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Short Communication

Mental Health Inclusion in HIV Management toward Whole-Person Care

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INTRODUCTION

The management of HIV has evolved dramatically since the introduction of antiretroviral therapy (ART), shifting the disease from a terminal illness to a manageable chronic condition. Yet, amidst these biomedical advancements, mental health remains an under-addressed component in HIV care, despite its profound impact on treatment adherence and overall well-being of people living with HIV (PLWH) [1]. Depression, anxiety, and substance use disorders are disproportionately high among PLWH, and these mental health conditions often exacerbate HIV-related health outcomes [2]. The psychological burden stemming from stigma, social exclusion, and economic instability only intensifies these challenges [3].

Studies have consistently demonstrated that untreated mental health disorders lead to poor ART adherence, which compromises viral suppression and contributes to disease progression [4]. Depression alone has been identified as one of the strongest predictors of non-adherence among PLWH [5]. The interaction between mental health and HIV is complex and bidirectional: While HIV can trigger mental health issues, pre-existing psychological disorders can increase the likelihood of HIV acquisition through high-risk behaviors [6]. This interconnection makes it essential to integrate mental health services into every stage of HIV management.

Models of integrated care wherein mental health services are embedded within HIV treatment clinics have shown significant benefits. These models reduce barriers to care, promote early identification of psychiatric conditions, and reduced a more holistic treatment approach [7]. For example, routine mental health screening using tools like the Patient Health Questionnaire-9 (PHQ-9) for depression and the Generalized Anxiety Disorder scale (GAD-7) facilitates early intervention [8]. When mental health and HIV services are co-located, patients are more likely to remain engaged in care and less likely to drop out, especially when multidisciplinary teams collaborate closely.

The COVID-19 pandemic highlighted the importance of accessible mental health support, prompting a shift toward telepsychiatry in HIV care [9]. Telehealth has helped bridge gaps, especially in rural or underserved areas, and should continue to be leveraged to increase access to mental health resources. Despite these advances, challenges remain, particularly in resource-limited settings where trained mental health professionals are scarce. Task-shifting approaches training lay health workers to provide basic mental health care have been successfully implemented in sub-Saharan Africa and parts of Southeast Asia, suggesting scalable and cost-effective solutions [10].

Community support structures, including peer-led counseling and social support groups, play an indispensable role in fostering resilience and reducing isolation. Addressing the social determinants of health, such as housing, employment, and education, is also vital in improving mental and physical health outcomes in PLWH. Importantly, stigma around both HIV and mental illness continues to act as a barrier to seeking care. Tackling this dual stigma through public education campaigns and inclusive policy frameworks is essential to create a supportive environment for integrated care delivery.

CONCLUSION

The inclusion of mental health services in HIV management is a critical step toward achieving whole-person care. Beyond viral suppression, it enhances quality of life, boosts adherence to ART, and addresses the broader psychosocial needs of individuals. Integration should not be viewed as an optional add-on but rather as a foundational element of comprehensive HIV care. With continued investment, policy support, and collaborative care models, we can move closer to a system that truly values the mental and emotional health of all individuals living with HIV.

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