MEETING TARGETS AND MAINTAINING EPIDEMIC CONTROL (EPIC) PROJECT

COOPERATIVE AGREEMENT NO. 7200AA19CA00002

# Experiences from the Field: Considerations to Inform the Use of Mental Health Screening Tools in HIV Programming

JANUARY 2025

PEPFAR

USAID FROM THE AMERICAN PEOPLE

EpiC Meeting Targets and Maintaining Epidemic Control

fhi360

## Acknowledgements

This brief was written by Maggie McCarten-Gibbs and Robyn Dayton, with contributions from Kriti Adhikari and Thu Vuong, and review by Caterina Casalini, Emily Headrick, Giuliana Morales, Michele Lanham, Jerome Galea (USAID), and Maura Reap (USAID GHTASC Contractor: Public Health Institute). It was edited by Janine Albaugh.

Suggested citation: EpiC, FHI 360. Experiences from the Field: Considerations to Inform the Use of Mental Health Screening Tools in HIV Programming. Version 1. Durham (NC): FHI 360; 2025.

This work was made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The contents are the responsibility of the EpiC project and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government.

EpiC is a global cooperative agreement (7200AA19CA00002) led by FHI 360 with core partners Right to Care, Palladium International, and Population Services International (PSI).

## The Clear Need for Integrated HIV and Mental Health Services

The COVID-19 pandemic exacerbated the global mental health crisis,[i] increasing the focus of many health programs on the mental well-being of health care workers (HCWs) and clients. As urgency grew to address this issue, country programs under the PEPFAR- and USAID-funded Meeting Targets and Maintaining Epidemic Control (EpiC) project began incorporating mental health support into their HIV programs. Mental health conditions (MHCs) are the leading cause of disabilities worldwide, with an estimated 13 percent of the global population living with an MHC.[ii]

There is a strong bidirectional link between HIV and MHCs. The prevalence of MHCs is higher for people living with HIV (PLHIV), with a meta-analysis showing that 24 percent of PLHIV in low- and middle-income countries (LMICs) are living with depression.[iii] MHCs affect HIV outcomes: living with an untreated or poorly managed MHC reduces the likelihood of HIV testing,[iv,v] initiating antiretroviral therapy (ART), continuing with treatment, and viral suppression.[vi,vii] Treating MHCs supports adherence to HIV treatment by improving emotional well-being and reducing barriers that can hinder people's ability to consistently manage their medication and care routines. Research showed that the odds of a client adhering to HIV treatment were 83 percent higher when treated for depression.[viii]

Even in the context of the increasingly urgent need and clear benefits of integrating HIV and mental health services, there is inadequate access to services and support for people with MHCs, particularly PLHIV. The World Health Organization estimates that more than 75 percent of people in LMICs do not receive adequate treatment for their depression.[ix]

To end the HIV epidemic, communities and HCWs are calling for greater attention to mental health and well-being in the context of HIV prevention, treatment, and care.[x] At the normative level, the global HIV targets for 2025 in the Global AIDS Strategy 2021–2026[xi] and the United Nations Political Declaration on HIV and AIDS[xii] include specific targets for the integration of HIV services and mental health.[xiii] Achieving this integration requires a holistic approach to ensure person-centered, context-specific, HIV and mental health services.

## Screening as a Potential First Step in Integration

Many programs that are starting to integrate mental health support into HIV services employ mental health screening tools to identify clients who may benefit from targeted mental health support. There are numerous validated mental health screening tools, which use a standard set of questions to identify potential symptoms of MHCs, indicating a client may benefit from mental health services. Screening tools are not diagnostic and cannot be used to diagnose a client with a specific MHC. Two of the most reliable and frequently used mental health screening tools are the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7). They have been used extensively in research, included in many clinical guidelines, and implemented in various health care and community settings globally.[xiv] The PHQ-9 is a nine-question screening tool that care providers can use to assess the severity of depressive symptoms. The GAD-7 is a seven-question tool used to assess the severity of anxiety symptoms. Other commonly used tools include shortened versions of the PHQ-9, known as the PHQ-2 and PHQ-4, which consist of two and four questions, respectively, used for both depression and anxiety; the Alcohol Use Disorders Identification Test (AUDIT-C), which is a three-question tool that can help identify patients who may have an active alcohol use disorder; and the Kessler Screening

Scale for Psychological Distress (K6), a six-question tool used to identify serious psychological distress. These tools can be administered in person by a clinician, trained HCW or other staff, or self-administered by the patient.

*Table 1. Examples of commonly used screening tools*

| Common mental health concerns | Validated screening tools |
|---|---|
| Depression | PHQ-9; PHQ-4; PHQ-2 |
| Anxiety | GAD-7 |
| Alcohol and Substance Abuse | AUDIT-C |
| Psychological Distress | K-6 |

As well as identifying clients who may benefit from mental health and psychosocial support services, screening can provide an opening for clients to disclose mental health struggles and be an entry point to treat clients through stepped care, an approach where the most effective, yet least resource-intensive, treatment is delivered first.[xv]

## Country Experiences

EpiC first integrated mental health services into HIV programs in Asia, in part due to high levels of documented need. One study in Southeast Asia found that 18 months after the initial COVID-19 outbreak, 46 percent of people were experiencing severe or extremely severe symptoms of depression, 49 percent were experiencing symptoms of anxiety, and 36 percent were experiencing symptoms of severe stress.[xvi] To initiate the integration process, EpiC teams began using mental health screening tools with their clients at HIV service delivery sites in Vietnam and Nepal. The project teams collected data and information on the experiences of clients and providers throughout the process.

### VIETNAM

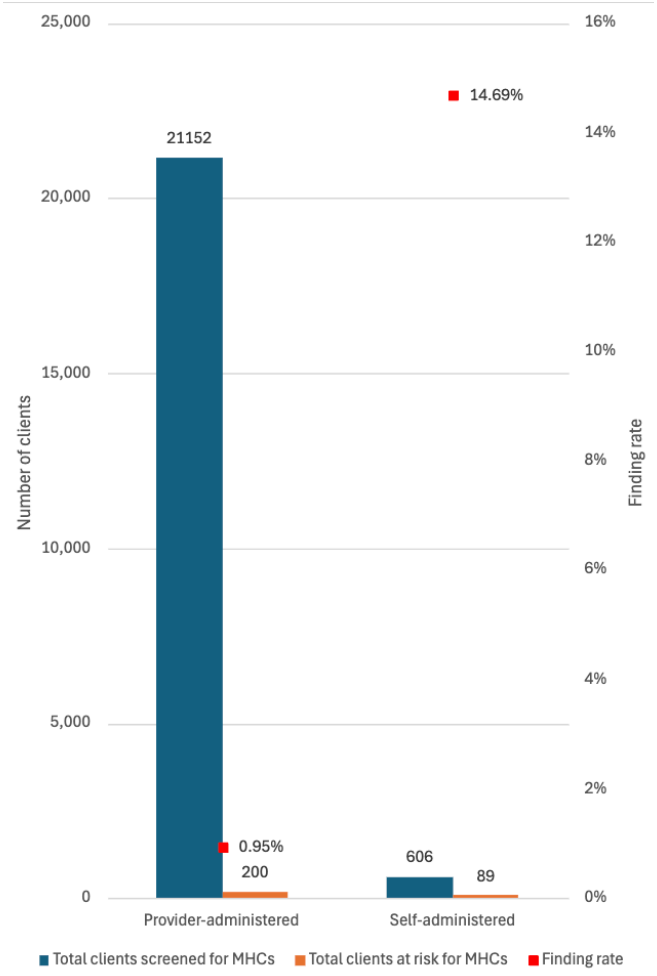
In June 2022, EpiC Vietnam began using the PHQ-4—a nationally validated tool recommended by the Ministry of Health—in routine checkups at select public HIV treatment facilities and key population (KP)-led pre-exposure prophylaxis (PrEP) clinics. From June 2022 through March 2023, the PHQ-4 was used with PLHIV and HIV-negative PrEP clients via self-administered screening at one clinic and counselor-led screening at 20 clinics. The team noticed substantial variations in screening outcomes across clinics, yet all 21 sites had lower positive screening outcomes than expected. A 2022 meta-analysis estimated that the prevalence of depression in Vietnam was around 14 percent during the early years of COVID-19.[xvii] However, another study suggested that the prevalence of depression may be much higher among PLHIV, with estimates of depressive disorders being closer to 36 percent.[xviii] By contrast, the EpiC-

Heath staff at clinic in Vietnam (Photo credit: EpiC Vietnam).

supported sites found closer to 1 percent of clients at risk for either anxiety or depression in February 2023.

After analyzing data from multiple clinics on clients who screened as at risk for a MHC, the team found that the sites using self-administered mental health screening yielded much higher rates of clients at risk for depression or anxiety than the sites using provider-facilitated screening (Figure 1). Upon further investigation, EpiC learned from providers that the self-administered approach allowed clients sufficient time to reflect while completing the questionnaires and that clients felt more comfortable when they did not have to share their symptoms verbally with a provider, possibly due to perceived or internalized stigma around MHCs. There were some drawbacks to self-administration. Providers shared that self-administration required additional time, as clients asked more questions about how to fill out the forms and data from completed paper forms had to be entered electronically at a later time, whereas during provider-assisted screening, health staff at the clinics were able to enter information directly into the hospital's digital records. In addition, some clients felt that the questions were invasive, regardless of the way they were administered.

*Figure 1. Clients who screened as at risk for MHCs, by screening method, from June 2022 to February 2023*




In April 2023, EpiC Vietnam facilitated a learning exchange on self-administered screening for four clinics that expressed interest in learning more about the potential benefits and drawbacks of self-administered screening tools. As a result, two of the four facilities adopted self-administration in place of provider-led administration. At these two clinics, prior to switching to the self-administered screening, 4.7 percent (809) of PLHIV were identified as at risk of depression or anxiety at the public clinic, compared with 3.7 percent (697) of PrEP clients at the KP-led clinic. The self-administered approach was adopted in May, and from May through September 2023, finding rates increased to 11.7 percent (795) at the public clinic and 11.4 percent (282) at the KP-led clinic. The finding rates at the two sites that participated in the learning exchange but did not adopt self-administered screening remained low, at about 0.38 percent, or five out of 798 clients, during the same period.

## NEPAL

In July 2022, EpiC Nepal began training staff and peer outreach workers on the use of mental health screening tools to identify KPs and PLHIV at risk of MHCs as a component of HIV prevention and treatment services. The Nepal team used the K6 to identify clients experiencing psychological distress and refer them for additional screening. While this tool was not available in all local languages, it was considered the best option by the local psychologist supporting EpiC Nepal. In the community, the K6 was administered by trained peer outreach workers, while in the facilities, the tool was administered by HCWs. Anyone who scored above the screening cut-off value was referred to the project-supported psychological counselors or psychiatrists to complete additional screening using the PHQ-9 and the AUDIT-C.

From October 2023 to March 2024, the EpiC peer outreach workers assessed 20,985 clients in the community using the K6. Among them, only 1 percent (132) had scores above the cut-off value for this tool. This was lower than expected, based on a study using Nepal's 2022 Demographic and Health Survey Data, which found a prevalence of depression and anxiety of about 4 percent and 17 percent, respectively.[xix]

Following the seemingly low identification of clients who scored above the tool's cut-off value and challenges with referral—among the 1 percent (132) who scored 13 or above with K6 screening in the community and were referred for further assessment, only half completed the referral—EpiC conducted informal consultations with clients, peer outreach workers, and HCWs to determine barriers and enablers to better identify clients with MHCs. Stigma and fear of privacy breaches were the main concerns from the clients being assessed by peer outreach workers in the community. They expressed the desire to be assessed in the clinic rather than in a community setting and by an HCW instead of a peer worker. The informal consultations revealed that the fear of being diagnosed with a mental illness, a lack of awareness about mental health, and not prioritizing mental health were some of the main causes of the low referral completion rates. Providers were also given the opportunity to share their own experiences of screening and referrals. Both peer outreach workers and HCWs requested additional training and ongoing coaching but also reported feeling overwhelmed with the additional responsibilities related to managing the mental health of clients.

EpiC Nepal redesigned its mental health care model and will be piloting a new approach starting in October 2024. Peer outreach workers will offer community-based mental health education using a vignette-based tool called the Community Informant Detection Tool (CIDT).[xx] This tool consists of paragraph-long vignettes with pictures. Peer outreach workers will use the tool to gauge the extent to which people match these scenarios based on questions beneath the vignettes. If the person's symptoms do not match the story in the CIDT, then the process is concluded. If the symptoms match the story with a moderate match, good match, or very good match, two additional questions are asked: the first question is whether the individual has impaired daily functioning, and the second is whether the person would want support in dealing with personal challenges. Individuals who respond yes to at least one of the additional questions will be referred to the clinic for further screening and treatment.

## Considerations for Mental Health Screening

While both EpiC Vietnam and Nepal approached screening as a first step to ensure that clients who could benefit from mental health services receive care, the teams reflected that their experiences to date suggest that mental health screening is not as straightforward as initially envisioned. As a result of these experiences, efforts were made to further examine when and how screening may be the best option.

When considering the incorporation of mental health screening tools into HIV services, programs should review the validity of tools in their country context and for the specific populations of interest. Screening tools are not universal, and some may not be appropriate in specific cultural and country contexts. It is also important to recognize that even if the questions are valid, clients may feel uncomfortable being asked personal questions, such as those about their mental health. This may be particularly true for clients facing multiple stigmas, such as PLHIV and KP individuals. Programmers should be aware that even with validated tools, the population for which the tool was validated may not include individuals who are most likely to engage in HIV programs and may not accurately capture their experiences of mental health.

As Nepal's experience underscores, screening is not the only option. Programs can also consider alternative forms of identifying clients who may be at risk for MHCs, such as observation (the provider watches and listens and makes notes), interviews (structured and formal, from a script of prewritten questions; semi-structured; or informal question-and-answer type discussion), or vignettes. HCWs can also use their best judgment—informally assessing a client's appearance, attitude, activity, mood and emotions, and speech and language—to decide when to offer referrals for mental health services. To best support HCWs to develop competence and confidence in such judgment calls, supportive supervision structures should be in place to ensure not only continuous training but also interpersonal support as HCWs build a more nuanced practice that involves both quantitative screening tools and qualitative dialogue.

As the example in Vietnam clearly demonstrated, if the decision to formally screen clients is made, the location and modality of screening should be carefully considered. While some research shows that self-administration of mental health screening tools, such as the PHQ, results in higher scores,[xxi] self-administration is not always possible or preferable. In countries with low literacy rates or with many local languages, provider administration may be preferable. Programmers should also consider the setting in which screening takes place. Assessing the feasibility of guaranteeing privacy and confidentiality in community-based screening in a given setting will be important for both the clients' well-being and accurate results.

Furthermore, screening for MHCs requires that providers become accustomed to tools with lower accuracy than those used to identify many physical health conditions. The tools used to screen for MHCs are unlikely to identify everyone who could benefit from care—as compared to a highly sensitive blood test for a specific health condition. Mental well-being can change from day to day, and the timing of screening may not coincide with the presence of symptoms. Elevated scores on a screening tool can indicate that a provider should spend time assessing the client further, but they do not provide proof of a mental health condition. Educating clients about mental health generally could help address the issue of point-in-time screenings by equipping individuals with essential mental health "first-aid" skills and enabling them to recognize early signs of distress in themselves and others and seek help before issues become severe.

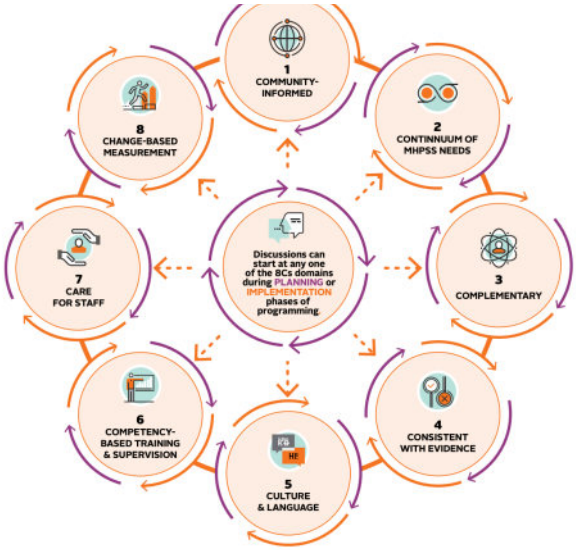
Of fundamental importance, all mental health initiatives must prioritize doing no harm. Programs should also only proactively seek to identify individuals who need mental health services—through screening or another modality—if competent mental health care is locally available and a referral network is in place to treat the specific condition and provide suicide prevention services. In addition, programs that use screening or other modalities to identify individuals who may be experiencing MHCs should consider that the data they generate are not only relevant to the individuals who may or may not be correctly identified. Unidentified clients who need support can generate numbers that grossly underestimate the need for mental health care, harming efforts to adequately resource this growing epidemic.

## Conclusion

Formal screening for MHCs should be given careful consideration and needs thoughtful adaptation for country and cultural contexts. While mental health screenings can be an effective tool, they do not take the place of building a connection with clients. Clients are more likely to share their needs and experiences honestly when they feel comfortable with the provider, which may take time and be influenced by larger issues such as mental health stigma, rather than just the specific questions asked. While tailored, person-centric approaches are critical to increase the identification of MHCs among PLHIV and KP clients, adequate provider training and time commitment are essential to ensure a friendly environment and to assist clients with questionnaire completion. Furthermore, the physical site of the screening may impact clients' feelings of safety in answering deeply personal questions.

There is much to learn about the role of screening as the first step in effective mental health support within HIV services. Given the diverse landscape of coordination opportunities; the growing body of guidelines and recommendations; and the wide array of evidence-based interventions, tools, and evaluation strategies, FHI 360 developed the 8Cs Model of Collaborative Consultation for Mental Health and Psychosocial Support Programs to serve as a roadmap when designing, implementing, improving, or evaluating integrated mental health and psychosocial support (MHPSS)services into new or existing public health, development, or humanitarian programs. As EpiC continues to identify both strengths and gaps in mental health and HIV service integration, the project will continue to share lessons—prioritizing the voices of those implementing and attending programs—to inform effective efforts across the field.

*Figure 2. The 8Cs Model for MHPSS Collaborative Consultation*



[i] World Health Organization. Mental health and COVID-19: Early evidence of the pandemic's impact: Scientific brief, 2 March 2022 [Internet]. World Health Organization. 2022. Available from: https://www.who.int/publications/i/item/WHO-2019-nCoV-Sci_Brief-Mental_health-2022.1.

[ii] World Health Organization. World mental health report: Transforming mental health for all [Internet]. www.who.int. World Health Organization; 2022. Available from: https://www.who.int/publications/i/item/9789240049338.

[iii] Patel P, Rose CE, Collins PY, Nuche-Berenguer B, Sahasrabuddhe VV, Peprah E, et al. Noncommunicable diseases among HIV-infected persons in low-income and middle-income countries. AIDS. 2018 Jul;32:S5–20.

[iv] Senn TE, Carey MP. HIV testing among individuals with a severe mental illness: review, suggestions for research, and clinical implications. Psychological Medicine. 2008 Jul 8;39(3):355–63.

[v] Tao J, Vermund SH, Qian HZ. Association Between Depression and Antiretroviral Therapy Use Among People Living with HIV: A Meta-analysis. AIDS and Behavior. 2017 Apr 24;22(5):1542–50.

[vi] Cholera R, Pence BW, Gaynes BN, Bassett J, Qangule N, Pettifor A, et al. Depression and Engagement in Care Among Newly Diagnosed HIV-Infected Adults in Johannesburg, South Africa. AIDS and Behavior. 2016 Jun 1;21(6):1632–40.

[vii] Pence BW, Mills JC, Bengtson AM, Gaynes BN, Breger TL, Cook RL, et al. Association of Increased Chronicity of Depression with HIV Appointment Attendance, Treatment Failure, and Mortality Among HIV-Infected Adults in the United States. JAMA Psychiatry. 2018 Apr 1;75(4):379.

[viii] Sin NL, DiMatteo MR. Depression treatment enhances adherence to antiretroviral therapy: a meta-analysis. Annals of behavioral medicine: a publication of the Society of Behavioral Medicine [Internet]. 2014;47(3):259–69. Available from: https://www.ncbi.nlm.nih.gov/pubmed/24234601.

[ix] World Health Organization. Depressive disorder (depression) [Internet]. World Health Organization. World Health Organization; 2023. Available from: https://www.who.int/news-room/fact-sheets/detail/depression.

[x] Integration of mental health and HIV interventions Key considerations [Internet]. Available from: https://www.unaids.org/sites/default/files/media_asset/integration-mental-health-hiv-interventions_en.pdf

[xi] UNAIDS. Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. [Internet]. www.unaids.org. 2021. Available from: https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy.

[xii] UNAIDS. Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 [Internet]. www.unaids.org. Available from: https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids.

[xiii] UNAIDS Programme Coordinating Board. Agenda item 5: Mental health and HIV. UNAIDS/PCB (47)/20.28. [Internet]. www.unaids.org. Available from: https://www.unaids.org/sites/default/files/media_asset/Mental_Health_&_HIV_EN.pdf.

[xiv] Kroenke K, Wu J, Yu Z, Bair MJ, Kean J, Stump T, et al. Patient Health Questionnaire Anxiety and Depression Scale. Psychosomatic Medicine [Internet]. 2017;78(6):716–27. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4927366/.

[xv] Ho FYY, Yeung WF, Ng THY, Chan CS. The Efficacy and Cost-Effectiveness of Stepped Care Prevention and Treatment for Depressive and/or Anxiety Disorders: A Systematic Review and Meta-Analysis. Scientific Reports. 2016 Jul 5;6(1).

[xvi] Tay WWY, Jesuthasan J, Wan KS, Ong T, Mustapha F. Eighteen months into the COVID-19 pandemic: The prevalence of depression, anxiety, and stress symptoms in Southeast Asia and the associated demographic factors. Frontiers in Public Health. 2022 Aug 4;10.

[xvii] Duc TQ, Chi VTQ, Quang PN. Depression prevalence in Vietnam during the Covid-19 pandemic: A systematic review and meta-analysis. Ethics, Medicine and Public Health. 2022 Jun;100806.

[xviii] Thai TT, Jones MK, Harris LM, Heard RC, Hills NK, Lindan CP. Symptoms of Depression in People Living with HIV in Ho Chi Minh City, Vietnam: Prevalence and Associated Factors. AIDS and Behavior. 2017 Oct 27;22(S1):76–84.

[xix] Achyut Raj Pandey, Adhikari B, Bista B, Bipul Lamichhane, Joshi D, Saugat Pratap KC, et al. Prevalence, Determinants and Care Seeking Behavior for Anxiety and Depression in Nepalese Population: An Analysis of Nepal Demographic and Health Survey Data 2022. medRxiv (Cold Spring Harbor Laboratory). 2023 Jul 24.

[xx] HealthNet TPO Community Informant Detection Tool [Internet]. Mental Health Innovation Network; 2014. Available from: https://www.mhinnovation.net/resources/healthnet-tpo-community-informant-detection-tool.

[xxi] Lysandrou M, Quaye N, Landes K, Crawford RD, Desai P, Creary S, et al. Evaluating self- vs interviewer-administered screening for depression in sickle cell disease. Blood Advances. 2023 Dec 19;8(3):699–702.