test our programmes ability to provide comprehensive care as this disorder is renowned for lower adherence and many other psychosocial issues. Although very rewarding to treat, this particular illness still has many problems that need attention and further research.

A general day in the life of a Luthando staff member is many fold. Not only did the doctors need to become skilled in integrated care but the counsellors had to deal with patients who were psychotic or suffering from dementia. Crisis mode is a term a Luthando staff member is well aware of, but well

versed in. It became evident that ongoing HIV education and specialist HIV support was needed. This is in part provided by a team of dedicated infectious disease doctors from Cleveland in the USA and is held through two weekly conference calls.

We pride ourselves in taking initiative in every situation often disregarded by others.

Our clinics mission is to provide culturally appropriate integrated psychiatric, HIV and TB care to mentally ill patients with a dual diagnosis. We are proud to serve a marginalized and vulnerable population who often face double or triple stigma. We serve a growing population, including the Soweto area and surrounds.

We initially started at a tertiary centre but soon realized we needed to expand to the community and therefore expanded to Imbalenhle clinic in Orange Farm. We initiated with Secure the Futures community based programme in order to ensure adherence in the long run. As poverty is a huge issue in the area, income generation activities were started to ensure sustainability. This initiative had a very slow uptake and many hurdles were faced as integrated care poses many challenges. As a huge emphasis is placed on task shifting in South Africa, 2 Psychiatric nurses were trained in NIMART and now follow up patients at the community-based clinic. A specialist supervises these nurses and also sees patients weekly at the clinic.

We have also expanded to a rural site and have initiated the "Luthando network project" and support this service in the Eastern Cape. This programme has relied on the model pioneered by Luthando clinic and has therefore replicated this innovative structure.

Mental illness and HIV care has brought to light many issues that need addressing on a local and regional level. Consent to testing remains a problem for providers not trained in mental health care. Ongoing changes with generic pharmaceutical companies supplying medication with different colour and shapes of pills make adherence problematic for mentally ill people to navigate. Perceived Non-adherence, stigma and gender inequalities continue to plague this population.

Similar to many HIV treatment programmes in South Africa and abroad we face an ongoing human resource shortage and financial insecurity. We rely heavily on funding through the PEPFAR and USAID support systems through Anova Health Institute. Without the support of Anova Health and Secure the Future our horizon looks bleak. Mentally ill and vulnerable patients may then face a disjointed and non-integrated community health system, where expert psychiatric teams are not available.

We are all enormously proud of this clinic and its achievements, as this pioneering work is very important for others to replicate and implement. We urge others to be vigilant of common mental disorders in the HIV population and to strive to integrate screening for common mental disorders. 

Luthando Neuropsychiatric HIV Clinic
serves a growing population from Sioweto

Competition

Competition for our READERS

Answer these 3 simple questions and have a chance to win Dr Rita Thom's new book, **"HAART and Mind; common mental disorders in people living with HIV."**

Question 1

Name 3 screening tools that can be used in the assessment of HIV-related cognitive disturbance.
Find the answer in Dr Zahir Vally's article.

...

Question 2

Name 2 non-pharmacological interventions that can be followed to manage depressive disorders.
Find the answer in Dr Greg Johnsson's article.

...

Question 3

According to Farhana Goga & Kirsten Thomson, a strong work ethic is upheld by the support of the team. Name three ways that a health professional can use to create support for her/himself and colleagues.

Find all the answers in the articles of this issue.

Email your answers to Nonhlanhla Motlokoa at nonhlanhla@sahivsoc.org by 31 October 2012. The correct entries will be entered into a draw whereby three winners will receive HAART and Mind; common mental disorders in people living with HIV. The winners will be notified by 15 November 2012.

NDOH/SANAC Nerve Centre Hotlines

• Any HCT concerns from facility and district managers should be reported to the NDOH/SANAC

Nerve Centre Hotline and, specific emails for each province:

- **Western Cape:** 012-395 9081
sanacwesterncape@gmail.com
- **Northern Cape:** 012-395 9090
sanacnortherncape@gmail.com
- **Eastern Cape:** 012-395 9079
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- **KZN:** 012-395 9089
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- **North West:** 012-395 9088
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AIDS Helpline 0800 012 322

The National AIDS Helpline (0800-012-322) provides a confidential, anonymous 24-hour toll-free telephone counselling, information and referral service for those infected and affected by HIV and AIDS.

The helpline was initiated in 1991 and is a partnership of the Department of Health and **LifeLine Southern Africa**. The Helpline, manned by trained lay-counsellors, receives an average of 3,000 calls per day, and is seen as a leading telephone counselling service within the SADC region.

Services Offered by the AIDS Helpline:

- **Information:** The Line creates a free

and easy access point for information on HIV and AIDS to any member of the public, in all of the 11 official languages, at any time of the day or night.

- **Telephone Counselling:** Trained lay-counsellors offer more than mere facts to the caller. They are able to provide counselling to those battling to cope with all the emotional consequences of the pandemic.
- **Referral Services:** Both the South African Government and its NGO sector have created a large network of service points to provide a large range of services (including Voluntary Counselling and Testing, medical and social services) to the public. The AIDS Helpline will assist the caller to contact and use these facilities. The National AIDS Helpline works closely with the Southern African HIV Clinician's Society to update and maintain the **Karabo Referral Database**. www.sahivsoc.org
- **Treatment Line:** A specialised service of the AIDS Helpline, the Treatment Line, is manned by Professional Nurses. They provide quality, accurate and anonymous telephone information and/or education on antiretroviral, TB and STI treatment. They also provide relevant specialised medical referrals to individuals affected and infected by HIV and AIDS in South Africa.





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0860

RESULT 737858

This line is dedicated to providing results nationally for HIV Viral Load, HIV DNA PCR and CD4 to Doctors and Medical Practitioners, improving efficiency in implementing ARV Treatment to HIV infected people. This service is currently available to members of Health Professionals Council of the South Africa and the South African Nursing Council. The hotline is available during office hours from 8am to 5pm Monday to Friday.

Register to use the RESULT HOTLINE

Follow this simple Step-by-step registration process

Dial the **HOTLINE** number **0860 RESULT (737858)**

Follow the voice prompts and select option 1 to register to use the hotline

A hotline registration form will be sent to you by fax or e-mail.

Complete the form and return it by fax or e-mail to the hotline to complete your registration process.

Once you are registered, you will be contacted with your unique number. This number is a security measure to ensure that the results are provided to an authorized user.

To use the hotline dial **0860 RESULT (737858)**

Select option 2 to access laboratory results.

- You will be asked for your HPCSA or SANC number by the operator.
- You will be asked for your Unique Number.
- Please quote the CCMT ARV request form tracking number (bar coded) and confirm that the result requested is for the correct patient.

Should the results not be available when you call, you will be provided with a query reference number which must be used when you follow up at a later date to obtain the result.

Once you have a Reference number

Select option 3 to follow up on a reference number

Should the requested results not be available, a query reference number will be provided to you.

A hotline operator will call you within 48 hours of receiving the laboratory results.

Registering for this service from the NHLS, will assist in improving efficiency, providing improved patient care and streamlining clinic processes. Call now and register to access results for HIV Viral Load, HIV DNA PCR and CD4.



Hospice Palliative Care Association of SA



Short Course in Palliative Nursing for Professional and Enrolled Nurses run in conjunction with the Hospice Palliative Care Association of SA and the Foundation of Professional Development.

INTRODUCTION

The WHO defines palliative care as "an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psycho-social and spiritual."

Palliative care is an integral part of every nurse's role. This course equips the nurse with the particular skills and knowledge required to care for patients with non-curable and terminal illness and to support the patient's family members. This short course is run as a collaborative venture between HPCA and FPD.

WHO SHOULD ENROL?

All professional and enrolled nurses registered with the SANC who care for patients with life-threatening illness.

ASSESSMENT / CERTIFICATION

Formative and summative assessment methods are used to evaluate learning at both theoretical and practical levels. To qualify for the certificate of completion for this short course, participants should fully attend the workshops, successfully complete the assessment process and complete the clinical work.

COURSE DESIGN

The course consists of 3 parts:

1. Day release learning based on methods suitable for adult learners.
2. Assessment component (examination, communication skills and portfolio).
3. 128 hours clinical work – done in a HPCA approved Hospice.

COURSE STRUCTURE

1. Describe the development of palliative care and its role within the health care system and apply legal, ethical and professional principles in the care of patients and families, with particular reference to death and dying.
2. Describe the management principles of pain and symptom control in advanced illness with particular reference to malignant disease, HIV and AIDS, progressive neurological disorders and end stage organ disease.
3. Be competent in the interpersonal communication skills required to establish rapport and facilitate the grieving process with patients, families and colleagues.
4. Demonstrate the ability to understand the developmental stages as applied to social, cultural and spiritual dimensions in the provision of palliative care based on respect for the uniqueness of the individual.

Starting date:

February - 2012
Day Release: 9 February 2012
Distance Learning: 6 February 2012

REGISTRATION

Educational Grant

This course is partially sponsored through an educational grant from HPCA

All interested nurses can apply for this grant from:

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A history of HIV/TB research in Southern Africa and the way forward

Welcome Reception

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SESSIONS

When to start ARV treatment

Contraception and HIV

Biomedical tools for HIV prevention

Managing treatment failure in paediatric patients

DAY 3

SESSIONS

HIV and ageing

TB prevention

HIV and cervical cancer

Drug-induced complications

Celebration Dinner

DAY 4

SESSIONS

Getting to zero: PMTCT

New drug developments for paediatrics

Strategies to address maternal mortality

Confirmed Invited Faculty

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