The CQUIN Learning Network

Patients at High Risk: Perspectives from the Front Line

Treatment Failure:
Time for the Ambulance to be at the Top

The case for proactive PSS and monitoring

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HIV LEARNING NETWORK
The CQUIN Project for Differentiated Care

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Case 1: Grace

18 year old double orphan

- Vertically acquired HIV
- 2 years: father dies
- 3 years: mother dies
- 14 years: disclosure of HIV status
- 16 years: Aunty loses job – goes to live with maternal grandmother
- 18 years: Maternal grandmother dies

Case 1: Grace

19 years:

- Deep depression
- Stops ART
- Develops disseminated TB – treated
- Admitted to HDU on Christmas eve with severe pneumonia

Case 1: Grace

- Climbs stairs to Clinic Director
- Referral to youth psychiatrist
- Talk therapy and tricylic antidepressant for 6 months
- Out of depression
- Back on ART
- Back to school
- Started “Speed” support
- Starts University in August

Case 2: Patrick

- 45 year old married labourer on 3rd line ART
- October 2016 admitted with treatment failure: severe pneumonia and CD4 of 80 cells/mm^3
- Had defaulted ART for 4 months due to marital discord → anger and depression
- Restarted ART after admission

Case 2: Patrick

- June 2017: admitted with Cryptococcal meningitis and CD4 of 2/mm^3
- Had defaulted clinic attendance and ART for 6 months
- Anger and depression due to being made redundant leading to severe food security issues and further marital discord
- Treated, counselled, job back
- Out of depression, food security improved
- Weekly follow-up

Case 3: Tinashe

- 27 year old single unemployed male from rural Seke, vertically acquired HIV
- Presents with clinical treatment failure and disseminated TB, CD4 = 68
- Isolated
- Father died when he was 2 years old
- Twin brother died of HIV when he was 14
- Fathered a child by a 17 year old HIV positive girl but she left him for someone else- no money
- Persistent alcohol and drug problems

Case 4

- 36 year old women from Mkoba Gweru diagnosed with HIV in 2012
  - Baseline CD4 30
  - Started Tenolam–E (tenofovir, lamivudine, efavirenz)
- Was perfectly well until last week when she presented with Cryptococcal meningitis and CD4 = 20
- Says she was taking treatment
- No CD4 or viral load since 2012

Cases 1 & 2 & 3

- What do they have in common?
- PSS risk factors causing them to not adhere to ART
  - Multiple losses → anger, grief and depression
  - Marital discord → anger and depression
  - Unemployment → serious finance and food security issues → anger and depression
- Substance abuse
- Isolation, lack of supports
- Lack of follow-up and retention in care

Case 4

- What stands out?
- Lack of monitoring: CD4 and viral load
- No early warning system

Recommendations

1. **<u>Psycho-social risk assessment front on</u>**: why wait for treatment failure?
2. **<u>If significant PSS risk factors:</u>**
   - More frequent follow-up, VL and CD4
   - Referral to higher level counselling-psychologist or psychiatrist- we need mental health services in clinics
     - Maybe not a psychologist but a mental health nurse
   - Referral to social worker for advocacy in the extended family for help- we need social workers in clinics
   - Community based peer support
   - Improvement in continuum of care and communication between hospital, clinic, and community

Training

- Training for PSS for all levels of health workers involved in treatment & care
- Training in doing a PSS risk assessment
- Training in identification of chronic grief, chronic anger, depression, PSS implications of disclosure of status, self-stigma, family dysfunction-marital discord, substance abuse, financial hardship