## SCREENING FOR AND MANAGEMENT OF ACUTE SUICIDAL OR VIOLENT IDEATION OR BEHAVIOR

Has the patient had thoughts of self-harm or harm to others since the last clinical visit or, if the patient is new to care, within the last 60 days? *

YES → **Acute Danger?**
- Specific current plan and means to carry it out

NO → **Is any one of the following present?**
- ☐ Intoxication or withdrawal from alcohol or other substances
- ☐ Acute change in Mental Health
- ☐ Current severe psychiatric symptoms, including psychosis, agitation, hopelessness or depressive symptoms
- ☐ History of near-fatal suicide attempt or violence

YES → Escort to emergency department or call 911 for immediate psychiatric evaluation

NO → 
- Initiate open, non-judgemental dialogue with patient
- Discuss factors that would prevent acting on suicidal/ violent thoughts and provide an emergency 24 hour hotline or a provider/support person to call
- Consult with/refer to a Mental Health Provider
- Access social support and consider involving patient's family and friends - with patient's permission

NO → STOP

*The following questions may be used as part of an assessment for suicidal ideation and violent behavior:

☐ Questions for suicidal ideation: Since your last visit [or in last 2 months] :
✓ Have you ever wished you were dead, or wished you could go to sleep and not wake up?
✓ Have you ever had actual thoughts of killing yourself?
☐ Questions for violent behaviour: Since your last visit [or in last 2 months] :
✓ Have you ever lost your temper to the point where you would hurt someone?
✓ Have you ever slapped or hit someone? …What about grabbing and shaking?



## ADDITIONAL RESOURCES

Blood Borne Pathogens Team 250-565-7362
Catie- Canada's source for HIV and hepatitis information:
www.catie.ca/en/home

The Body: The complete HIV/AIDS Resource: www.thebody.com

Northern HIV/AIDS information Source: HIV101.ca

Community Response Unit (CRU) acts as an entry point for Mental Health and Addiction programs, agencies and supports by facilitating referral and access to services. CRU provides brief assessments, short term supportive counseling and crisis intervention, in a variety of environments to meet the needs of the clients. Clients can be referred or self refer. 250-565-2668

Canadian Mental Health Association: British Columbia Division:
www.cmha.bc.ca

National Institute of Mental Health Shared Services BC: www.numh.nih.gov

World Health Organization Department of Mental Health and Substance Use:
www.who.int/mental_health www.who.int/substance_abuse

northern health
*the northern way of caring*

10-400-6104 (IND12/13)

## MENTAL HEALTH AND SUBSTANCE USE SCREENING

**A Quick Reference Guide for HIV Primary Care Clinicians**

People with HIV are more likely to experience mental health symptoms than those in the general population.

Depression, anxiety, post-traumatic stress disorder (PTSD) and cognitive impairment are among the most common disorders. Risk for suicide or violence may be present. Any sudden change in cognitive function, level of consciousness, or behavior should prompt immediate assessment for delirium caused by an acute medical complication.

The complexity of mental health diagnosis and treatment in the setting of HIV often requires a collaborative approach between primary care and mental health providers.*

** Mental health providers include psychiatrists, physicians, nurse practitioners, clinical social workers, counselors, and nurses*

### MENTAL HEALTH SCREENING[a]

**All HIV infected patients should receive baseline and ongoing assessment of the following:**

- ☐ Mental health disorders:
  - ☐ Depression (every visit)
  - ☐ Anxiety (at least annually)
  - ☐ Post-traumatic stress disorder (at least annually)
- ☐ Cognitive function (at least annually)
- ☐ Sleep habits and appetite (every visit)
- ☐ Psychosocial status (at least annually)
- ☐ Suicidal/violent ideation (every visit)
- ☐ Alcohol and substance use (at least annually[b])

[a] *For most patients, mental health screening requires approximately 10 - 20 minutes.*

[b] *At risk drug and alcohol users should be screened more frequently to identify escalation of present levels of use or harmful consequences from use.*

## ASSESSMENT FOR DEPRESSION, ANXIETY, AND PTSD

A brief screening tool, such as the PHQ2, may be used for routine depression screening. For annual mental health screening, an answer of "yes" to any one of the following questions from the SAMISS questionnaire should prompt further evaluation by a member of the health care team and, if necessary, referral to a mental health provider.

**Questions to Identify Depression:**

- ☐ In the past year, were you ever on medication or antidepressants for depression or low mood problems?
- ☐ In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row?
- ☐ In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?

**Questions to Identify Anxiety:**

- ☐ In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?
- ☐ In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?
- ☐ In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath?

**Questions to Identify Post-traumatic Stress Disorder:**

- ☐ During your lifetime, as a child, or adult, have you experienced or witnessed traumatic event (s) that involved harm to yourself or to others?
  - ☐ If "yes": In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma?
- ☐ In the past 3 months, have you experienced any event(s) or received information that was so upsetting it affected how you cope with everyday life?

**Questions to Identify Mania:**

- ☐ In the past year, when not high or intoxicated, did you ever feel extremely energetic or irritable and more talkative than usual?

*Questions have been based on the validated screening instrument developed by the University of North Carolina at Chapel Hill, Departments of Psychiatry Medicine, Public Policy, and Community and Family Medicine; and the Health Inequities Program of Duke University*

## ASSESSMENT OF COGNITIVE FUNCTION

The International HIV Dementia Scale is a validated brief screening instrument that can be administered by non neurologists and may detect early motor and cognitive slowing.

**Cognitive Function Screening Tools: International HIV Dementia Scale (IHDS)**

Memory Registration – Give 4 words to recall (dog, hat, bean, red) – 1 second to say each. Then ask the patient all 4 words after you have said them. Repeat the words if the patient does not recall them all immediately. Tell the patient you will ask for recall of the words again a bit later.

1. **Motor Speed:** Have the patient tap the first two fingers of the non-dominant hand as widely and as quickly as possible.
   - ✓ *Score:*
     - 4 = 15 in 5 seconds
     - 3 = 11—14 in 5 seconds
     - 2 = 7—10 in 5 seconds
     - 1 = 3—6 in 5 seconds
     - 0 = 0—2 in 5 seconds
2. **Psychomotor Speed:** Have the patient perform the following movements with the non-dominant hand as quickly as possible:
   1. Clench hand in fist on flat surface.
   2. Put hand flat on surface with palm down.
   3. Put perpendicular to flat surface on the side of the 5th digit. Demonstrate and have the patient perform twice for practice.
   - ✓ *Score:*
     - 4 = 4 sequences in 10 seconds
     - 3 = 3 sequences in 10 seconds
     - 2 = 2 sequences in 10 seconds
     - 1 = 1 sequence in 10 seconds
     - 0 = unable to perform
3. **Memory Recall:** Ask the patient to recall the 4 words. For words not recalled, prompt with a semantic clue as follows: animal (dog); piece of clothing (hat); vegetable (bean); color (red).
   - ✓ *Score:* Give 1 point for each word spontaneously recalled Give 0.5 point for each correct answer after prompting Maximum – 4 points

**Total International HIV Dementia Scale Score:** This is the sum of the scores on items 13. The maximum possible score is 12. Patients with a score of ≤10 should be evaluated further for possible dementia.

*Reference: Sacktor NC, Wong M, Nakasujja N, et al. The International HIV Dementia Scale: A new rapid screening test for HIV dementia. AIDS 2005;19:(13):13671374.*

## ASSESSMENT OF SLEEP AND APPETITE

Insomnia occurs frequently in HIV infected patients and during all stages of HIV disease, and weight loss is a strong predictor of HIV disease progression. Go to www.hivguidelines.org for resources including:

- ☐ HIV and Mental Health Guidelines Somatic Symptoms
- ☐ Insomnia Screening and Treatment Quick Reference Guide
- ☐ Mental Health Screening Tools

## SCREENING AND ONGOING ASSESSMENT FOR SUBSTANCE USE

Clinicians should be vigilant in screening HIV-infected patients for all levels of alcohol and other substance use and abuse. Even intermittent use can interfere with adherence to medications, raise the risk of side effects from medications, and reduce the patient's ability to practice safer sex. HIV-infected patients should be screened annually for substance use even if the baseline screen is negative.

### Inquire about the following:

- Current and past substance use
- Most commonly used recreational drugs including alcohol, marijuana, stimulants (cocaine including crack cocaine, methamphetamines), opiates, and benzodiazepines
- Use of prescription opiates and benzodiazepines
- Whether the patient, or those around him/her, has any perception of having a substance use problem, now or in the past

### Approach:

- Use non-judgmental language when screening for substance use
- Do not screen if patient has alcohol on his/her breath or appears to be under the influence of drugs
- Ask screening questions that vary from brief to more detailed, using the more detailed questions to explore situations that are suspicious from problem drinking/ substance use

### Approach con't:

- When the patient discloses use of a particular substance or when you suspect the use of a particular substance, ask about:
  - injection drug use, both current and past
  - use of other additional substances. Polydrug use is common in substance-using patients
- Screen patients who are heavy smokers for other addictions

## SUBSTANCE USE SCREENING

A positive screen with any one of the following tools indicates the need for additional evaluation. Many more tools are available.

**Single Alcohol Screening Question**

**How many times in the past year have you had x or more drinks in 1 day?** where x = 4 for women and x = 5 for men, and one or more heavy drinking days in the past year is considered a positive screen

*Reprinted from the National Institute on Alcohol Abuse and Alcoholism. Helping Patients Who Drink Too Much: A Clinician's Guide, 2005. Available at: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm*

**The Two Item Conjoint Screen (TICS)**

1. In the last year, have you ever drunk or used drugs more than you meant to?
2. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

**≥1 positive may be suggestive of a problem**

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**CAGEAID (CAGE Adapted to Include Drugs)**

1. Have you ever felt the need to c ut down on your use of alcohol or drugs?
2. Has anyone annoyed you by criticizing your use of alcohol or drugs?
3. Have you ever felt guilty because of something you've done while drinking or using drugs?
4. Have you ever taken a drink or used drugs to steady your nerves or get over a hangover (eye opener)?

**A total of ≥2 may be suggestive of a problem**

*Reference: Ewing, JA. Detecting Alcoholism: The CAGE questionnaire. JAMA*