

# **Adding Life to Years**

**A Guide to HIV and Depression  
for Community-Based  
AIDS Service Organizations**



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Adding Life to Years: Building the Community's Capacity to Identify and Treat Depression in People Living with HIV/AIDS (Project Proposal, January 2003)

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# Adding Life to Years

## A Guide to HIV and Depression

### Preface

#### Why a Guide to HIV and Depression?

The development of antiretroviral therapies has added years to the lives of people with HIV/AIDS (PHAs). But their ability to enjoy those years is being limited by extremely high rates of depression. Better and earlier diagnosis and treatment of depression has the potential to reduce distress and disability, increase survival rates, and to add life to years.

Community-based AIDS service organizations (ASOs) can play a key role in helping to identify and treat depression, but many ASOs report that they are ill-equipped to meet their clients' mental health needs.<sup>1</sup> According to the Community Linked Evaluation AIDS Resource (CLEAR) Unit, which works directly with ASOs in Ontario to evaluate and strengthen their programs, "none of the 30 ASOs in Ontario working with CLEAR have personnel trained in providing mental health care yet these clients represent their highest users."<sup>2</sup>

This guide was developed by the Adding Life to Years Project, a collaborative initiative of the Centre for Research on Inner City Health at St. Michael's Hospital in Toronto, the Ontario AIDS Network (a provincial organization of community-based AIDS organizations), and the AIDS Bureau of the Ministry of Health and Long-Term Care, with funding from the Public Health Agency of Canada.

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## What's in the Guide?

This guide to HIV and depression is designed to help AIDS service organizations (ASOs) and other community-based organizations that provide services for PHAs:

- ◆ understand depression, its signs and symptoms, and the impact of depression on HIV
- ◆ reduce the stigma associated with depression
- ◆ develop the knowledge and skills to help community support workers (CSW) and PHAs identify and obtain appropriate support to manage depression. In particular, to identify clients who can be served appropriately by ASOs and those who require more specialized mental health services
- ◆ provide effective interventions for PHAs with mild to moderate depression and make appropriate referrals to other professionals
- ◆ develop collaborative working relationships with mental health professionals in their communities and improve PHAs access to mental health services, ASOs' access to advice, training, and support on mental health issues, and mental health professionals' understanding of the needs of PHAs.

## Who Should Use this Guide?

The guide is intended primarily for **front-line community support workers (CSWs)** who provide counselling, practical assistance and support services for PHAs. It can also be used by:

- ◆ PHAs who want to know more about depression, ways of coping and possible interventions
- ◆ executive directors, educators and planners in ASOs to help guide staff training, PHA support services and education/prevention programs
- ◆ community mental health providers and addictions counsellors who want to know more about HIV.

The following chapters in this manual are designed to give ASO staff the information and tools to identify and help clients with depression:

Module 1 - Depression and HIV -- defines depression and describes its impact on PHAs

Module 2 - Talking About Depression -- addresses the stigma associated with depression

Module 3 - Identifying Depression, Screening and Assessment -- provides information and tools that ASOs can use to help staff feel more confident about their ability to identify depression

Module 4 - Providing Effective Interventions -- describes the types of strategies and programs ASOs can use to help clients manage mild and moderate depression

Module 5 - Collaborating to Manage Depression - describes how ASOs can build partnerships with mental health services and providers

## Acknowledgements

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# Module 1. Depression and HIV

## What is Depression?

### *Clinical Depression*

Clinical Depression is a serious medical condition that involves the body, mood, and thoughts.<sup>3</sup> The most common forms of depression are major depression, dysthymia, and bipolar disorder.

### *Major Depression*

Major depression involves a combination of symptoms that interferes with the ability to work, study, sleep, eat, and enjoy once pleasurable activities.

The standard clinical definition of major depression, according to the Diagnosis and Statistical Manual of Mental Disorders (DSM-IV), is the experience of at least five of the symptoms listed in Table 1, almost daily for a period of at least two weeks.<sup>4</sup> A major depressive episode may occur only once; but it is more common for several episodes to occur in a lifetime.

**Table 1. Criteria for Major Depressive Episode<sup>4</sup>**

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Five (or more) of the following symptoms have been present during the same two-week period; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

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1. Depressed mood most of the day
  2. Reduced or loss of interest or pleasure in almost all activities
  3. Significant weight loss/gain or decreased/increased appetite
  4. Insomnia or hypersomnia (sleeping too little or too much)
  5. Psychomotor retardation or agitation (slowed or restless movements)
  6. Fatigue or loss of energy
  7. Feelings of worthlessness or excessive guilt
  8. Reduced ability to think or concentrate, or indecisiveness
  9. Recurrent thoughts of death or suicide
- 

### *Dysthymia*

*Dysthymia* is a less severe type of depression involving long-term symptoms that are not seriously disabling, but keep one from functioning well or feeling good.<sup>3</sup> Individuals with dysthymia may also experience major depressive episodes at some time in their lives.

**Clinical Depression** is a serious medical condition that involves the body, mood, and thoughts

## ***Bipolar Disorder***

Bipolar disorder is characterized by severe mood changes, cycling from highs (mania) to lows (depression), often with periods of normal mood in between.<sup>3</sup> When in the depressed cycle, an individual can have any or all of the symptoms of depression. When in the manic cycle, an individual may be overactive, over-talkative, and have a great deal of energy. Mania often affects thinking, judgment, and social behaviour in ways that cause serious problems and embarrassment.

## **Situational Depression**

Depression may be experienced on a wide range of levels. Not all experiences are encompassed by, or meet the criteria for, the standard clinical definitions of depression. It is often natural for people to feel some or all of the symptoms of depression when they are dealing with certain life events.

Situational depression occurs when significant emotional or behavioural symptoms of depression develop in response to certain psychosocial stressor(s).<sup>4</sup> Stressors can range from injection drug use to immigration to homelessness to coming-out to bereavement (i.e. the death of a loved one). The stressor may be a single event or multiple events (e.g., a break-up of a close relationship, diagnosis of HIV); it may be recurrent or continuous; it may affect a single individual, an entire family, or a larger group or community (e.g., discrimination); it may accompany specific developmental events.

**Situational Depression** occurs when significant emotional or behavioural symptoms of depression develop in response to certain psychosocial stressor(s)

## **Depression in Canada**

In a survey conducted in 2002-2003, it was found that 36% of Canadians have suffered from depression or anxiety.<sup>5</sup> Women (40%) were more likely to have personally experienced depression or anxiety than men (32%). People under 25 (27%) and over 65 (29%) were less likely to have suffered from depression or anxiety than people between the ages of 25 and 54 (39%).

## **HIV and Depression**

People living with HIV are experiencing very high rates of depression.<sup>6-8</sup> According to research in the U.S., about 30 to 40% of men with HIV and 40 to 60% of women with HIV experience significant depression.<sup>9-11</sup> A recent study of 360 people living with HIV or AIDS (PHAs) conducted for the Ontario AIDS Network (OAN) revealed that

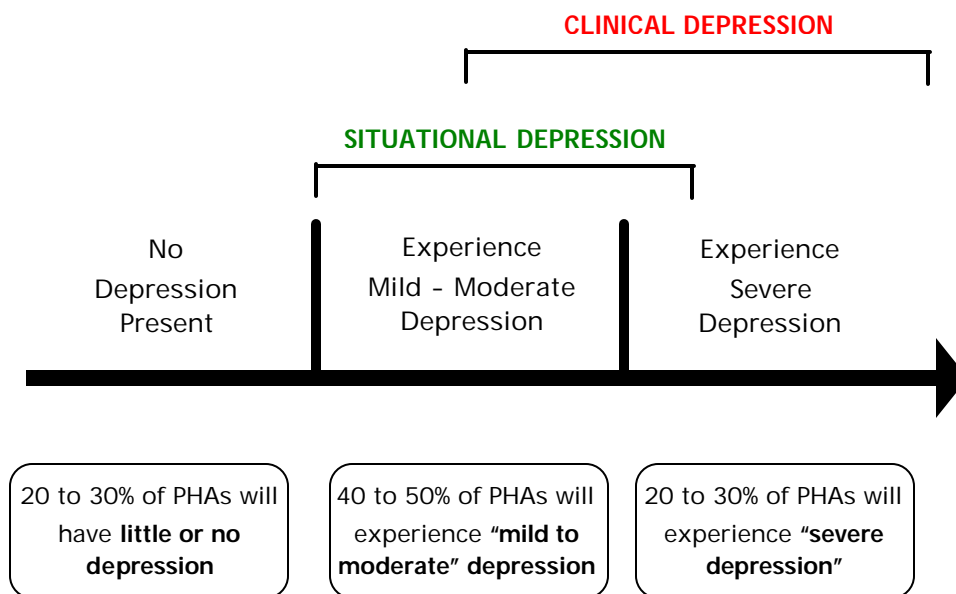
57% had a major depressive disorder.<sup>12</sup> Similar studies of PHAs in Peterborough and Ottawa reported similar results: 54%<sup>13</sup> and 40%<sup>12</sup> respectively were suffering from depression.

Our recent survey data suggests that CSWs<sup>14</sup> generally believe that depression is a serious problem for people with HIV who access community-based ASOs: 18% feel that between 41 to 60% of clients likely suffer from depression. A significant proportion of community support workers estimate the proportion of clients with depression as being much higher: 36% think that depression affects between 61 to 80% of clients, and 20% believe that between 81 and 100% of clients are affected by depression.

While depression is a serious issue among PHAs, the extent to which people suffer from depression and the severity of their depression will vary, depending on many factors including life situation and coping skills. Some will experience little or no depression; most will have mild to moderate depression; and some will experience severe depression (see Figure 1).

PHAs  
People living  
with HIV or AIDS

**Figure 1. Severity of depression in PHAs**



## ***The Impact of Depression on the Lives of PHAs and People at Risk for HIV***

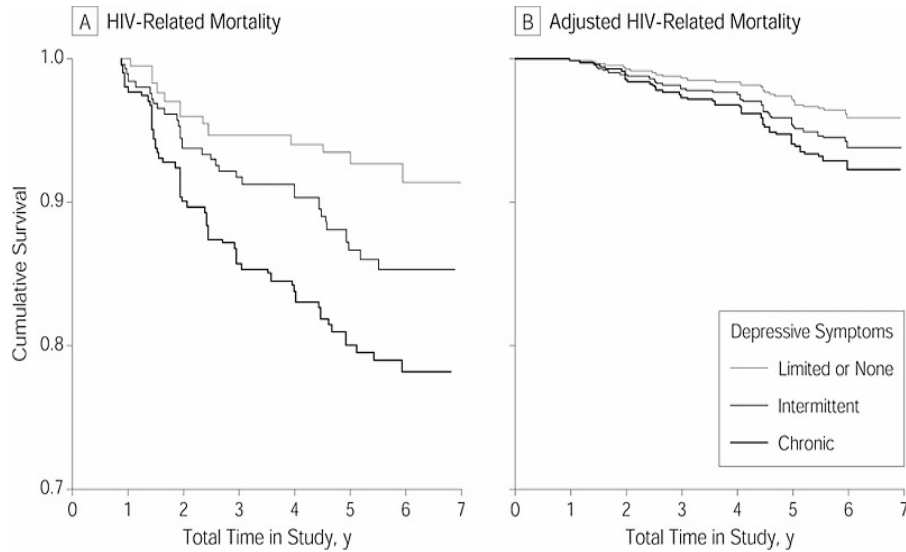
Depression, especially in people living with HIV, is often unrecognized and untreated.<sup>1</sup> In particular, the diagnosis and treatment of depression in PHAs is complicated by the fact that the symptoms of depression may be confused with the symptoms of HIV disease itself and the side-effects of Highly-Active Antiretroviral Medications (HAART).<sup>15</sup>

Depression in PHAs is often unrecognized and untreated

Undiagnosed and/or untreated depression has a debilitating impact on PHAs. It affects their day-to-day functioning, their ability to manage their illness, their immune system and their survival rates:<sup>1</sup>

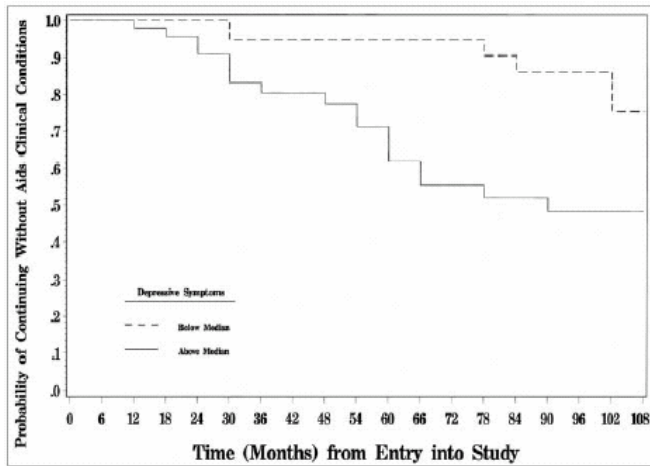
- ◆ PHAs who are depressed may not live as long as PHAs who are not depressed (i.e. increased mortality)(see Figure 2).<sup>16,17</sup> Moreover, PHAs who use mental health services appear to live longer.
- ◆ Depression is associated with faster disease progression (see Figures 3)<sup>18-20</sup> and a decline in CD4 counts in PHAs.<sup>11,21</sup>
- ◆ Depression is associated with lower levels of adherence to medication regimens in PHAs.<sup>22,23</sup> Lack of adherence is the major cause of treatment failure and the development of drug resistant HIV.<sup>12</sup>
- ◆ The risk of suicide increases with depression.<sup>24</sup>
- ◆ Because depression has an impact on people's ability to maintain safer sex and drug use practices, it has serious implications for secondary prevention.<sup>25-28</sup>
- ◆ Depression is associated with a reduction in health-related quality of life in people living with HIV.<sup>29,30</sup>
- ◆ Depression may also be the underlying cause of alcohol and drug use, problems maintaining housing or employment, and difficulty maintaining relationships: all health and social problems that rob people of quality of life.

**Figure 2. HIV-related mortality and depression**



In B, survival curves stratified by level of depressive symptoms from the final Cox proportional hazards model, controlling for baseline CD4 count, viral load, HIV-related symptoms, ARV medication, age, and employment status<sup>11</sup>

**Figure 3. Disease progression and depression**



This figure shows how depression increases the probability of living with AIDS-defining conditions<sup>20</sup>

\* **Note:** Permission will be requested for the inclusion of the above figures, in addition to their modification in order to make them more amenable for a lay audience.

## The Challenge: Accessing Care for Depression

Today, a large number of Canadians who are suffering from depression do not receive the services and care they need.<sup>31,32</sup> A survey of Ontario AIDS service organizations (ASOs), HIV outpatient clinics and other organizations that serve people with HIV in Ontario identified mental health - in particular, depression - as one of the most significant unmet needs of people living with HIV.<sup>33</sup>

This gap in services is due to the lack of recognition of depression as an illness, a shortage of psychiatrists and psychologists, and the expense of their services.

So where do people with HIV who suffer from depression seek help? In the OAN study, the majority (89%) access the services of community-based ASOs.<sup>12</sup> This finding was reinforced by the Peterborough AIDS Resource Network study, which determined that clients who are more depressed are significantly higher users of the organizations' services than those who are less depressed.<sup>13</sup>

ASOs

AIDS Service Organizations

The majority of PHAs who are depressed seek help in ASOs

## Toward a Continuum of Services for PHAs with Depression

Because of the gap in services, many providers and organizations are looking at a different model for providing care for PHAs. Instead of starting with the assumption that mental health services must be provided exclusively by mental health professionals, this client-centred model starts with PHA needs, and then identifies the services required to meet their needs (using a client-centred care approach), and the different agencies/providers that could provide those services.

This approach is based on the fact that people take different actions to cope with depression depending on its severity.<sup>34</sup> For example, people with mild depression use everyday strategies, such as participating in enjoyable activities, exercising, and spending time with friends and family, while people with moderate distress use self-help strategies, such as complementary therapy and dietary changes, and people with severe depression may need professional help.

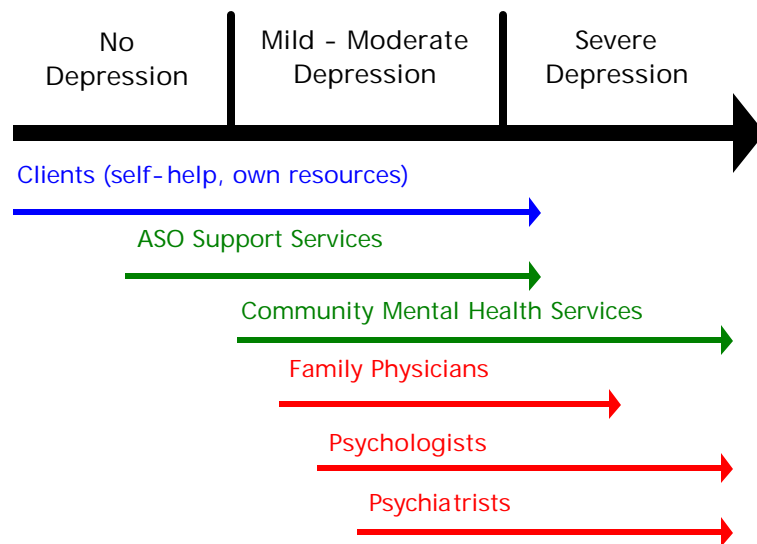
Figure 4 illustrates the range of providers who can help people with depression, based on the severity of their illness. It reinforces that PHAs have personal strengths and resources, and play a key role in preventing and managing depression. It also acknowledges the potential role of ASOs. Table 2 gives a description of the different treatment providers.<sup>35</sup>

Our recent survey data found that almost all community support workers have received some training in mental health issues: 92%

**Client-centred approach** is a form of therapy where the therapist takes the direction of the client in terms of areas to look at

through conferences or workshops and 75% through courses. A significant proportion have had formal education in either psychology (44%) or social work (53%), which suggests that many community support workers already have valuable skills in helping clients deal with depression.<sup>14</sup>

**Figure 4. Spectrum of treatment providers for depression**



**Family Physicians** are members of the Royal College of Physicians and Surgeons of Canada  
<http://rcpsc.medical.org>

**Psychiatrists** are members of the Canadian Psychiatric Association  
[www.cpa-apc.org](http://www.cpa-apc.org)

**Psychologists** are members of the Canadian Psychological Association  
[www.cpa.ca](http://www.cpa.ca)

**Table 2. Description of treatment providers**

Provider	Description
Family Physicians	Family physicians are medical doctors who may or may not have training in counselling.
Psychiatrists	Psychiatrists are medical doctors with special training in counselling, and usually require a referral from a family physician. Only psychiatrists and medical doctors can prescribe medications.
Psychologists	Psychologists are trained counsellors with special expertise in psychotherapy. They are not medical doctors, and cannot prescribe medications.
Social workers	Social workers are trained counsellors who are often associated with social service agencies, although some work independently.
Therapists/Counsellors	Therapists and counsellors refer to someone who practices one of many different kinds of counselling. They may be trained in a particular kind of counselling, or may have developed expertise on their own.
ASOs	ASOs are community-based organizations that provide a variety of services to people living with HIV/AIDS, possibly including mental health support.

**Social Workers** are members of the Canadian Association of Social Workers  
<http://www.casw-acts.ca>

## What is the Role of ASOs in Helping Clients Manage Depression?

Many effective interventions for depression - including screening, prevention programs and support services - can be delivered by community-based organizations. For example:

- ◆ a number of community-based organizations are collaborating with the Mental Health Screening initiative in the U.S. and Canada to provide sites for free screening for depression<sup>36</sup>
- ◆ community-based organizations can provide information and education about depression and coping skills, and about the relationship between depression and other health/social problems.
- ◆ community-based organizations can provide social support services, such as counselling, support groups and assistance with practical needs (e.g., assistance with housing, food, income)
- ◆ community-based organizations can make referrals to mental health services and providers.

In fact, ASOs are in a unique position to help PHAs with depression because they already have established supportive relationships with clients, as well as services that are provided in a trusting, empathetic, confidential, and non-judgmental environment - all of which are essential in managing depression and other stressful life events.

Our survey data suggests that many CSWs are already providing support to their clients for depression: 94% provided assistance with housing and practical needs, 83% provided one-on-one counselling, 74% provided support around finding volunteer opportunities, 60% helped clients find peer support groups, 57% provided assistance in developing social support networks, and 51% provided group counselling services.<sup>14</sup>

### ***Barriers to ASOs Providing Depression Services***

ASOs can play a critical role helping PHAs with depression and adding life to years, but they are often limited by:

- ◆ the stigma associated with depression and other mental health problems
- ◆ lack of confidence - by PHAs and by ASO staff themselves - in their ability to identify depression, distinguish between mild/moderate and severe depression, or knowing when to refer clients to mental health specialists providers

"Counsellors at [an ASO] are not psychologists. How can they do anything for somebody with depression when they're not trained? How do you recognize depression?...Where do I [refer] them...?"

Focus Group Participant, 2003

CSWs  
(Front-line)  
Community  
Support Workers

- ◆ lack of knowledge about effective interventions
- ◆ lack of links to mental health services and providers in their communities
- ◆ staff concerns about their own mental health
- ◆ lack of time and resources
- ◆ pressure to help clients deal with what may be perceived as more urgent issues, such as a housing, income and adherence to medication

This manual does not directly address the ASO issues of limited time/resources and competing demands but - because depression is an underlying factors in so many other health and social problems, such as housing, addictions, and problems adhering to medications - we believe that identifying and managing depression will reduce the need for other services.

## Module 2. Talking About Depression

### Depression and Stigma

In our society, there is a stigma associated with mental health problems, including depression.<sup>37</sup> This stigma can take the form of the public feeling uncomfortable around people who have mental health problems and discriminating against them. This type of externalized stigma can also make ASO staff uncomfortable talking about depression or providing services for people who are depressed.

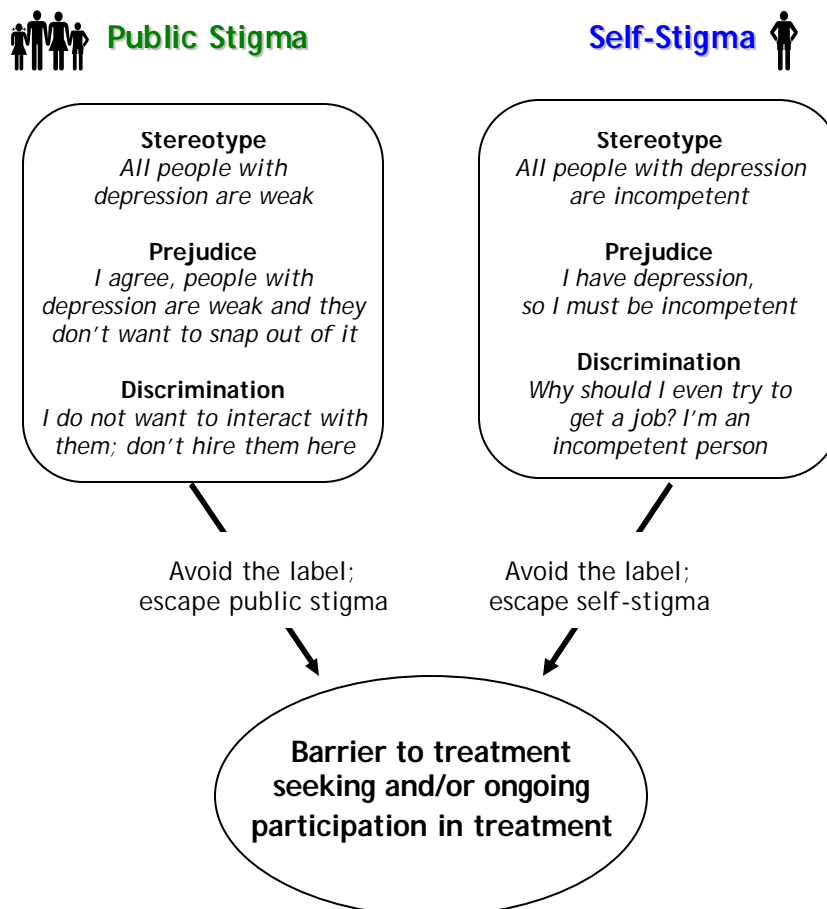
Stigma can also take the form of self-loathing, in which people who are depressed internalize negative public attitudes towards mental illness.<sup>38</sup> This internalized stigma can prevent PHAs from acknowledging their depression or seeking help for fear of being labelled mentally ill<sup>39</sup> (see Figure 5). It also compounds the stigma that many members of marginalized groups already experience having HIV.

“There [are] people who stigmatize people who are depressed... ‘Like, what’s the matter with you? Why can’t you do it?’”

Focus Group Participant, 2003

Figure 5. Factors that may influence seeking treatment

Adapted from Corrigan 2004<sup>38</sup>



Disclosure of HIV status can be very stressful, having to confront the reality of dual-diagnoses of both depression and HIV can make it that much more difficult to accept. Disclosure of HIV status can also have the potential of creating HIV stigma towards loved ones, family and friends who are associated with a PHA. As a result, HIV stigma is often silenced or denied for fear of social exclusion or even violence.

The stigmatization of mental illness may be especially prevalent in certain populations. It has been suggested that stigma is a barrier to accessing mental health services in Asian Americans,<sup>40</sup> Pacific Islanders and African Americans.<sup>41</sup>

## **Reducing Stigma**

To reduce the harm that depression is causing PHAs, we must reduce the stigma associated with mental illness. For more than 50 years, mental health organizations have worked hard to destigmatize depression. People now talk more openly about depression and the available treatments, and some progress has been made. ASOs can help reduce stigma and increase access to care by:

- ◆ increasing mental health literacy in PHAs and staff
- ◆ normalizing depression by talking about it as a normal response to HIV and to other life pressures
- ◆ integrating information about depression into other programs.

## ***Increasing Mental Health Literacy***

Mental health literacy is the level of knowledge and beliefs that people have about mental disorders (e.g. their causes, consequences, and treatments). People who have high mental health literacy are more likely to be able to recognize, manage, and prevent mental illness,<sup>42</sup> while low mental health literacy can increase illness severity in PHAs<sup>43</sup> and prevent people with mental health issues from receiving the best possible treatment.<sup>42</sup> For example, one study found that depression was more likely to go unrecognized in people with less education.<sup>44</sup> This suggests that having a low level of depression literacy prevented people from accessing care.

ASOs can help to reduce stigma by increasing mental health literacy in PHAs. Previous research has found that providing information about depression, such as through a depression information website, can significantly reduce personal stigma in depressed individuals.<sup>45</sup> In addition to talking about depression, there are many effective ways to provide information on depression in order to improve mental health literacy in PHAs.

Other information/communication strategies include:

- ◆ displaying posters and brochures about the signs and symptoms of depression and self-help strategies to reduce stress
- ◆ including articles about depression, stress, and life events in newsletters
- ◆ promoting mental health and wellness throughout the year (e.g., national depression screening day and mental health week)
- ◆ offering education sessions about depression and other mental health issues
- ◆ developing peer support networks

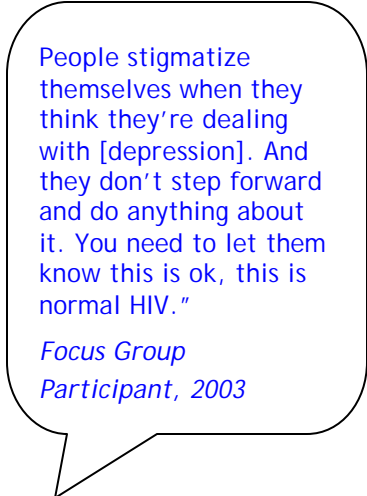
ASOs can also work to increase mental health literacy in their own staff. In doing so, ASO staff can develop the language they need to be able to communicate with mental health providers and make appropriate referrals.

### ***Normalizing Depression/Choosing Language Carefully***

The way we talk about depression can help reduce stigma. Depression is a common experience for people living with HIV/AIDS, and it is often a normal response to dealing with HIV and other life pressures. Therefore, some people object to using the clinical definitions of depression because they may unduly pathologize or stigmatize an experience that is prevalent among people with HIV/AIDS. Instead they describe depression as “stress” or “sadness”, and they talk less about what is lost to depression (Table 1 on page 1).

Furthermore, factors such as culture and gender can shape the experience and communication of depression. For example, Latino and Mediterranean cultures may be more likely to complain of “nerves” and headaches, whereas Middle Eastern cultures may be more likely to complain of problems of the “heart”.<sup>4</sup> With regard to gender, men may be more willing to acknowledge fatigue, irritability, loss of interest in previously enjoyable activities, and sleep disturbances, rather than feelings of sadness, worthlessness, and excessive guilt.<sup>46,47</sup> Consequently, it is important to consider both culture and gender when we talk about depression.

One way in which we can change the way we talk about depression is by including positive affect. Previous studies have found that measures of positive affect, such as how often they feel just as good as other people, feel hopeful, feel happy, and enjoy life, may be associated with health outcomes.<sup>48,49</sup>



People stigmatize themselves when they think they're dealing with [depression]. And they don't step forward and do anything about it. You need to let them know this is ok, this is normal HIV."

*Focus Group  
Participant, 2003*

### ***Integrating Depression into Other Programs and Services***

Community-based AIDS organizations can help to alleviate certain barriers to care by integrating information about depression into other programs and services. In this way, clients who do not actively seek help with depression will still have access to information and support. For example:

- ◆ screening for mental health issues/depression should be integrated with other assessment and screening processes (see Module 3)
- ◆ all support programs/groups include information on depression and strategies to improve mental health (i.e., coping strategies)
- ◆ all prevention programs include strategies that enhance mental health, such as exercise, diet and social support

## Module 3. Identifying Depression: Screening and Assessment

### What is Screening?

Depression is a common medical condition that can be treated. Screening is an objective way of identifying whether someone may be depressed and assessing how severe that depression may be. The purpose of screening is NOT to diagnose depression, but to identify people who may be depressed and who may require further assessment.

Screening for depression is based on using a valid screening tool - usually a series of questions - designed to pick up changes in a person's daily habits or the way he or she thinks, feels and behaves that could be early signs of depression (see Figure 6). Everyone being screened is asked the same questions. The results are scored, and the scores can indicate whether a person is coping well, is at risk of depression or should be referred for further investigation. It is worth noting that some of these questions are already asked by CSWs at ASOs.

### Why Screening is Important?

Screening is important because it can help identify depression very early (i.e., in the early stages before the person develops more severe signs and symptoms). Because of the relatively high rates of depression in PHAs, screening offers many advantages: It can increase by 10% to 47% the diagnoses of depression.<sup>50</sup>

- ◆ People with depression who are screened and identified early are more likely to get the support and treatment they need early, and enjoy better health outcomes.<sup>51</sup> The earlier people are diagnosed and treated, the less likely they are to progress to severe depression and the more likely they are to avoid depression in the future. For PHAs, the benefits include better adherence to medications, better management of HIV, less stress, greater capacity to manage life events, and longer survival.

Regular screening for depression (i.e., once every 6 or 12 months) gives ASOs an effective way to monitor clients' mental health over time, and pick up any problems that they may develop. This also helps increase psychosocial interventions, which may be the cause or consequence of underlying problems.

**Psychosocial**  
Looking at the  
emotional and  
environmental  
aspects of a  
problem



**Figure 6. Emotional, Mental, Behavioural, and Physical Signs of Depression**

<b>Changes in Feeling</b>	<b>Changes in Thinking</b>	<b>Changes in Behaviour</b>	<b>Physical Changes</b>
<p><i>Have you experienced:</i></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Loss of interest in activities that once gave pleasure?</li><li><input type="checkbox"/> Decreased interest in and enjoyment from sex?</li><li><input type="checkbox"/> Feelings of worthlessness, hopelessness and excessive guilt?</li><li><input type="checkbox"/> Deadening or absence of feelings?</li><li><input type="checkbox"/> Sense of overwhelming or impending doom?</li><li><input type="checkbox"/> Loss of self-esteem?</li><li><input type="checkbox"/> Feeling sad, blue, down in the dumps?</li><li><input type="checkbox"/> Unexplained crying for no apparent reason?</li><li><input type="checkbox"/> Irritability, impatience, anger, aggressive feelings?</li></ul>	<p><i>Have you experienced:</i></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Thoughts are slowed, difficulty thinking, concentrating or remembering information?</li><li><input type="checkbox"/> Difficulty making decisions?</li><li><input type="checkbox"/> Obsessive ruminations, sense of impending doom/disaster?</li><li><input type="checkbox"/> Preoccupation with perceived failures or personal inadequacies?</li><li><input type="checkbox"/> Harshly self critical and unfairly judgmental?</li><li><input type="checkbox"/> Loss of touch with reality - hearing voices, having fixed ideas?</li><li><input type="checkbox"/> Persistent thoughts of death or suicide?</li></ul>	<p><i>Have you experienced:</i></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Withdrawal from social, work and leisure activities?</li><li><input type="checkbox"/> Avoiding decisions?</li><li><input type="checkbox"/> Neglecting duties such as housework, gardening, paying bills?</li><li><input type="checkbox"/> Decrease in physical activity and exercise?</li><li><input type="checkbox"/> Decrease in self care -- personal grooming, eating?</li><li><input type="checkbox"/> Increased use of alcohol or drugs (prescription and non-prescription)?</li></ul>	<p><i>Have you experienced:</i></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Changes in appetite - weight loss or gain?</li><li><input type="checkbox"/> Sleep disturbances?</li><li><input type="checkbox"/> Sleep is not restful - feel worse in the morning?</li><li><input type="checkbox"/> Decreased energy - weakness and physical fatigue?</li><li><input type="checkbox"/> Agitation, restlessness, a need to move?</li><li><input type="checkbox"/> Phantom pains, headaches, muscle aches and pains?</li><li><input type="checkbox"/> Gastrointestinal upsets?</li></ul>

## Establishing a Screening Program

### *Who Should Be Screened?*

There are two possible approaches to screening for depression in PHAs:

- ◆ universal screening - that is, screening of all ASO clients as a routine standard of care
- ◆ targeted screening - that is, screening of a selected group of clients based on certain criteria, such as: people who express concern about their mood or who show signs of depression.

The advantages of universal depression screening are that: it helps “normalize” the experience of depression and makes it something that is discussed with all clients; and it reduces the risk of missing someone who is depressed and would benefit from services.

It is up to each ASO to consider establishing a screening approach or policy.

### *Who Should Do the Screening? What Skills are Required?*

It depends on the screening tool. Some complex tools are designed to be used by mental health experts: psychiatrists, psychologists and psychometrists. Some simpler tools can be used by counsellors. Some are designed to be used by individuals for self screening.

According to focus groups conducted for the Adding Life to Years project, PHAs would like easier access to screening that would help them identify any depression, but they are concerned that ASO staff may not have the skills to provide screening or help them deal depression. What if they were misdiagnosed? ASO staff are also concerned about their ability to do screening. Do they have the skills to interpret the results? How will they distinguish between mild depression and severe depression? Will screening alter their relationship with clients, making it more clinical and less supportive?

PHAs were interested in self screening: tools that they could complete on their own. But ASO staff were concerned about the possible impact of self screening on someone who was depressed - particularly because people often find it difficult to distinguish between screening and diagnosis.

In fact, screening tools like those in Appendix A and B can be administered effectively by ASO staff who:

- ◆ feel comfortable using the tool
- ◆ are able to present the issue well to client and with empathy

**Psychometrist** a person who has received training in psychology or related field with an emphasis in tests and measurement

- ◆ are able to exercise judgment on how to present the tool based on the client's characteristics (e.g., any cultural issues)
- ◆ knows how to interpret the results (i.e., has access to guidelines)
- ◆ understands that the tool does not make a diagnosis
- ◆ uses the tool in conjunction with a plan of action designed to help clients address any issues identified during screening.

### ***Which Screening Tool Should be Used?***

One method of quickly screening patients who may be depressed is by asking these two questions: During the past month, have you often been bothered by (1) little interest or pleasure in doing things or (2) feeling down, depressed or hopeless?<sup>52</sup> If the answer to **both** questions is "no", the screen is negative. If the answer to **either** question is "yes", the patient health questionnaire should be administered (described below).

As an alternative to the two-question screen, ASOs can use open-ended questions to address emotional issues.<sup>52</sup> For example, questions can be asked about depressed mood (e.g., how's your mood been lately?), the impact of symptoms on function (e.g., how are things at home/work?), psychological symptoms/suicidal ideation (e.g., do you ever feel like life is not worth living?), anhedonia (e.g., what have you enjoyed doing lately?), and physical symptoms (e.g., what about your appetite?).

ASOs can also use the Patient Health Questionnaire (PHQ-9) to screen for depression (see Appendix A). This screening tool was designed to be a self-administered questionnaire to assess high-risk patients.<sup>53,54</sup> It is comprised of a nine-symptom checklist that is derived directly from the DSM-IV diagnostic criteria for major depression, along with a question that asks about functional impairment and a question to probe for dysthymia. It has been validated for diagnostic assessment and for follow-up.

**Anhedonia** is the inability to gain pleasure from normally pleasurable experiences

**Dysthymia** is a disorder with similar but longer-lasting and milder symptoms than clinical depression

### ***How to Interpret the Results?***

The PHQ-9 allows for a provisional diagnosis of mild/minimal depressive symptoms, moderate depressive symptoms, moderately severe major depression, and severe major depression (see Table 3).<sup>53,55</sup>

**Table 3. Diagnostic categories for depression**<sup>53,55</sup>

PHQ-9 Symptoms & Impairment	PHQ-9 Severity	Provisional Diagnosis	Treatment Recommendations
1 to 4 symptoms, functional impairment	< 10	Mild/Minimal Depressive Symptoms	- self-care - stress-management - education
2 to 4 symptoms, question a or b +, functional impairment	10-14	Moderate Depressive Symptoms	- social/peer support - practical assistance - self-efficacy - solution-focused therapy
= 5 symptoms, question a or b +, functional impairment	15-19	Moderately Severe Major Depression	- refer client to psychologist/psychiatrist
= 5 symptoms, question a or b +, functional impairment	> 20	Severe Major Depression	

### ***How to Distinguish Between Mild/Moderate and Severe Depression?***

Screening is not the only way to identify people who may be developing severe or clinical depression. ASOs can also watch clients for changes in behaviour that indicate a person may be slipping into a clinical depression, including:

- ◆ a change in adherence to treatment (e.g., missing appointments or medications)
- ◆ an inability to make life choices, including those related to medical care
- ◆ a preoccupation with a particular problem usually something minor
- ◆ a change in functioning, including an inability to perform activities of daily living
- ◆ a return to substance use
- ◆ self-imposed isolation.

### ***When Should a Client be Referred?***

It is important to refer the client to a psychologist/psychiatrist when severe depression is suspected. This is especially important if the client poses a suicide risk. The following questions may be asked to assess suicide risk:<sup>52</sup>

- ◆ Have these symptoms/feelings we've been talking about led you to think you might be better off dead?
- ◆ This past week, have you had any thoughts that life is not worth living or that you'd be better off dead?
- ◆ What about thoughts about hurting or even killing yourself? IF YES, what have you thought about? Have you actually done anything to hurt yourself?

If the client answers "yes" to any of these questions, refer the client to a psychologist/psychiatrist immediately.

## Module 4. Providing Effective Interventions

### Expert-Based Therapies

Traditional expert-based treatments for depression are delivered by highly trained regulated health care professionals, such as psychologists/psychiatrists. These include pharmacological treatments, psychotherapy (in particular, cognitive-behaviour therapy [CBT], interpersonal therapy [IPT], electroconvulsive therapy [ECT]), or a combination of these various forms of treatment.

#### **Pharmacotherapy**

The clinical guidelines of the Canadian Psychiatric Association for the treatment of depressive disorders recommend selective serotonin reuptake inhibitors (SSRIs) as the first-line of treatment for depression.<sup>56</sup> Previous research has shown that SSRIs are at least as effective as tricyclic antidepressants (TCAs) and have relatively better tolerated side-effects. According to these guidelines, TCAs should be used where SSRIs have been proven to be ineffective.

#### **Psychotherapy**

Two types of psychotherapy for depression are cognitive-behavioural therapy (CBT) and interpersonal therapy (IPT). Cognitive-behavioural therapy teaches patients to modify thoughts and beliefs that may worsen depressive symptoms in order to help patients accept and adjust to their current disease status.<sup>57</sup> This is conducted in a structured, time-dependent, and goal-directed manner.<sup>15</sup>

Interpersonal therapy (IPT) is a brief and structured form of psychotherapy that usually runs from 12 to 16 weeks. It helps patients to relate changes in their mood to changes in their environments, particularly in the interpersonal context.<sup>15</sup> Due to the assumption that there is an interpersonal component in depression, IPT specifically focuses on problems in social functioning (e.g. interpersonal disputes, role transitions, grief, interpersonal deficits) with consequent benefits in symptom experience.<sup>58</sup> One study found that 16 weeks of IPT was more effective in reducing symptoms of depression in PHAs than supportive therapy.<sup>59</sup>

It is important to note that a combination of treatments (e.g. psychotherapy and medication) may result in additive or synergistic effects.<sup>60</sup>

#### **Pharmacotherapy**

The treatment of disease with medicine

#### **SSRIs & TCAs**

Selective serotonin reuptake inhibitors and tricyclic antidepressants are different classes of antidepressants used mainly to treat clinical depression

#### **Cognitive-Behavioural Therapy**

A process where the individual uses awareness of their behaviour to produce change

#### **Interpersonal Therapy**

A short-term psychotherapy that focuses on improving interpersonal relationships and communication skills

## ***Complementary Therapies***

Some complementary medicines, such as acupuncture, massage therapy,<sup>15</sup> and St. John's Wort,<sup>61</sup> have recently become more acceptable forms of treatment for depression, although reports of potential interactions between St. John's Wort and antiretroviral therapy remain a cause for concern. It is currently advised to avoid this herbal remedy if you are taking antiretrovirals.

However, not everyone who is depressed will need antidepressant medication or other expert interventions, as there are other treatment options available.

## **Community-based Therapies**

A wide range of interventions that can be delivered by ASOs are effective in helping PHAs - particularly PHAs with mild or moderate depression - prevent and manage their illness. These interventions include: education, social support, practical assistance, peer support, self efficacy, stress management, and solution focused therapy.

### ***Education***

Community-based AIDS organizations can give PHAs information that they can use to promote and maintain good health, and to make treatment choices. This approach has been used effectively with other health issues (e.g., programs to promote breast self examination, healthy diets and smoking cessation). Education enhances health literacy and self care,<sup>62</sup> and can empower PHAs to become the primary managers of their mental health care.

Educating PHAs about depression is an effective method of decreasing their symptoms of depression. Previous research has found that providing educational materials is as effective as a supportive-expressive group intervention in reducing distress over time in people living with HIV.<sup>63</sup>

In particular, computer-based health care applications are becoming an increasingly important source of education and support for patients,<sup>64,65</sup> and have the potential to increase mental health literacy and decrease symptoms of depression by providing information about depression. For example, a psychoeducation website offering information about depression significantly improved participants' understanding of effective evidence based treatments for depression and reduced symptoms of depression.<sup>66</sup>

Health literacy is an important factor in the health and treatment of people living with HIV/AIDS. PHAs with lower health literacy had lower CD4 cell counts, higher viral loads, were less likely to be taking antiretroviral medications, reported a greater number of hospitalizations, reported poorer health, and had more negative health care perceptions and experiences.

*Kalichman et al. (2000)*

## ***Social Support***

Social support has been shown to have a positive impact on general health and mortality,<sup>67</sup> a person's emotional adjustment to stress,<sup>68</sup> as well as symptoms of depression.<sup>69-72</sup> Social support is thought to improve psychological well-being by meeting a person's need for belonging and counteracting feelings of loneliness.<sup>71</sup> Some studies have suggested that social support acts to buffer or mediate the impact of a variety of stressful life experiences, including depression and chronic and physical illness (e.g. HIV/AIDS).<sup>71,73-75</sup> While evidence for the buffering effects of social support remain somewhat inconclusive, social support is consistently shown to have a direct positive impact on depression.<sup>69-72</sup> A recent large-scale study found that women reported higher levels of social support than men, and that emotional social support was more protective against depression for women more than men.<sup>70</sup> This highlights the importance of social support networks, particularly for women, to counteract the effects of depression.

Social support can help people adjust to and cope with an HIV diagnosis.<sup>75-77</sup> PHAs have a number of stressors in their lives and could benefit from support, however HIV disease can have a direct effect on the kind and amount of support they receive.<sup>76</sup> For example, unpredictable disease progression can make it difficult for caregivers to maintain the high levels of support needed.<sup>78</sup>

There are different types of social support:

- ◆ Informational - advice or guidance regarding a problem
- ◆ Instrumental or Tangible - help with meal preparation or household chores
- ◆ Emotional - caring, love, and empathy.<sup>76,79</sup>

ASOs are in a strong position to provide all three types of social support, and have extensive experience in this field.

The perceived function or quality of social support that people receive is more important than the actual number of supports in a person's life.<sup>80,81</sup> Although partners/spouses, friends and family are the most common sources of social support, additional support can be found in online discussion forums and community groups for PHAs (see Other Resources: Useful Websites).

## ***Practical Assistance***

Practical assistance can play a key role in helping people manage depressing. Housing problems and/or lack of food or income can be a significant source of stress. When people have help managing those

stresses, it also helps manage depression. ASOs already have considerable expertise in these areas which can help alleviate depression in PHAs.

### **Peer Support**

People living with HIV/AIDS can use computer-based applications to communicate with other PHAs, thereby accessing a source of peer support. In one study, people living with AIDS used a home-based computer network that combined an electronic encyclopaedia, a decision support system, and a communications pathway.<sup>82</sup> Use of the network effectively reduced social isolation and improved decision making confidence. As communication services were used more extensively than other services, it was suggested that peer contact was the primary contributing factor.

"...depression is really about community. It's got to be about, '...you lift my spirits and I'll lift yours.'"

*Focus Group Participant, 2003*

### **Self Efficacy**

**Diet.** It has been suggested that omega-3 fatty acids, compounds derived from fish oils, play a role in depression.<sup>83</sup> In a comparison of international variations in the prevalence of depression, a high national prevalence of depression was associated with a low dietary intake of fish and seafood. This led researchers to look into the possibility of using omega-3 fatty acids to treat depression.<sup>84</sup> In one study, patients with recurrent depressive disorder were given an omega-3 fatty acid, in addition to maintenance antidepressant therapy.<sup>85</sup> This therapy significantly reduced core symptoms of depression, including depressed mood, guilt feelings, worthlessness, and insomnia.

**Exercise** has beneficial effects in a wide range of health problems, including HIV/AIDS. Previous research suggests that performing aerobic exercise is safe and may improve both cardiopulmonary fitness and psychological well-being in adults living with HIV/AIDS.<sup>86</sup> More specifically, studies have shown that physical activity can reduce a person's risk for developing depression and reduce the symptoms of depression.<sup>15</sup>

**Bibliotherapy** involves a patient independently working through a treatment plan that is described in a book.<sup>87</sup> Bibliotherapy is superior to no treatment for depression, and can be as effective as individual or group therapy.<sup>88</sup>

**Self-care.** There are several other ways for PHAs to care for themselves, thereby making their own health and well-being a priority. This includes making time for pleasurable activities (e.g. schedule a fun activity each day), spending time with people who can

support you (e.g., friends and loved ones can accompany people on their activities), and practicing mental and physical relaxation (e.g. trying deep breathing).<sup>89</sup>

### ***Stress Management***

Stress-management techniques, such as relaxation training and imagery, coping-skills training, and interpersonal-skills training, may reduce depression, social isolation, and anxiety in PHAs by lowering tension and increasing self-efficacy.<sup>90</sup>

For example, one study found that group-based cognitive-behavioural stress management/expressive-supportive therapy interventions and individual psychoeducation interventions are effective at improving the aspects of quality of life that are related to mental health in women with AIDS.<sup>91</sup> Similarly, another study found that African American mothers with HIV who participated in an HIV self-care symptom management intervention reported fewer feelings of stigma, higher physical function scores, and a reduction in negative affective state.<sup>92</sup>

**Psychoeducation** is the education of a person in subject areas that serve the goals of treatment and rehabilitation

### ***Solution Focused Therapy***

Solution-focused therapy involves constructing solutions in brief therapy. The main assumption is that focusing on the positive, on the solution, and on the future facilitates change in the desired direction. Therefore, practitioners (1) work in a positive way with people, instead of labelling or pathologizing mental illness, (2) are oriented to the future in therapy, rather than concentrating on the client's past, and (3) focus on solution-oriented talk rather than on problem-oriented talk.

**Pathologize** to view or characterize as medically or psychologically abnormal

During therapy, the practitioner can discuss what the clients are doing that is working, or what they want to do to make things better for themselves (e.g., clients see themselves solving their problems). Strategies that have been successful in the past can be capitalized on in order to help clients build solutions in their life. Throughout this process, the client is the expert while the practitioner assists them in achieving their goals.

### **Strategies to Counter the Common Effects of Depression**

The following table sets out some of the common effects of depression and strategies that ASOs can use to help PHAs manage them.

**Table 2. Problem solving strategies**

Common Effects of Depression	Strategies
<b>Negative thoughts</b>	<ul style="list-style-type: none"> <li>◆ Do not accept negative thinking; present the positive side to provide a more balanced perspective</li> <li>◆ Break large tasks into small ones, set some priorities; encourage individuals to do what they can when they can, a bit at a time</li> <li>◆ Encourage individuals not to expect too much too soon, as this will only increase feelings of failure</li> <li>◆ Avoid blaming individuals for their depressed mood or expecting them to “get over it”.</li> </ul>
<b>Sense of hopelessness or helplessness</b> <b>Lack of motivation</b> <b>Difficulty with planning, memory, making decisions</b>	<ul style="list-style-type: none"> <li>◆ Provide reminders for appointments and medication regimes</li> <li>◆ Provide lots of encouragement, including having someone accompany individuals to appointments or social activities</li> <li>◆ Create a bright and cheerful environment</li> <li>◆ Encourage attention to self care (e.g., cleanliness, appearance, tidy living environment, treats)</li> <li>◆ Help individuals schedule and organize their routines</li> <li>◆ Provide reminders to practice safer sex and ensure that a supply of lube and condoms are always visibly available.</li> </ul>
<b>Social</b>	<ul style="list-style-type: none"> <li>◆ Ensure individuals have regular social contact - encourage them to be with other people; arrange for friends or volunteers to visit</li> <li>◆ Encourage individuals to participate in social activities they enjoy (e.g., movies, volunteering, exercise faith groups, self-help group)</li> <li>◆ Help individuals build a strong social support network (e.g., phone support, visits, group outings)</li> <li>◆ Encourage activities that provide an alternative to drinking or drug use; support individuals who were previously involved with alcohol or drugs to develop a new more positive peer group</li> </ul>

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<b>Common Effects of Depression</b>	<b>Strategies</b>
<b>Physical</b>	<ul style="list-style-type: none"><li>◆ Monitor diet, and encourage individuals to eat nutritious meals</li><li>◆ Set up regular physical exercise routines/activities</li><li>◆ Teach relaxation methods, such as meditation</li><li>◆ Establish regular sleep patterns; encourage individuals to get enough sleep</li></ul>
<b>Suicidal Tendencies</b>	<ul style="list-style-type: none"><li>◆ Ask the person: are you thinking about suicide? do you have a plan?</li><li>◆ Listen without making value judgements: someone who is depressed needs a supportive ear more than being told what to do</li><li>◆ Believe what the person says and take all threats seriously</li><li>◆ Never encourage someone to keep suicidal feelings a secret: maintain trust and assist them to contact someone trained to deal with suicide</li><li>◆ Encourage individuals to seek help; ask them to agree to get support when they feel overwhelmed (e.g., contact you, call suicide services)</li><li>◆ Develop a "plan for life" contract with a list of people to contact in an emergency and steps individuals can take to prevent self harm</li></ul>

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## Module 5. Collaborating to Manage Depression

### Building a Network of Support

Partnerships with other community organizations, such as local branches of the Canadian Mental Health Association (CMHA), hospitals, and community care clinics, can create a support network for ASOs. It is important to recognize that we are all serving the same clients and communities, and that healthy living includes mental and physical wellness. Our organizations exist to serve people; our approach and support should focus on the people's need, not on their illness.

### Developing collaborative relationships

There are many ways that organizations and providers can collaborate to help clients manage depression and other mental health needs. For example:

- ◆ ASOs can identify community mental health services, psychiatrists, psychologists and physicians who are willing to take referrals of clients with signs of severe depression, or to provide advice to ASO staff
- ◆ mental health professionals can give workshops for ASO staff on identifying and managing depression
- ◆ ASOs can give workshops for mental health professionals on HIV and the complex issues faced by people living with HIV
- ◆ mental health professionals can work with ASOs to plan and present workshops or other programs for clients designed to enhance their mental health
- ◆ staff from a community mental health agency can be assigned to work out of an ASO and provide counselling and other mental health services

To facilitate these partnerships, ASOs should have access to local training for mental health issues, while other agencies should be educated about HIV issues.

One example of a possible training tool for mental health issues is the Mental Health First Aid training course.<sup>93</sup> This training course, similar to medical emergency training, was designed to enable the general public to help people in mental health crises and/or in the early stages of mental health problems by increasing their mental health literacy. It was found that people who participated in the course were more confident in providing help to others, were more likely to advise people to seek professional help, were more in line with

### Collaboration in Action

The Canadian Mental Health Association (CMHA) and Oasis, a community health centre in Ottawa, actively collaborate to meet the needs of homeless clients, many of whom have HIV, addiction and mental health issues. Under their agreement, a CMHA mental health outreach worker provides services at the Oasis clinic one day each week, and is available to consult with clinic staff.

health professionals about treatments, and had less stigmatizing attitudes. Furthermore, the participants experienced an improvement in their own mental health. As community support workers already have a significant amount of knowledge on mental health issues, this course may be even more beneficial to them.

When organizations are determining whether they can work effectively together, they should consider the following questions:<sup>94</sup>

- ◆ are we compatible - do their individual missions work together?
- ◆ do we share common values and goals (e.g., a client-centred approach, harm reduction approach)?
- ◆ are we serving similar clients?
- ◆ how can we mutually collaborate to serve our clients better?
- ◆ can we agree on issues such as criteria for referrals, method of contact for referrals, respect for confidentiality, and worker sensitivity?

Other strategies for effective collaboration:

- ◆ start with small projects
- ◆ focus on “how can we collaborate to serve our clients” rather than “this is what you can do for us and what we can do for you”
- ◆ establish an evaluation process from the beginning
- ◆ Periodically review the collaboration: is it working? Do we still need this service? What changes should we make?

## Sample Collaborative Workshops for Clients

Here is the program for a 4-part workshop series on depression for people living with HIV, which was developed by an ASO and the local Community Mental Health Association. PHAS identified the issues they wanted to know more about:

### **HIV Issues:**

- ◆ Psycho-social issues
- ◆ Loss of relationships
- ◆ Loss of autonomy
- ◆ Loss of well-being
- ◆ Stigma & discrimination
- ◆ Disclosure
- ◆ Treatment

### **Mental Health Issues:**

- ◆ Depression - what is it
- ◆ Coping - what works and what doesn't
- ◆ Lifestyle - what helps and what doesn't
- ◆ Active Plans

ASO staff and mental health workers then planned and conducted the four sessions.

### **Session 1: Depression**

- ◆ Causes
- ◆ Signs & Symptoms
- ◆ The Role of Medication

### **Session 3: Lifestyle**

- ◆ Physical
- ◆ Emotional
- ◆ Spiritual

### **Session 2: Coping**

- ◆ Mechanisms
- ◆ Techniques
- ◆ Utilizing your network

### **Session 4: Personal Plans**

- ◆ What is it
- ◆ How do I create one
- ◆ Healthy boundaries

## **Formalizing Collaboration**

When different organizations agree to provide certain services (e.g., make or accept referrals, provide staff or resources), those commitments should be formalized in service agreements (verbal agreements are not enough). This is extremely important because the activities will then become part of the organizations' planning process and will be documented. If there is a change in management at any organization, there will be no disruption in services because the service agreements will be binding.

The service agreement should include:

- ◆ a description of the agencies
- ◆ vision, mission, goals
- ◆ the services to be offered and eligibility criteria
- ◆ the process for referrals
- ◆ roles and responsibilities
- ◆ a process for feedback.

## Useful Web sites

### **GENERAL INFORMATION:**

#### **Canadian Mental Health Association Information on Depression**

[www.ontario.cmha.ca/content/about\\_mental\\_illness/mood\\_disorders.asp?cID=1584](http://www.ontario.cmha.ca/content/about_mental_illness/mood_disorders.asp?cID=1584)

This Canadian web site provides information on different mood disorders, including depression. Although this website is not specific to people living with HIV/AIDS, you can learn about:

- what is depression?
- what causes depression?
- what are the symptoms?
- what can friends and family do?
- what are the treatments?
- where can one go for help?

#### **National Institute of Mental Health (USA) Information on Depression & HIV/AIDS**

[www.nimh.nih.gov/publicat/dephiv.cfm](http://www.nimh.nih.gov/publicat/dephiv.cfm)

This American web site provides specific information on depression and HIV/AIDS. You can learn about the following;

- depression facts
- HIV/AIDS facts
- specific treatments of depression for PHAs
- other mental disorders associated with HIV/AIDS

#### ***beyondblue* (Australia) National Depression Initiative [www.beyondblue.org.au](http://www.beyondblue.org.au)**

*beyondblue* is a national, independent, not-for-profit organization working to address issues associated with depression, anxiety and related substance misuse disorders in Australia. It aims to:

- increase community awareness of depression, anxiety and related substance misuse disorders and addressing associated stigma.
- provide people living with depression and their care-givers with information on the illness and effective treatment options
- develop depression prevention and early intervention programs.
- improve training and support for healthcare professionals on depression.
- initiate and support depression-related research.

**Australian National University  
BluePages**

<http://bluepages.anu.edu.au/>

This Australian web site provides information on:

- the symptoms of depression and how depression is diagnosed
- which medical, psychological and alternative treatments work for depression (and which don't)
- Australian-based people, organizations, books, web sites and other resources that may be helpful if you are depressed

**Canadian Mental Health Association  
Stress & Coping with Stress**

[www.cmha.ca/english/coping\\_with\\_stress](http://www.cmha.ca/english/coping_with_stress)

This web site includes general information on stress, including its effects on health. In some cases, chronic stress can result in depression or anxiety. Learn tips on coping with stress and find resources available in Ontario.

**SUPPORT INFORMATION & SERVICES:**

**AIDS Committee of Toronto (ACT)  
Finding & Choosing a Counsellor**

[www.actoronto.org/website/home.nsf/pages/choosecounsellor](http://www.actoronto.org/website/home.nsf/pages/choosecounsellor)

This Toronto-based web site provides information on finding and choosing a counsellor for people living with HIV/AIDS. Learn about the differences between a variety of "counselling" professional, such as psychiatrists, psychologists, social workers, therapists, counselors, and some family physicians

**Australian Federation of AIDS  
Organisations**

**Partners, family and friends**

[www.afao.org.au/view\\_articles.asp?pxa=ve&pxs=99&id=255](http://www.afao.org.au/view_articles.asp?pxa=ve&pxs=99&id=255)

This Australian web site is targeted for the partners, family members and friends of people who are HIV positive. It provides basic information about HIV/AIDS as well as tips for people close to, or caring for, people living with HIV/AIDS. This web site is also applicable for people living outside of Australia.

**Ontario AIDS Network**

[www.ontarioaidsnetwork.on.ca](http://www.ontarioaidsnetwork.on.ca)

On line discussion groups for PHAS on a variety of topics. The site also offers a place for PHAs to describe and share the impact of HIV on their lives in words, pictures and poetry.

**AIDS Committee of Toronto (ACT)**

**ACTalk**

[www.actoronto.org/actalk](http://www.actoronto.org/actalk)

ACTalk is a Toronto-based online discussion forum for people with HIV/AIDS, their friends, families and loved ones, and people concerned about HIV/AIDS. Post your questions, comments, concerns and rants and respond to other peoples' postings - all in a confidential, online setting.

**Mood Disorders Association of Ontario**

**Online Support Forums**

<http://mdao.v-cc.com/>

The Mood Disorders Association of Ontario provides 3 online support forums:

- Depression & Bipolar Support
- Family Support
- Postpartum Depression Support

These Support Group is free and moderated by trained volunteers.

**SCREENING TOOLS:**

**BC Partners for Mental Health & Addictions Information**

**Here To Help: Beyond the Blues**

[www.heretohelp.bc.ca/events/index.shtml](http://www.heretohelp.bc.ca/events/index.shtml)

The Beyond the Blues web site offers people a chance to learn more about mood and anxiety disorders, complete a brief questionnaire, speak one-on-one with a clinician, and find out about the range of community resources available to help. It also offers a free online anonymous screening for depression and other mental health disorders.

**Mood Disorders Association of Ontario  
Web-Based Depression & Anxiety Test**

<http://mdao.v-cc.com/wb%2Ddat/>

This test has been designed to help your mental health professional in their diagnosis of depression or anxiety. When you have finished the test you can either print your Final Report or email your Final Report directly to your mental health professional.

**National Mental Health Association  
(USA)**

**Depression-Screening**

[www.depressionscreening.org](http://www.depressionscreening.org)

This American web site is aimed at:

- educating people about clinical depression
- offering a confidential way for people to get screened for symptoms of depression
- guiding people toward appropriate professional help if necessary

**The Australian National University  
Centre for Mental Health Research  
MoodGYM**

<http://MoodGYM.anu.edu.au>

MoodGYM is a free web-based intervention program that provides cognitive behaviour therapy for the prevention and early intervention of depression, especially in young people.

This program aims to:

- help you identify and overcome problem emotions
- show you how to develop good coping skills

**IMPROVING MENTAL HEALTH LITERACY:**

**Canadian Alliance on Mental Illness &  
Mental Health**

**Mental Illness Awareness Week**

[www.miaaw.ca/home.html](http://www.miaaw.ca/home.html)

Mental Illness Awareness Week is an annual national public education campaign designed to help open the eyes of Canadians to the reality of mental illness.

**Canadian Alliance on Mental Illness &  
Mental Health**

**A Call for Action**

[www.cpa-  
apc.org/public/Action/callforaction.as  
p](http://www.cpa-apc.org/public/Action/callforaction.asp)

This web site provides information primarily for health care professionals. A Call for Action (a Canadian collaboration) addresses the following goals:

- ensure that those with a mental illness and their families receive the care, supports and attention they deserve from our society and our health care system
- ensure that mental health promotion is undertaken as a coordinated and regular educational and awareness building activity
- ensure that mental illness and mental health hold a higher priority on the health and social policy agendas

**National Institute of Mental Health (USA)**

**Real Men, Real Depression**

<http://menanddepression.nimh.nih.gov>

This American web site shares stories of men who have experienced depression. Although this website is not specific to people living with HIV/AIDS, you can learn about:

- depression in men,
- the signs and symptoms of depression,
- the treatments available, and
- getting help for depression

**Screening for Mental Health (USA)**

**National Depression Screening Day**

[www.mentalhealthscreening.org/events/ndsd/index.htm](http://www.mentalhealthscreening.org/events/ndsd/index.htm)

National Depression Screening Day® (NDS), the first and largest nationwide (USA), community-based mental health screening program, provides in-person and online screening for four of the most common and frequently co-occurring mental disorders: depression, bipolar disorder, generalized anxiety disorder and post-traumatic stress disorder.

**The Royal College of Psychiatrists (United Kingdom)**

**The Defeat Depression Campaign**

[www.rcpsych.ac.uk/campaigns/defeat/](http://www.rcpsych.ac.uk/campaigns/defeat/)

The Defeat Depression Campaign is a 5-year national (UK) campaign launched in January 1992. The campaign has 3 broad aims:

- to educate health professionals, about recognition and management of depression
- to educate the general public about depression and the availability of treatment, in order to encourage people to seek help earlier
- to reduce the stigma associated with depression

**The Royal College of Psychiatrists (United Kingdom)**

**Changing Minds Campaign**

[www.rcpsych.ac.uk/campaigns/cminds](http://www.rcpsych.ac.uk/campaigns/cminds)

The Changing Minds Campaign is aimed at increasing public and professional understanding of mental health problems (e.g. anxiety, depression, schizophrenia, dementia, alcohol and drug addiction, eating disorders), and reducing stigma and discrimination. This campaign targeting doctors, children and young people, employers, the media and the general public.

## Patient Health Questionnaire-Depression (PHQ)

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Over the last 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 the television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

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