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Giving "Sadness" a Name: The Need for Integrating Depression Treatment into HIV Care in Uganda

Raymond Odokonyero, MBChB[1], Glenn Wagner, PhD[2], Victoria Ngo, PhD[2], Noeline Nakasujja, MBChB[1], Seggane Musisi, MBChB[1], and Dickens Akena, MBChB[1]

Abstract

Depression is common among people living with HIV/AIDS (PLWHA) in sub-Saharan Africa (SSA), and can have significant consequences for HIV disease progression, treatment response and prevention. Yet mental health services are limited in most HIV care programs in this region, in part due to severe shortages of mental health professionals. To address the need for establishing an effective, sustainable model for integrating depression treatment into HIV care in SSA, we have embarked upon a 3-year research project, INDEPTH Uganda (INtegrating DEPression Treatment and in HIV care in Uganda), to evaluate a task-sharing, protocolized approach to providing antidepressant care in ten HIV clinics in Uganda. In this paper we share our experiences with two treated cases identified during the initial days of implementation, which we believe highlight the potential value and policy implications for task shifting depression care models in under-resourced settings.

Keywords

Uganda, antidepressants

In sub-Saharan Africa (SSA), depression is common among people living with HIV/AIDS (PLWHA) [1-4] and can have significant consequences for HIV disease progression,[5] treatment response,[6] ability to work[7] and use condoms consistently,[8] and of course quality of life.[9] Yet mental health services are limited in most HIV care programs in SSA.[10] With not enough mental health professionals,[11] and overburdened primary health care providers, there is reluctance among clinicians to engage in mental health service provision, including the prescription of antidepressants to those who need them.

To address the need for establishing an effective, sustainable model for integrating depression treatment into HIV care in SSA, we have embarked upon a 3-year research project, INtegrating DEPression Treatment and in HIV care in Uganda (INDEPTH Uganda), which is funded by the US National Institute of Mental Health and President's Emergency Plan for AIDS Relief. The project evaluates a task-sharing, protocolized approach to providing antidepressant care in 10 HIV clinics housed within government-run or private, faith-based nonprofit health care centers in towns and districts near Kampala, the capital city of Uganda. The model includes (1) routine depression screening[12] at each clinic visit for all clients using the 2-item Patient Health Questionnaire (PHQ)-2 administered by "expert clients" (experienced clients who are trained to assist in lower level tasks) at triage, (2) evaluation and diagnosis of medically stable clients who screen positive for depression conducted by trained nurses using the PHQ-9[12] and Mini International Neuropsychiatric Interview (MINI),[13] (3) algorithm-based prescription and management of antidepressant treatment (fluoxetine or imipramine) provided jointly by nurses and primary care providers, and (4) ongoing supervision provided by a psychiatrist to ensure quality of care (provided weekly at first and then monthly). Clients receiving treatment are seen biweekly for the first month, then monthly until in remission, after which they are seen at their routinely scheduled HIV care visit (every 2-3 months). At each follow-up visit, depressive symptoms, side effects, and treatment adherence are assessed. The model of care and study protocol are described in more detail elsewhere.[14]

The project is still ongoing, so we are unable to report on the results; however, we want to share our experiences during the initial days of implementation, which we believe highlights the potential value and policy implications for task shifting depression care models in the most underresourced settings.

[1] Department of Psychiatry, Makerere University, College of Health Sciences, Kampala, Uganda
[2] RAND Corporation, Santa Monica, CA, USA

Corresponding Author:
Glenn Wagner, RAND Corporation, 1776 Main Street, Santa Monica, CA 90407, USA.
Email: gwagner@rand.org

Following a 2-day training of clinic staff from each site, which included clinical and medical officers and nurses, in addition to on-site trainings with expert clients, clinic staff began to implement the model of care under direct monitoring and mentorship by the supervising psychiatrist and other project personnel. In the first week of implementation, several depressed clients were identified and treated, including 2 suicidal cases that we describe here to showcase how task-shifting, protocolized approaches can be effective for identifying and treating even severe cases, and the importance and urgency of integrating depression treatment into HIV care programs in developing regions such as SSA.

Case No. 1

On the initial day of implementation at one of the clinics in the town of Entebbe, we came into contact with a 39-year-old gentleman, a mason and painter, who 6 months prior had a stroke that led to a right-sided hemiplegia. As a result, he had great difficulty in undertaking his normal day-to-day activities, including work and household chores. He also separated from his wife 5 years ago, and now lives alone. For the past 2 months, nearly everyday, he had a heavy feeling in his heart. The fact that he was crying disturbed him a lot as men are not supposed to cry in Ugandan culture. Eventually, he lost his sleep, appetite, and weight. He preferred to be alone but had no energy to do his daily activities. He also felt hopeless and something inside him kept telling him to kill himself. A month prior to his clinic visit, he bought a rope with the intention to hang himself, though he had not yet made any attempts on his life.

On his visit to the clinic, he was asked the 2 PHQ-2 questions at triage and screened positive for potential depression. His nurse then administered the PHQ-9, which revealed the suicidal ideation in him, and he received a score of 19 and diagnosis of major depression on the MINI. Per protocol, the nurse conducted a suicide risk assessment and then consulted with the supervising psychiatrist who also assessed the client; it was determined that the client could be treated as an outpatient, pending the results of a home visit to further assess the level of suicide risk. The experience of being asked about depressive symptoms shocked the client. He asked the nurse how she knew what he was going through. He was even more surprised to learn that the deep sadness and hopelessness that he felt was a recognized disease—one that had a name no less. ''You mean 'it' has a name?!'' he exclaimed, ''and I can get treatment for it?!'' When the nurse answered both the questions in affirmative and explained that the treatment was often successful, the client smiled for what he claimed was the first time in months. He had hope and invited a staff member to go with him to get rid of the rope that he had kept because he had renewed commitment to live. He was prescribed fluoxetine (20 mg) and seen 2 weeks later at which time most of his symptoms had dissipated (PHQ-9 = 2). By week 4 of treatment, he had no depressive symptoms (PHQ-9 = 0), which has remained for the past 12 months. A few months into treatment, he was working again, had gotten several painting jobs (and had hired 4 men to work for him), and had a new girlfriend.

Case No. 2

During the second week of implementation at another clinic at Mpigi district, the clinic staff came into contact with a single mother in her mid-20s. Her 5-year-old son, whose father left 4 years prior, had mental retardation. Over the past year, she had experienced difficulties coping with her own health and caring for her child. She presented with symptoms of depressed mood, hopelessness, loss of interest, and strong desire to kill her son, whose death she felt might help to ease some of her ''bad'' feelings and if that didn't work, then she would kill herself too. She planned to suffocate her son while he slept, but she had not yet attempted this. She received a score of 25 on the PHQ-9 and a diagnosis of major depression on the MINI. She was quite surprised when the clinician informed her about depression and its treatment. She reassured us that as treatment was available, she would not kill her son or herself, and following an assessment by the supervising psychiatrist and consultation with a family member who promised to provide support and oversight to ensure the safety of the client and her child, it was agreed that she could be treated as an outpatient.

She was prescribed fluoxetine (20 mg) and seen 2 weeks later, with a home visit made within the first week of treatment. Three weeks into treatment, she reported feeling happier (PHQ-9 = 4), loving her child and showed remorse for her earlier infanticidal ideas. Five months into treatment she continued to respond well, had remarried, and soon thereafter transferred to a new clinic after moving to a new district.

These anecdotal cases highlight the impact of depression care on the lives of our clients. In the initial days of implementation, the project may have saved a number of lives—none of which would have been achieved without providers asking these clients about symptoms of depression. In a culture where depression is rarely talked about and stress is a part of life for many, even the most serious levels of depressive symptoms, like suicidal thoughts and intent, are often overlooked. For many of these clients, this was the very first time they were asked about their emotional state in a health setting. Many of these clients expressed shock and intense relief that they could be helped. They often had no idea what depression was, so they were surprised and relieved to learn that their condition has ''a name''—a widely recognized disease and an established treatment that is often successful. Despite the lack of mental health awareness, clients were generally welcoming of treatment and the support of the staff.

The introduction of depression care training, particularly the screening process in these HIV clinics, highlighted the impact of raising mental health awareness and literacy of providers. The providers were surprised that by asking 2 simple questions (PHQ-2), the doors had been opened to learn a lot about how their clients felt—information they had not uncovered through their usual lines of enquiry. They also marveled at how these identified clients had always seemed ''normal''

despite what they now discovered, and they wondered how many clients had been lost to undetected and untreated depression. Although mental health problems and concerns appear to be an inherent concern when working with clients having chronic and fatal illnesses like HIV/AIDS, these issues are often not addressed in medical training for these providers, therefore few inquired about the stress and emotional state of their clients, and even fewer had prior experience with diagnosis and treatment of depression. Several providers were shocked to realize that clients whom they thought were coping well, were in fact depressed, including the providers of clients who were suicidal. The providers described these cases as being an eye-opener to the value of depression screening and treatment, which served to enhance their commitment to the program.

A leading concern about task-shifting approaches to depression care is the question of whether nonmental health professionals can adequately manage cases of severe depression. The cases we present here suggest that primary care clinic staff, who have no prior mental health training and experience, can provide quality depression care with relatively little upfront training but with ongoing support and supervision from mental health specialists. On-site training, supervision, and mentorship were keys to enabling these providers to feel equipped to take on challenging cases, particularly in the initial weeks of implementation. Supervisors were present on-site each week (most sites had HIV clinics only 1 or 2 days a week) for the first 2 months and then monthly thereafter, in addition to being available 24/7 by phone, to provide the support and oversight needed, especially in the case of severe depression and suicide.

The cases described in this report showcase the value of antidepressant therapy and depression treatment more generally, but we do not wish to convey the impression that antidepressant medication is always sufficient to help clients overcome the adversity that drives their depression and suicidal ideation. Our clients face a myriad of challenges as many live in extreme poverty and struggle to provide for themselves and their family, in addition to managing their HIV disease. While antidepressant medication was the sole treatment prescribed in these cases, the assessment and treatment of depression likely increased depression awareness and reduced mental health stigma as well as offered psychological benefits of hope and optimism for a brighter future to clients. We chose to focus solely on antidepressant medication as a starting point for the inclusion of depression care in this setting because we believe it is the most resource-efficient and scalable form of treatment; however, some form of talk therapy is also needed for this population to enable clients to talk about and work through how to cope and manage their life stressors with a trained counselor. We are currently working to develop and pilot a form of group therapy that will incorporate evidence-based behavioral activation[15] and problem-solving therapies[16] delivered by trained lay counselors.

While the lack of mental health professionals in SSA needs to be addressed, this should not prevent depression care from becoming more widely available. Collaborative care, task-shifting approaches, in which primary care providers (doctors and nurses) have been trained to diagnose and treat depression using a structured protocol, have been shown to be successful in other low-resource settings[17–18] but have not yet been demonstrated in SSA or in the context of HIV care. INDEPTH Uganda seeks to fill this gap by documenting challenges and lessons learned in integrating a task-shifting, protocolized model of depression treatment into HIV care, examining the quality of care provided, and assessing the impact of depression treatment on quality of life and public health indicators—all in an attempt to provide evidence to the feasibility and necessity of providing depression care to PLWHA, in SSA. Our study is being conducted in public health facilities and by health care providers that care for both HIV and non-HIV clients; therefore, if successful, this model of care could have application not only in HIV care but in primary care settings, more generally in Uganda and elsewhere in SSA.

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