Integrating Mental Health Services into HIV Care: Global Guidelines and Strategies

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Introduction and Rationale

People living with HIV (PLHIV) and those affected by HIV face elevated rates of mental health conditions such as depression, anxiety, substance use disorders, and neurocognitive impairments. These comorbid conditions negatively impact HIV outcomes by reducing retention in care, adherence to antiretroviral therapy (ART), and overall well-being. In response, global health authorities – including the World Health Organization (WHO), the U.S. Centers for Disease Control and Prevention (CDC), the European Centre for Disease Prevention and Control (ECDC), UNAIDS and others - emphasize integrating mental health services into HIV prevention, treatment and care. This comprehensive analysis outlines the recommended mental health services in HIV care, delivery modalities, required resources, guideline integration, special population considerations, and implementation strategies with real-world examples.

Mental Health Services Recommended in HIV Care

Global guidelines consistently recommend a range of mental health and psychosocial services as part of routine HIV care. Key services include:

- **Routine Screening and Assessment:** Systematic screening for common mental health conditions (especially depression, anxiety, and substance use) should be offered to all PLHIV during HIV service encounters. WHO and UNAIDS stress that regular mental health screening (using tools like PHQ-9 for depression) be integrated with HIV care to enable early identification and intervention. ECDC likewise advises countries to implement regular mental health screening for people accessing HIV services. Clinical assessment for conditions like depression, suicidality, or substance use is particularly urged for high-risk groups – for example, adolescents, those not achieving viral suppression, or patients lost to follow-up.
- **Psychosocial Support and Counseling:** Psychosocial support is considered an essential component of HIV care. This includes basic counseling for emotional support, stress management, and coping strategies, as well as more structured **peer support** and support group interventions. Updated WHO HIV service delivery guidelines **strongly recommend psychosocial interventions** (e.g. problem-solving therapy, peer counseling) for adolescents and young adults living with HIV. Psychosocial support may be provided one-on-one (by counselors, psychologists, or trained peers) or in group settings (support groups, group therapy), to help PLHIV manage stigma, treatment adherence, disclosure, and mental health challenges.
- **Psychological Therapy (Psychotherapy):** Evidence-based psychological treatments are recommended for those who screen positive for mental health disorders. WHO's Mental Health Gap Action Programme (mhGAP) and related guidelines outline therapies like **cognitive-behavioral therapy (CBT)**, interpersonal therapy, problem-solving therapy, relaxation training, and motivational interviewing as effective for depression, anxiety, and substance use disorders in PLHIV. These therapies can often be delivered

in **low-intensity formats** by trained non-specialists (e.g. lay counselors or nurses) under supervision, making them scalable in low-resource settings. Group-based psychotherapy (such as group CBT) has shown particular efficacy in reducing depressive symptoms in PLHIV.

- **Psychiatric Evaluation and Treatment:** For moderate to severe mental disorders, guidelines call for referral to specialized care or integration of psychiatric services into HIV clinics. This may include diagnostic evaluation by a psychiatrist or trained clinician and use of psychiatric medications (e.g. antidepressants, anti-anxiety medication, treatment for serious mental illness) when indicated. The CDC and PEPFAR underscore that **psychiatric medication management** (for depression, psychosis, etc.) should be part of the comprehensive mental health services accessible to PLHIV in care. Integration can range from having a psychiatrist on the HIV care team to established referral pathways for specialty mental health care.
- **Substance Use Treatment and Harm Reduction:** Because substance use disorders are closely linked to both mental health and HIV outcomes, integrated services often include screening and treatment for alcohol and drug use. WHO recommends that HIV programs offer brief interventions for substance use, psychosocial support for behavior change, and linkage to addiction treatment (such as opioid substitution therapy or rehabilitation services) as needed. Harm reduction services (needle exchange, overdose prevention) and management of substance-related mental health issues (e.g. substance-induced depression) are considered part of a holistic HIV care package. These interventions can improve ART adherence and reduce HIV transmission risk by addressing underlying substance use.
- **Adherence Support and Behavioral Interventions:** Many guidelines embed mental health within adherence counseling. For example, supporting ART adherence may involve counseling to address depression or trauma that interferes with medication-taking. WHO notes that *support for HIV treatment adherence and retention in care, including psychological support, should be available for all people on ART*. Interventions like reminder messaging, problem-solving for barriers, and skills-building are often delivered in tandem with mental health support to optimize treatment outcomes.
- **Crisis Intervention and Suicide Prevention:** HIV care providers are encouraged to be vigilant for acute mental health crises, including suicidal ideation. Integrating mental health means having protocols to manage psychiatric emergencies or severe distress – for instance, conducting suicide risk assessments during clinic visits and having referral links for urgent psychiatric care. WHO guidance includes early identification of suicide risk as part of routine care in HIV programs. Psychosocial support in crisis, safety planning, and emergency referral can save lives and keep patients engaged in care.

In summary, the **essential mental health services in HIV care** encompass routine *screening*, basic psychosocial support (including peer support and counseling), *psychological therapies*, *psychiatric treatment* (medications/referral for complex cases), and *substance use services*. These components are intended to be offered within HIV programs at appropriate intensity based on patient needs, rather than treating mental health as a separate silo. By addressing

mental health alongside HIV treatment, programs aim to improve retention, adherence, quality of life, and ultimately HIV outcomes for affected individuals.

Modalities of Delivery for Integrated Services

Global guidelines highlight that mental health services for PLHIV can be delivered through various modalities and service models. Key delivery approaches include clinic-based and community-based strategies, leveraging digital tools, group interventions, and task-shifting. The optimal modality often depends on the setting's resources and the target population. Major delivery modalities are:

- **Clinic-Based Integration:** Embedding mental health services within HIV clinics or primary care facilities is a common approach. This can involve *co-locating mental health professionals* (psychologists, social workers, or psychiatrists) in HIV treatment centers or training HIV care providers to deliver basic mental health care. Integrated clinic models are often **patient-centered with co-located services**, allowing PLHIV to receive counseling or psychiatric consultation in the same clinic where they get HIV care. For example, many specialist HIV clinics in high-income settings employ an interdisciplinary team (doctors, nurses, mental health providers) to address patients' medical and psychological needs together. Co-location improves convenience and access, and evidence shows it can increase uptake of mental health care and improve HIV outcomes by streamlining referrals. Even in resource-limited settings, integrating a *mental health corner* or dedicated counselor within an ART clinic can facilitate routine screening and on-the-spot psychosocial support.
- **Community-Based and NGO-Delivered Services:** Community delivery brings mental health support closer to where PLHIV live, often through non-governmental organizations (NGOs) or community health workers. Community-based models include *home visits, community support groups, drop-in centers,* and collaborations with civil society. For instance, peer support groups led by PLHIV networks or NGOs provide safe spaces for sharing experiences, adherence encouragement, and basic counseling. Outreach programs can deliver counseling at community venues outside formal clinics, which is especially useful for key populations who may face stigma in healthcare settings. **Task-sharing to community health workers (CHWs) and peer counselors** is a cornerstone of community mental health integration. WHO and UNAIDS document numerous cases where lay providers in the community are trained to screen for distress, provide basic psychosocial interventions, and link individuals to care. Such community-led approaches can be highly effective in reaching those who might not otherwise access clinic-based mental health care. Notably, ECDC's guidance on HIV and migrants encourages *culturally sensitive community mental health resources* to reach marginalized groups.
- **Digital Health Interventions:** In recent years, digital and mobile health tools have emerged as promising modalities to deliver mental health support within HIV care. Examples include mobile apps for mental health self-management, SMS-based mood

tracking and support messages, tele-counseling via phone or video, and online support communities. While global guidelines acknowledge the potential of digital modalities (especially in improving access for youth or during crises like COVID-19), they usually complement rather than replace in-person services. For instance, *text messaging interventions* have been used to monitor depressive symptoms and remind patients of coping strategies or appointments (integrated with adherence messaging). WHO's 2022 guidance notes that an **electronic registry and measurement-based care** (tracking symptoms via tools like PHQ-9 at each encounter) is one component of effective integrated care models. Telemedicine can also facilitate remote consultation between primary HIV providers and mental health specialists – an approach especially useful in rural settings with psychiatrist shortages. Digital modalities expand reach and frequency of support, though ensuring privacy and digital literacy is essential.

- **Group-Based Interventions:** Group therapy and support groups are frequently recommended, both for their therapeutic benefit and efficiency. **Group psychoeducation or therapy** (e.g. group cognitive-behavioral therapy for depression, or support groups for coping with HIV stigma) can be delivered in clinics or community settings. WHO has highlighted interventions like *group problem-solving therapy* for pregnant women living with HIV to address perinatal depression and facilitate disclosure. Peer support groups led by trained facilitators can help participants build coping skills, reduce isolation, and share strategies for managing HIV and mental health challenges. Some programs integrate mental health topics into existing adherence clubs or teen clubs for adolescents with HIV, providing a combined forum for medication pickup, health education, and mental well-being check-ins. **Family therapy or counseling** in a group format is also used, especially for children or adolescents with HIV, to engage caregivers in supporting the young person's mental health and treatment adherence. Group modalities leverage **peer support and shared experience**, which are powerful tools against stigma and can normalize mental health care as part of HIV management.
- **Task-Shifting and Task-Sharing Models:** Given the global shortage of mental health specialists, many guidelines promote *task-shifting*—training non-specialist providers (nurses, doctors, social workers, community volunteers) to deliver mental health interventions. The WHO mhGAP Intervention Guide provides protocols enabling primary care and HIV staff to manage common mental health conditions in routine care. For example, nurses can be trained to conduct basic depression screening and counseling, and to initiate or refill antidepressants under supervision. Lay counselors or outreach workers can deliver structured therapy like behavioral activation or problem-solving therapy after focused training. A **collaborative care model** is often used, where a *team* shares responsibilities: the HIV clinician manages medical needs and can prescribe psychiatric medication; a trained counselor provides therapy and follow-up; and a mental health specialist (psychiatrist or psychologist) offers periodic case consultation and sees complex cases. This model has been successfully implemented in low-resource settings and is **compatible with HIV care settings**, leveraging regular case reviews by a specialist to support the frontline team. Task-sharing not only increases service capacity but also builds local skills. WHO recommends optimizing health worker training so that **HIV prevention,**

testing, and treatment competencies are included in mental health training curricula (and vice versa). In practice, task-shifting has enabled mental health integration even in clinics with no on-site psychologist – for instance, equipping ART nurses to deliver brief psychosocial interventions and refer to external specialists only when needed.

In summary, the *modalities of delivery* range from **integrated clinic teams** to **community and digital platforms**, and often involve **multidisciplinary partnerships and task-shifting**. Multilevel delivery (clinic + community + digital) can coexist to form a comprehensive support system. Global frameworks emphasize flexibility: services should be delivered wherever PLHIV find it easiest to access care – be it a friendly clinic, their home community, or even via their phone – in order to maximize uptake and impact.

Required Resources for Effective Integration

Implementing mental health services within HIV care requires careful allocation of resources and strengthening of health system capacities. Key resources and prerequisites identified by global guidelines include human resources, infrastructure, training, financing, and an enabling policy environment:

- **Human Resources and Training:** A trained workforce is the backbone of integrated services. Guidelines call for increasing the number and capacity of providers who can address mental health in HIV settings. This includes *specialist staff* (psychiatrists, psychologists, psychiatric nurses) as well as *non-specialists* (general nurses, physicians, social workers, peer counselors) with enhanced training. WHO recommends *optimizing and harmonizing training* so that HIV service providers gain skills to **screen for and manage mental health conditions and provide psychosocial support** Similarly, mental health professionals should be HIV-aware (knowledgeable about ART, HIV stigma, etc.). Cross-training expands the effective workforce. Task-shifting strategies mean *ongoing supervision* and mentorship from mental health specialists is also a critical resource – programs need to allocate experienced supervisors to support lay counselors or primary care staff. Ensuring *multi-disciplinary teams* (e.g. adding a counselor or social worker to an HIV clinic) has resource implications, requiring hiring or partnering with NGOs to provide personnel. In low-resource settings, leveraging community health volunteers and PLHIV peer networks as human resources for psychosocial support is a cost-effective approach, but it still necessitates investment in training and supervision quality.
- **Infrastructure and Space:** Effective integration often requires dedicated space and tools. At the clinic level, having a **private area for counseling** or mental health consultations is important for confidentiality and quality of care. Some high-volume HIV clinics have created quiet counseling rooms on-site. Resource needs also include **screening tools and materials** – for example, paper or electronic forms for mental health screening questionnaires, patient education leaflets on coping with depression, etc. An **electronic medical record system** that incorporates mental health indicators (screening results,

referrals, treatment plans) can greatly facilitate integrated care by enabling tracking of outcomes. WHO notes that using patient registries and symptom rating scales (e.g. PHQ-9 scores at each visit) is part of measurement-based care to ensure accountability in integrated programs. In terms of broader infrastructure, a *network of referral facilities* is needed – integration doesn't mean every service is on-site, but rather that strong referral linkages exist (e.g. to a psychiatric hospital for acute care, or to community rehabilitation services). Thus, having communication and transport infrastructure to coordinate between HIV clinics and mental health facilities is also a resource consideration.

- **Medications and Psychotherapeutic Inputs:** Integrating mental health means ensuring essential psychotropic medications and other therapeutic inputs are available. This includes antidepressants, anti-anxiety drugs, antipsychotics, as well as medication-assisted therapy for substance use (like methadone or buprenorphine for opioid dependence). **Ensuring access to psychiatric medications** at HIV treatment sites (or via referral) is highlighted by PEPFAR's guidance as part of comprehensive service integration. Likewise, basic supplies for psychological interventions (e.g. manuals for therapies, educational materials, workbooks for problem-solving therapy) need to be procured or developed. These are often low-cost but must be adapted to the local language and context. If digital tools are used, tablets or phones and internet connectivity become necessary resources.
- **Financing and Program Support:** Sustainable integration requires funding streams that cover mental health activities within HIV programs. Historically, HIV programs have been separately funded from mental health programs; integration demands bridging this gap. International donors like PEPFAR are increasingly prioritizing mental health – PEPFAR's 2024 strategy explicitly frames mental health services as part of the HIV response and encourages funding them as key to sustaining epidemic control. WHO's guidance suggests governments and programs should identify opportunities to *increase mental health funding within existing HIV budgets* and leverage universal health coverage initiatives to cover mental health care. Human resource costs for counselors, training costs, procurement of medications, etc., must be budgeted. Some countries have started integrating mental health indicators and activities in their Global Fund grants for HIV/TB, reflecting a blended funding approach. Over time, demonstrating cost-effectiveness is crucial for sustained financing – for instance, it is often cited that every $1 invested in treatment of mental disorders yields ~$5 in economic return, and addressing mental health can improve HIV outcomes cost-effectively by averting downstream costs of treatment failure. Program managers should also consider financing for *monitoring and evaluation* specific to mental health outcomes within HIV care to guide continuous improvement.
- **Policy, Guidelines, and Leadership:** An often intangible but vital resource is the policy framework and leadership buy-in for integration. Having national HIV treatment guidelines that include mental health protocols, or national mental health strategies that reference HIV, provides the mandate and guidance needed at the service delivery level. WHO and UNAIDS have encouraged countries to **integrate mental health into HIV policies and care packages**. ECDC and WHO's European Office issued a joint call for *"stigma-free" HIV services that address mental health and wellness* of PLHIV as an aspect of high-quality care. Leadership from health ministries and program directors can

allocate resources (human and financial) to this area and oversee implementation. Additionally, establishing partnerships with mental health agencies, professional associations, and PLHIV advocacy groups can bring in technical expertise and community support (a "resource" in the sense of collaboration). For example, CDC's guidance emphasizes *transformative partnerships* with mental health stakeholders and inclusion of people with lived experience to rapidly expand mental health programs for PLHIV.

- **Stigma Reduction and Community Support:** A supportive environment is a resource that significantly affects integration success. Stigma related to HIV or mental illness can deter individuals from seeking care. Therefore, programs need to invest in **stigma-reduction training** for staff and *create clinic environments that are welcoming*to those with mental health issues. WHO advises equipping health providers to deliver *stigma-free, adolescent-friendly, women-friendly, and LGBTI-friendly services* so that all PLHIV feel safe disclosing mental health concerns. Community awareness campaigns and psychoeducation (public or within PLHIV groups) are important resources to normalize mental health care. Essentially, building an *enabling social environment* – through patient education, media engagement to promote non-discriminatory messages, and inclusion of mental wellness in HIV support programs – will facilitate uptake of services. Peer networks and support groups (often resourced via NGOs or community organizations) are a form of community capital that integration efforts should leverage.

In summary, integrating mental health into HIV care is resource-intensive at first, requiring **investment in workforce, training, tools, and systems**, but these resources enable long-term sustainability. Global targets (like the WHO Comprehensive Mental Health Action Plan 2013–2030) call for doubling community-based mental health facilities and substantially increasing service coverage by 2030 – achievements that will benefit HIV care integration. Even where resources are constrained, guidelines suggest starting with feasible steps (e.g. adding a depression screening and referral protocol, training a few nurses in counseling, collecting mental health data) to build momentum. Over time, as programs demonstrate improved patient outcomes, it becomes easier to justify and secure the necessary resources.

Embedding Mental Health in Global HIV Service Guidelines

Mental health integration is now embedded in numerous HIV service guidelines and strategies at the global and regional level. A review of key guidelines illustrates the growing consensus on this issue:

- **World Health Organization (WHO) and UNAIDS:** WHO has incorporated mental health into its HIV guidance through various documents. The *WHO Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring* (2021) include psychosocial support as a recommended component of care, with a **strong recommendation to provide psychosocial interventions for adolescents and young adults living with HIV**. These consolidated guidelines recognize that

addressing mental health is critical for maximizing treatment outcomes and quality of life. Additionally, WHO's 2016 and 2019 service delivery guidelines for key populations stressed offering mental health and substance use services as part of a comprehensive package for populations like people who inject drugs, sex workers, and men who have sex with men. In 2022, WHO and UNAIDS jointly released *"Integration of Mental Health and HIV Interventions – Key Considerations"*, a technical document collating best practices and recommendations. This publication explicitly calls for integrating mental health into all stages of HIV programming (prevention, testing, treatment, care) and provides examples of how to do so. It refers to tools such as WHO's mhGAP Intervention Guide, harm reduction guidelines, and other mental health resources to guide countries in implementation. In short, at the policy level, WHO/UNAIDS are urging a shift from treating mental health as optional to making it a standard part of HIV care protocols. They also emphasize human rights and person-centered approaches, noting that mental health services should be delivered with attention to dignity and without discrimination.

- **U.S. Centers for Disease Control and Prevention (CDC) and PEPFAR:** The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), with CDC as an implementing agency, has increasingly prioritized mental health in the global HIV response. While CDC's domestic guidelines (for the U.S.) encourage screening for depression and substance use in HIV care, it's PEPFAR's policies that have a broader global impact. PEPFAR's 2022–2025 strategy identifies mental health services as integral to sustaining epidemic control. A recent CDC-authored paper (Emerging Infectious Diseases, 2024) outlines *five key strategies (or "pillars")* for integrating mental health into HIV/TB programs. Notably, **Pillar 2** (Sustaining the Response) directs PEPFAR-supported countries to ensure **comprehensive mental health and substance use disorder services at all PEPFAR-supported facilities**, including *screening, psychological treatments, psychosocial support, referral pathways, and psychiatric medications*. This effectively sets an expectation that any clinic funded by PEPFAR should be incorporating these services. The framework also highlights establishing partnerships and health system infrastructure (Pillar 3 and 4) to support integration. While PEPFAR does not issue clinical "guidelines" per se, its annual Country Operational Plan guidance now often includes directives to integrate mental health – for example, requiring programs to budget for mental health training or to report on mental health indicators. The CDC has also produced training resources and policy briefs (in collaboration with HRSA and SAMHSA in the U.S.) making the case for behavioral health integration in HIV settings. Overall, the U.S. global HIV program stance is clear: addressing mental health is necessary for achieving HIV epidemic control and is part of the standard of care expected in funded programs.
- **European Centre for Disease Prevention and Control (ECDC):** In the European context, ECDC and the WHO European regional office have acknowledged mental health as part of quality HIV care, though explicit guidelines are less centralized than WHO's. ECDC's monitoring of the Dublin Declaration on HIV includes assessments of whether countries integrate mental health. In a 2022 progress report focused on HIV and migrants, ECDC noted that data on mental health services for PLHIV are limited and found that *8 of 10 surveyed countries in Europe had not integrated regular mental health screenings into*

HIV care nationwide. As a recommendation, the report states: **"Countries should consider implementing regular mental health screening for people accessing HIV services, and integrate mental health services into HIV services."**. This is a strong endorsement at the regional level for integration. Additionally, a joint ECDC/WHO-Europe *"Quality of care"* assessment in recent years highlighted mental health and psychosocial support as components of person-centered HIV care, particularly for aging cohorts of PLHIV who face co-morbid depression or cognitive issues. On World AIDS Day 2020, WHO-Europe and ECDC issued statements calling for holistic approaches including stigma reduction and mental wellness for those with HIV. While the ECDC doesn't provide care guidelines like WHO, it works with EU/EEA countries to share best practices – for example, identifying models of good practice in community-based services that often include mental health support (peer counseling in community testing programs, etc.). European clinical societies (like EACS) have also incorporated mental health screening (for depression, etc.) in their standards of care, which aligns with the public health recommendations of ECDC.

- **UNAIDS and Global Strategies:** UNAIDS, in its role to lead the global AIDS response, has increasingly highlighted mental health in high-level strategies. The **Global AIDS Strategy 2021–2026** frames a vision of integrated, people-centered HIV services and explicitly calls for integrating services like mental health and substance use treatment to improve outcomes and advance human rights. For example, one of the targets for 2025 is that 90% of people living with HIV with an unmet need for mental health care receive services they need. UNAIDS, together with networks of people living with HIV, has advanced the concept of "Positive Health, Dignity and Prevention" – a policy framework that includes mental health and well-being as core elements of long-term HIV care. At the country level, this influence means national strategic plans for HIV are starting to mention mental health support as part of the service package (e.g. many countries now list psychosocial support in their HIV treatment guidelines, often referencing WHO/UNAIDS guidance).

In summary, **mental health services are increasingly embedded in global HIV guidelines**, moving from a peripheral consideration to a recommended standard of care. WHO and UNAIDS provide the technical frameworks and evidence base, CDC/PEPFAR supply funding priorities and operational directives, and ECDC along with other regional bodies reinforce the message in different contexts. For healthcare providers and program planners, this means there is strong international mandate and support for integrating mental health – it is no longer optional or innovative, but rather "expected" as part of comprehensive HIV care. Guidelines not only endorse integration but also offer detailed recommendations (e.g. what screenings to use, which psychosocial interventions to implement for specific groups), making the path to integration clearer.

Considerations for Different Populations

Integration efforts must address the diverse needs of all populations living with or affected by HIV – including adults, adolescents, and children – as well as key sub-populations like pregnant women, older adults, and key populations (e.g. LGBTQ individuals, people who use drugs). Global guidance emphasizes tailoring mental health services to be age-appropriate and context-specific:

- **Adults (Including Older Adults):** Adult PLHIV commonly face depression, anxiety, and substance use issues, often linked with life stressors or HIV-related stigma. Guidelines for adults highlight the importance of routine depression screening in HIV clinics and providing accessible counseling or psychiatric care for those who need it. For example, an adult on ART who screens positive for depression should ideally receive on-site brief counseling and possibly antidepressant treatment, with follow-up to monitor improvement. Another consideration for adults is managing serious mental illnesses (like schizophrenia or bipolar disorder) that can complicate HIV care – these patients may need closer collaboration with psychiatric services and support with treatment adherence (ensuring they can consistently take ART along with psychiatric meds). WHO has pointed out that *ageing with HIV* brings additional mental health challenges: older PLHIV have higher risks of social isolation, cognitive impairment, and depression. Thus, mental health integration for older adults might involve cognitive screening (to detect HIV-associated neurocognitive disorder or dementia) and interventions to promote social engagement and brain health. It's recommended that *cognitive impairment assessment and management be integrated into routine HIV visits* for older adults. This could include memory screening and advising on cognitive exercises or managing polypharmacy that might affect cognition. The key is an individualized approach – adult patients should be routinely asked about their mental well-being and substance use, and offered interventions suited to their circumstances (be it referral to a psychiatrist or enrollment in a community support group for loneliness).
- **Adolescents and Young People:** Adolescents living with HIV (whether perinatally infected or behaviorally infected) are a priority group for integrated mental health services. This age group experiences unique stressors: dealing with HIV during formative years, disclosure issues, stigma among peers, and transitioning to adult care. They also have high prevalence of mental health conditions – for example, depression often emerges in adolescence and can significantly affect adherence to ART. WHO's guidelines strongly recommend psychosocial interventions specifically for adolescents with HIV. This can include life skills training, peer support groups (adolescent support clubs), and youth-friendly counseling that addresses both typical teen issues and HIV-related challenges. Interventions like *cognitive-behavioral therapy adapted for adolescents*, or family therapy involving caregivers, have proven beneficial. One guiding principle is to involve youth in service design – making clinics adolescent-friendly in terms of privacy, convenient hours, and a non-judgmental atmosphere encourages utilization of mental health services. It's also critical to screen for issues like substance use, which may start in adolescence, and to provide early intervention. For example, some programs use short questionnaires (like the PHQ-9 modified for teens, or CRAFFT for substance use) during routine visits for adolescents. **Multidisciplinary team meetings**that include the adolescent, healthcare

providers, and peer supporters can help create a tailored adherence and mental health plan. Additionally, digital modalities (mobile apps, texting) are particularly useful for young people – enabling self-report of mood or receiving supportive messages – and guidelines encourage leveraging these tools to complement in-person care for youth. Overall, mental health integration for adolescents must address issues of consent and confidentiality (ensuring teens feel safe to discuss depression, trauma, or sexuality), and involve *both psychosocial support and clinical care* when needed. For instance, an adolescent with significant depression might receive counseling from a psychologist and, if severe, also be evaluated for antidepressant medication, with parental involvement managed sensitively.

- **Children (Including Perinatally Infected Children):** Children living with HIV, especially those infected perinatally, require mental health support that is tailored to their developmental stage. Younger children might experience neurodevelopmental delays or cognitive impairment associated with HIV. Studies indicate that *between 10% and 50% of children living with HIV on ART have some degree of cognitive deficit* or learning difficulty. Guidelines recommend early neurodevelopmental screening and interventions for children – for example, assessing milestones, attention, and memory, and providing cognitive stimulation or referrals to specialists (like pediatric neurologists or developmental therapists) if needed. Psychosocial support for children often means working with families: training and supporting caregivers to manage the child's condition and behavior. WHO advises that **psychosocial interventions for children involve parents or caregivers**, focusing on parenting skills, creating supportive home environments, and addressing any behavioral issues compassionately. Children also face mental health impacts of trauma or loss (many have lost parents to HIV or may face family instability). Thus, grief counseling or play therapy can be relevant services integrated into pediatric HIV care. Another aspect is disclosure – helping caregivers and children navigate the process of telling a child about their HIV status is both a psychosocial and clinical challenge, often needing mental health expertise to do in an age-appropriate way. Moreover, children on chronic medication may show treatment fatigue or emotional issues related to being "different"; regular sessions with a counselor or inclusion in peer play groups with other HIV-affected children can mitigate these feelings. As children mature into adolescents, continuity of mental health support is important to ensure a smooth transition. In practice, pediatric HIV clinics in many countries have incorporated child psychologists or social workers in the care team to assess developmental progress, address adherence struggles, and support the child's emotional health in collaboration with the family.
- **Pregnant and Postpartum Women:** Women living with HIV who are pregnant or have recently given birth have specific mental health needs, as they are at heightened risk for perinatal depression and anxiety. WHO notes that women with HIV have higher risk of perinatal depression than their HIV-negative counterparts, and experiences of gender-based violence or stigma can further increase that risk. Guidelines on prevention of mother-to-child transmission (PMTCT) now frequently integrate mental health screening into antenatal and postpartum care for women with HIV. For example, it is recommended to screen expectant mothers for depression during antenatal visits and again postpartum, using

tools like the Edinburgh Postnatal Depression Scale, and provide or link to treatment as necessary. Psychosocial support should be part of PMTCT programs – this can include **peer mentor mother programs** where experienced HIV-positive mothers support pregnant women, offering counseling on medication adherence and coping with emotions around pregnancy and HIV. WHO's 2022 guidance specifically mentions that *antenatal care is an opportunity to educate women about mental health, screen for conditions, deliver psychosocial support and low-intensity psychological therapies, and provide peer support*. Interventions like **interactive group counseling for women** (covering topics of HIV, motherhood, depression, partner disclosure, etc.) have been piloted in places like Tanzania with promising results. Postpartum, monitoring for postnatal depression or anxiety is crucial both for the mother's health and the infant's well-being (as maternal depression can affect infant care and breastfeeding). Integrated care means an HIV clinic or maternal health clinic treats mental health as a routine part of follow-up – e.g. a woman coming for her baby's HIV PCR test at 6 weeks postpartum might also receive a mental health check and referral if she's struggling emotionally. Addressing intimate partner violence is another consideration; many guidelines urge asking pregnant women about violence and linking to support services, since abuse is tied to poor mental health and poor HIV outcomes. In summary, for women in the PMTCT context, integration entails *screening, targeted counseling (often by peers), and ensuring referral for psychiatric care* if needed (for instance, severe postpartum depression needing medication).

- **Key Populations:** Key populations (such as men who have sex with men, transgender people, people who inject drugs, sex workers, prisoners) often experience a syndemic of HIV risk and mental health burdens due to stigma, criminalization, and social marginalization. Global strategies underscore that mental health services must be tailored and accessible to key populations in HIV programs. For example, MSM and transgender individuals have higher prevalence of depression and suicidal ideation; an affirming counseling environment is critical. Guidelines suggest offering *routine mental health screening and management alongside HIV services for key populations* to optimize outcomes. Moreover, interventions should address specific stressors: e.g. coping with discrimination, internalized stigma, or violence. For people who inject drugs, integrating harm reduction (needle exchange, opioid substitution therapy) with mental health and HIV care is vital – untreated mental health conditions can fuel relapse or risky behaviors. WHO/UNAIDS guidance calls for holistic approaches: if a key population member comes for HIV prevention (like PrEP or needle exchange), that encounter can also include mental health screening, brief intervention, or referral as needed. Culturally competent and *community-led services* are often most successful. Peer navigators from key population communities can help link individuals to friendly mental health professionals or provide lay counseling. For incarcerated people living with HIV, addressing mental health (e.g. high rates of trauma, anxiety in prisons) requires integration into prison health services and linkage post-release. Across all key pops, removing structural barriers is emphasized: decriminalization and anti-stigma measures are needed so that people actually feel safe to use the integrated services. In practice, many targeted programs have arisen – for instance, drop-in centers for sex workers that provide HIV testing also offer counseling for gender-

based violence and stress, or LGBTQ clinics that combine HIV services with mental health clinics. The message is that one-size-fits-all won't work; integration must be responsive to the unique mental health risk factors and service preferences of each group.

Overall, **age and population-specific considerations** are crucial when integrating mental health and HIV care. Children need family-centered developmental support, adolescents need youth-friendly engagement and empowerment, adults need convenient access and chronic disease management, and key populations need culturally safe and comprehensive approaches. Guidelines encourage programs to involve representatives of these groups in designing services. By addressing the distinct needs (for example, tailoring content of counseling sessions or types of support offered), integrated programs can be more effective and equitable. It is also worth noting intersectionality: many patients belong to multiple categories (e.g. an adolescent girl who is also a key population member like a young sex worker) – services should be prepared to handle overlapping needs (trauma-informed care in this example). The end goal is that **no subset of people living with HIV is left without appropriate mental health support**.

Implementation Frameworks and Strategies

Implementing the integration of mental health into HIV care can be guided by several frameworks and strategic approaches. These frameworks help planners systematically incorporate services and ensure they function effectively. Key strategies and models include:

- **WHO's Public Health Framework and mhGAP Approach:** WHO advocates for integrating mental health into primary care as part of Universal Health Coverage. The *Mental Health Gap Action Programme (mhGAP)* provides an operational framework for scaling up mental health care in low-resource settings, including in the context of chronic diseases like HIV. Using mhGAP, countries train general health workers to assess and manage priority mental health conditions. In HIV clinics, mhGAP guidelines (and the mhGAP Intervention Guide) can be applied so that, for example, a nurse follows a simplified algorithm to treat depression or initiate referral for psychosis. The framework emphasizes evidence-based interventions at all levels of the health system – from community to specialist care – arranged in a **stepped care model**. Stepped care means providing the least intensive, yet effective, intervention first and stepping up to more intensive care as needed. For instance, someone with mild depressive symptoms in an HIV clinic might first get psychoeducation and group support; if no improvement, they "step up" to individual therapy or medication, and if still not improving, step up to specialist psychiatric review. This ensures efficient use of resources. WHO's *Service Organization Pyramid for Mental Health*is often cited, which matches interventions to the level of care: self-care and community support at the base, primary care interventions (counseling, basic meds) in the middle, and specialist services at the top. Many countries have adapted this pyramid to integrate HIV – for example, *task-sharing collaborative care* (discussed below) at the primary care level and referral networks to psychiatrists at tertiary level. Overall,

WHO's framework is to **integrate mental health into existing health platforms (like HIV clinics), rather than creating parallel vertical programs**, thereby leveraging the widespread reach of HIV services to also address mental health needs.

- **Collaborative Care Model:** As introduced earlier, the collaborative care model is a well-validated implementation strategy for integrating mental health into chronic disease care. It was first developed in high-income settings for depression in primary care, but has been adapted globally for HIV. The model has *five core components*: 1) team-driven care with a primary provider and care manager, 2) population-based care using a patient registry, 3) measurement-based treatment to target (tracking symptoms like viral load and depression scores), 4) evidence-based interventions (therapy and meds), and 5) accountable care with specialist supervision. In an HIV context, a **collaborative care team** might involve the HIV clinician, a nurse or counselor as the behavioral health care manager, and a consulting psychiatrist or psychologist who reviews difficult cases. The care manager regularly follows up with patients (in person or by phone), delivers brief psychosocial interventions (e.g. behavioral activation or problem-solving therapy), and monitors outcomes with tools. The mental health specialist and HIV provider communicate frequently, adjusting treatment plans if the patient isn't improving (for example, adding an antidepressant if counseling alone isn't enough). This model has been piloted in countries like Uganda and Kenya with good acceptability, and notably in South Africa through the *InTEGRATE* project and others. By design, collaborative care leverages existing clinic staff and adds a layer of coordination and oversight – making it scalable. The CDC and others promote it as it aligns with a data-driven, outcome-focused approach (much like HIV viral load monitoring, one monitors PHQ-9 scores). Research shows collaborative care can significantly improve depression and even lead to better HIV viral outcomes compared to usual care, validating this strategy. Health systems implementing this model often need to invest in training a cohort of care managers and establishing regular case review meetings (e.g. weekly calls between clinic teams and a psychiatrist).
- **Stepped-Care and Tiered Service Models:** Beyond collaborative care, broader *stepped-care frameworks* guide how different intensity services can be layered. For example, a stepped model for an HIV program might delineate: Step 1 – mental health promotion and prevention for all (e.g. support groups, psychoeducation sessions on stress reduction); Step 2 – screening and low-intensity interventions for mild cases (brief counseling by a nurse, self-help materials); Step 3 – medium intensity for moderate cases (regular counseling sessions, maybe by a psychologist or trained social worker, and possibly medication); Step 4 – high intensity for severe or refractory cases (referral to psychiatrist, inpatient care if needed, intensive psychotherapy). Patients can move up or down steps based on response. This ensures efficient use of specialist resources by filtering who truly needs them. WHO's *"Good practice opportunities"* table in the 2022 guidelines (Integration of Mental Health and HIV) provides examples at **individual, health facility, and system level** of interventions across the HIV service continuum. It essentially outlines a multi-level strategy: at the individual level, educate and engage patients in self-care; at the facility level, train providers and integrate services; at the community/government level, strengthen supportive policies and linkages. By addressing each level, a stepped-care or

tiered approach is achieved. Implementers can use this kind of framework to ensure that, for instance, *every HIV clinic implements at least a "Step 1" intervention (like screening and basic support), while referral pathways are in place for higher steps*.

- **Integration in Existing HIV/TB Programs:** Many strategies leverage integration with related programs, especially TB clinics or primary care. Given the overlap of HIV and TB, some countries have one-stop clinics for HIV/TB and are now adding mental health to the mix, treating all three together. From an implementation standpoint, using the existing infrastructure of HIV programs – which often include counseling staff for testing and adherence – is strategic. It may involve expanding the role of an *adherence counselor* to also deliver mental health counseling, or using the platform of *ART adherence clubs* to introduce mental well-being check-ins. PEPFAR's guidance suggests utilizing current program platforms (like their community-based adherence support initiatives) and adding mental health modules. Another example is integration into *home-based care*: many HIV programs have community volunteers who visit patients – by training them in basic mental health support, one can reach bedridden or isolated patients with counseling at home. In short, integration frameworks often recommend *building on what exists*: if an NGO runs a successful HIV support center, equip it to offer mental health services rather than creating a separate mental health clinic.
- **Monitoring and Evaluation (M&E) Frameworks:** A critical aspect of implementation is establishing M&E to track success and learn from challenges. Frameworks like the WHO's indicators for mental health integration (e.g. percentage of PLHIV screened for depression, number receiving treatment for mental health issues, improvement in depression scores, etc.) are useful. CDC has encouraged countries to start **routine data collection on core mental health indicators through health information systems**. For example, integrating a depression screening field into the national ART clinic database, or tracking referrals made to mental health specialists. Setting targets (such as "by next year, 80% of patients in HIV care will be screened for mental health needs") and measuring outcomes (like retention in care differences between those with and without support) creates accountability. Implementation science frameworks, like RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance), are also being used to evaluate integrated programs. They help ensure the strategy reaches the intended population, is effective in improving outcomes, is adopted by providers, implemented with fidelity, and maintained over time. Case in point: a program in Zimbabwe might use such a framework to assess how well the Friendship Bench integration (described below) is being sustained and scaled across clinics. M&E frameworks also guide quality improvement cycles – if data show low screening rates at a clinic, targeted training or supportive supervision can be provided and then improvement tracked.
- **Policy and Advocacy Strategies:** Implementation is not just technical; it also involves advocacy to create a supportive policy environment. Frameworks for advocacy include building coalitions between HIV activists and mental health advocates to push for integrated service funding and removing policy barriers. An example strategy is aligning with global initiatives like the UN Sustainable Development Goals (SDGs) which call for good health and well-being (SDG3) and specifically include mental health in UHC. By

framing integrated care as necessary for achieving these international commitments, advocates can influence national health plans. Another strategic lever is highlighting **human rights and stigma**: linking the fight against HIV stigma with mental health stigma (often overlapping) and promoting "people-centered" care as a right. This framing has been used effectively by networks of people living with HIV and mental health organizations. Indeed, PEPFAR's recent strategy pillar on health equity stresses reducing stigma and discrimination as foundational to integration.

In practice, many countries have developed *implementation guidelines or manuals* for integrating mental health into HIV care, using combinations of these frameworks. For example, Uganda developed a manual for health workers on managing common mental disorders in HIV clinics, which draws from mhGAP and collaborative care principles. South Africa incorporated mental health into its National Adherence Strategy, outlining a stepped care approach at different tiers of the health system. These frameworks ensure that integration is systematic and not left to ad-hoc efforts. By following established models (adapted to local context), health systems can more quickly and effectively add mental health to HIV programs at scale.

Case Studies and Examples from Diverse Settings

Real-world implementations across various settings demonstrate the feasibility and benefits of integrating mental health and HIV services. These case studies, from specialized clinics to community-led interventions, provide practical insights:

A community health worker ("Friendship Bench" grandmother) in Zimbabwe provides problem-solving therapy to a woman living with HIV on a park bench. In Zimbabwe, the **Friendship Bench** program is a flagship example of community-based mental health care integrated into primary health and HIV services. It trains lay grandmothers to deliver evidence-based talk therapy (problem-solving therapy) on wooden benches in clinic yards. A recent study focused on PLHIV with common mental disorders found that those who received Friendship Bench therapy were *three times more likely to maintain viral suppression* over 6 months compared to those who received standard care. Participants in the intervention were also far less likely to have symptoms of a common mental disorder at follow-up. This model addresses the mental health treatment gap by using affordable, culturally acceptable counselors and has been scaled to over 70 primary care clinics in Zimbabwe, often serving many PLHIV who attend those clinics for ART refills. It illustrates how task-shifting and community engagement can dramatically improve both mental health and HIV outcomes – by empowering patients with therapy, their adherence to medication improved, leading to better viral loads. The Friendship Bench has inspired similar approaches in other countries (e.g. "Listener" programs in Zambia, "Safe Parks" in South Africa for youth counseling), highlighting that integrating mental health support can be done outside formal consulting rooms, even under a tree or in a marketplace, if it meets people where they are.

Another case comes from **South Africa**, where the government and research partners implemented the *Mental Health Integration Programme* in primary care clinics, many of which treat large numbers of PLHIV. Using the **Collaborative Care Model**, this program designated *primary care nurses as case managers* for mental health. Nurses received enhanced training in adult primary care mental health, enabling them to **screen, diagnose, initiate treatment and refer** for conditions like depression and alcohol use disorders. They worked alongside visiting psychologists or psychiatrists who provided weekly supervision and consultation. An evaluation in South Africa demonstrated that this approach improved detection of depression and led to more patients receiving treatment, with reported reductions in depressive symptoms over time. It also showed that nurses could competently manage psychotropic medications with remote guidance. This program underscores the value of building on existing clinic staff roles and adding mental health tasks, supported by a framework of regular specialist input (often via phone or periodic visits). Not only did it increase access in resource-limited rural clinics, but it also created a more person-centered service where patients felt their "whole health" was being addressed in one place. South Africa's experience has informed its national policy – mental health is now part of the Integrated Chronic Disease Management model that includes HIV, and screening for mental distress is meant to be a routine vital sign in chronic care.

In East Africa, an example is **Zambia's Adolescent Peer Support** program. The Zambian organization *Zvandiri*(originating in Zimbabwe, now adapted in Zambia and elsewhere) trains HIV-positive adolescents as peer counselors (called Community Adolescent Treatment Supporters – CATS). These peers provide home visits and support groups for other adolescents living with HIV, focusing on adherence, life skills, and mental well-being. Many of the CATS are equipped to identify signs of depression or severe stress and provide basic counseling or refer to clinic psychologists. A case study in Zambia found that integrating these peer supporters into HIV clinics dramatically improved viral suppression rates among adolescents and also reduced self-reported depression and stigma internalization. Adolescents often open up more to peers; hence, issues like suicidal thoughts or abuse were more frequently disclosed and managed. This model demonstrates integration through **NGO-community partnership**: clinics formally recognize and collaborate with the NGO-trained peers, effectively extending the mental health care team into the community. It also covers a traditionally hard-to-reach group (youth) with a tailored approach.

From a high-income setting, consider the **Veterans Aging Cohort** in the United States. The U.S. Veterans Health Administration (VA) integrated mental health into its HIV clinics serving military veterans, many of whom are aging and have multiple co-morbidities. They implemented *co-located mental health clinics* where psychologists and social workers work side by side with HIV physicians. A site culture of interdisciplinary team meetings was fostered, wherein complex cases (e.g. an older veteran with HIV, depression, and PTSD) are discussed by the whole team to formulate a unified care plan. The VA reports that this integration led to improved antidepressant treatment rates for those in need and better viral suppression among patients with mental health issues, because the mental health providers could aggressively address barriers to adherence (like untreated PTSD flashbacks or severe insomnia). One particular strategy in the VA was implementing **measurement-based care**, using tools like PHQ-9 at each visit and tracking those

in a registry – a very data-oriented approach that suits a large healthcare system. This case is an example of a specialized clinic integration with ample resources, showing what is achievable when funding and staffing are less constrained: full integration with on-site mental health specialists, shared electronic health records, and systematic evaluation of outcomes.

Another notable example is from **Kenya**, where an NGO-led program called *SHARE* (Supporting Health And Respect for Everyone) integrated mental health screening and counseling into HIV clinics for key populations. They trained lay counselors from key population communities to deliver a brief trauma-focused counseling intervention because many clients (e.g. MSM and sex workers) had high rates of trauma and depression. Over 12 months, the program saw a reduction in risky behaviors and an increase in consistent ART use among participants, attributed to improved mental health. This case highlights that even in stigmatized groups, integrating mental health (particularly addressing trauma) can be a gateway to better HIV outcomes. It also emphasizes partnering with community-based organizations that know the population's needs; in this case, a sex worker advocacy group helped design the counseling approach.

These diverse examples share a common theme: integrated mental health and HIV services result in **better health outcomes and patient satisfaction**. Whether it's an informal bench in a village or a formal clinic in a hospital, the principles remain: identify mental health needs early, provide some level of support on the spot, and ensure linkage to higher care when needed. We see that specialized clinics, NGOs, and community services each play a role:

- **Specialized HIV Clinics** bring clinical resources and can institutionalize practices (like the VA's model or South Africa's clinic-based program). They often lead on creating protocols and demonstrating efficacy which can be scaled.
- **NGOs and Community-Based Services** bring innovation, trust of the community, and reach. They can often pilot creative approaches like the Friendship Bench or peer supporter models and are crucial for uptake among hard-to-reach groups.
- **Public-Private and Academic Partnerships** (such as LSHTM working with Zimbabwe's city health department on Friendship Bench, or University of Washington with Ministries in Kenya on collaborative care trials) provide the evidence base through research and can mobilize funding for integration initiatives.

It's also instructive to look at challenges noted in case studies: issues like staff burnout when adding tasks, the need for ongoing funding after pilot phases, and initial resistance from some HIV providers who may feel mental health is "outside" their scope. Successful cases managed these by training and mentoring, showing quick wins (e.g. a patient's adherence improving after counseling, which convinces staff of the value), and advocating for policy changes to formally incorporate the new practices.

In conclusion, **integration is happening worldwide in various forms**, and case studies provide proof of concept. Programs from Zimbabwe to the U.S. have shown that treating the "whole patient" and including mental health yields dividends in both patient well-being and biomedical

outcomes (like viral suppression). These examples serve as models that others can adapt, and they reinforce the guidance from WHO, CDC, ECDC, and UNAIDS that mental health integration is not only necessary but achievable even in low-resource contexts. As more and more programs document their experiences and share lessons, the global community can accelerate the adoption of best practices and move closer to truly comprehensive HIV care that leaves no aspect of health behind.

Conclusion

Integrating mental health services into HIV care is now recognized as a **best practice and essential component** of a quality HIV response. Across global and national guidelines there is clear consensus that mental health screening, psychosocial support, and treatment should be provided alongside HIV prevention and treatment services. The modalities for delivering these services are diverse – from clinic-based collaborative care teams to community-led counseling on park benches – but all aim to make mental health support accessible to people living with or at risk of HIV. Sufficient resources, including trained human resources, infrastructure, and financing, are critical to implement these interventions at scale. Efforts must also be sensitive to the varied needs of adults, adolescents, and children, ensuring age-appropriate and culturally competent care.

Not only do integrated approaches improve individual outcomes (better adherence, viral suppression, and quality of life), they also strengthen public health efforts by addressing factors that fuel the epidemic, such as depression-related non-adherence or substance use-related transmission. As countries and programs adopt frameworks like task-shifting, stepped care, and collaborative care, mental health integration is moving from theory into routine practice. Early adopters have illustrated that challenges can be overcome and that even in low-resource settings, creativity and community engagement can bring mental health services to those who need them most.

Moving forward, continued emphasis from global bodies (WHO's guidance, PEPFAR's strategic pillars, ECDC's monitoring, UNAIDS' advocacy) will help maintain momentum and resource allocation for this integration. Implementation science and shared learning from case studies will refine approaches, making them more efficient and equitable. Ultimately, the vision is that any person receiving HIV services – whether an adolescent girl at a mobile testing site or a 60-year-old man at an HIV clinic – will also have their mental health cared for with the same priority and compassion as their physical health. By fully embedding mental health into HIV care, we move closer to holistic health for people living with HIV and to the broader goals of the global HIV response, ensuring that wellness and longevity go hand in hand.

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