HHS Public Access

Author manuscript

Lancet HIV. Author manuscript; available in PMC 2021 July 31.

Published in final edited form as:

Lancet HIV. 2020 July ; 7(7): e458–e459. doi:10.1016/S2352-3018(20)30025-4.

Integration of depression care with HIV treatment services: a Global Mental Health perspective

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Depression is recognized as a major factor leading to poorer outcomes among people living with HIV (PLWH) requiring urgent action[1]. Left untreated, PLWH with depression face a twofold-greater risk of mortality[2], lower uptake and adherence to medical care[3,4], and increases in viral loads even with high antiretroviral adherence[5]. But despite the high co-prevalence of HIV and depression, simultaneous management of the two diseases by the same care team is uncommon, constituting a mental health and HIV service "gap".[6]

To address this gap, integrated HIV and mental health service models and interventions are emerging, and because >90% of people living with HIV live in low- and middle-income countries (LMICs), much of this work is rightly being developed and tested in lower-resource settings (primarily sub-Saharan Africa)[7]. Absent in the research on integrated HIV/depression care, however, are studies exploring how countries will ultimately be able to scale these interventions to achieve population-level effects. A looming question must be asked: if integrated HIV/depression interventions are found efficacious, how long will it take for them to be sufficiently scaled so that those in need can benefit?

The question is not without precedent: the time lag for efficacious biomedical interventions to become practice is nearly twenty years[8]. But efficacious depression interventions for PLWH may face even greater barriers to scale when they, as several of the interventions under development do, rely on mental health professionals delivering advanced therapeutic techniques. This is because LMICs lack a trained mental health workforce to meet the increased demand. The WHO, for example, estimates that on average there are only 0·1 psychiatrists and 0·3 psychiatric nurses per 100,000 people in most LMICs[9]. Moreover, though some integrated models under development rely on task shifting to permit non-mental health professionals and even laypeople to deliver interventions, the needs of PLWH who require pharmacological interventions remain unmet where there is no psychiatrist

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We declare no competing interests.

available. Finally, LMICs wishing to integrate depression with HIV care may perceive the new interventions as “boutique”; a luxury that is financially out of reach in constrained health care budgets.

The field of Global Mental Health—concerned with the global scaleup of mental health interventions for all people—may hold some ready solutions to this problem. Recognizing both the growing burden of mental health disorders and a worldwide shortage of mental health professionals with advanced training, especially in LMICs, the WHO launched in 2009 the Mental Health Gap Action Programme (mhGAP),[10] now a centerpiece of the Global Mental Health movement. Included in mhGAP is a suite of evidence-based mental health interventions, including clinical algorithms designed for use by non-psychiatrist medical doctors for the pharmacological treatment of depression (and other common mental disorders) and three non-pharmacological “low intensity” depression interventions delivered by laypeople. The latter interventions require less resources than more traditional psychological interventions and can be delivered by people without previous mental health training.

The mhGAP tools are used in 90 LMICs as part of larger national strategies to reform and increase access to mental health services[11]. Since the HIV service delivery model used by many LMICs has long relied on laypeople to help deliver routine HIV treatment[6], there exists a ready and untapped resource for delivering depression care within the existing HIV service delivery platform using low-intensity psychological interventions. HIV physicians and other medical personnel could likewise be trained in the mhGAP tools for clinicians, so that depression and other common mental disorders requiring pharmacological treatment could be treated alongside HIV at the same time in the same place.

Most importantly, countries already implementing mhGAP may find that adapting and expanding tools already in use into new disease care settings makes more sense than establishing separate mental health protocols for different diseases; a similar argument has been made for the integration of mhGAP into tuberculosis treatment platforms[12]. Not only would this streamline the training and recruitment of mental health delivery personnel across the skills continuum, but it would allow reaching more people in less time at a lower cost than alternative disease-differentiated depression care models.

No depression intervention will be the panacea for all people in all settings, but given the high burden of depression among PLWH, why wait twenty years for new interventions to be brought to scale? By combining efforts, both the HIV and Global Mental Health communities can more quickly achieve the common goal of boosting and sustaining the quality of life for those in our care.

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