

FROM THE EDITOR



I am delighted to introduce you to our guest editors, who have done a sterling job in pulling together this 'Mental Health in HIV' edition.

They are two Capetonian colleagues who I am also fortunate to consider friends: John Joska is a psychiatrist and Landon Myer is a public health specialist.

John Joska is a senior specialist and lecturer in the Department of Psychiatry and Mental Health at the University of Cape Town. He is head of the Division of Neuropsychiatry, Western Cape provincial programme manager for HIV Psychiatry, and director of the GSH-HIV Mental Health Group. The latter is a newly formed

group of mental health professionals who are providing service and investigating the effects of HIV on people living with HIV/AIDS (PLWHA) from a mental health point of view. Current research projects include investigations into neurocognitive disorders in HIV, screening for mental disorders in HIV, and brief psychological interventions in PLWHA with depression.

Landon Myer is an associate professor in the School of Public Health and Family Medicine at the University of Cape Town. His research focuses on the roles of HIV/AIDS and other infectious diseases in shaping individual and population health in southern Africa. He is particularly interested in how the HIV epidemic influences other areas of population health, including mental health and women's reproductive health. In investigating these topics, his research incorporates biological mechanisms, individual behaviours and exposures, as well as structural socio-economic and health service conditions.

I am sure you will agree that with their colleagues they have provided a feast of important reading for you all in this edition.

LINDA-GAIL BEKKER
Editor

EDITORIAL

ADDRESSING MENTAL HEALTH IN ROUTINE HIV CARE AND TREATMENT

As this journal's readers are well aware, HIV has complex and wide-ranging impacts on the health of infected individuals. Much of this complexity is due to the nature of host-virus interactions and the pathophysiology of the virus and its sequelae in different organ systems over time. Other aspects are linked to the profound impact an HIV diagnosis has on the life of an infected individual, both through physical morbidity and the psychological and social consequences of a lifelong illness.

The area of mental health is a critical example of the diverse impacts of HIV on patients' health and well-being. The links between HIV and mental health are multiple: risk taking associated with HIV acquisition is more common among individuals with mental disorders; common mental disorders (such as anxiety, depression and alcohol/substance disorders) are often caused in part by the stress of an HIV diagnosis and related stigma; psychotic states are a relatively common presentation of HIV-



infected individuals; and neurocognitive manifestations of HIV infection such as HIV-associated dementia emerge later in the course of disease. Taken together, mental disorders may be viewed as their own class of 'opportunistic' conditions affecting HIV-infected individuals in a unique manner.

Dealing with the various mental health impacts of HIV infection is a core component of effective HIV care and treatment. Anxiety and depression among HIV-infected individuals can negatively impact on medication adherence; in these situations, management of mental disorders can help facilitate the management of HIV disease over the long term. The neurocognitive manifestations of HIV disease are a significant cause of morbidity; increasingly we are recognising that these disorders may

be managed effectively, including by early initiation of antiretroviral therapy, to improve the prognosis of affected individuals. In short, basic mental health care is part of good HIV management.

In this context, there is a clear need to make the diagnosis and management of mental disorders more feasible in general HIV care and treatment settings. At the primary and secondary levels of the health care system, medical officers and physicians must be able to identify patients with a possible mental disorder and work up these patients to arrive at a preliminary diagnosis, make management decisions, and follow up patients over time. Support from specialist psychiatrists is necessary in some instances, but most cases do not require specialist referral, and the availability of psychiatric services to support HIV care and treatment is limited in most settings across the region.

This special issue of the journal aims to address this need through a series of focused contributions from leaders in HIV mental health from across South Africa. The first two pieces focus on anxiety and depression in HIV in broad terms (Thom) and post-traumatic stress disorder

specifically (Pingo). Following this, the topic of psychotic presentations in HIV is dealt with by an algorithm for the diagnosis and management of psychosis in HIV (Jonsson) and then an extended case study (Boyles) to help reinforce key concepts. The topic of neurocognitive impairment in HIV/AIDS is discussed in detail (Singh) with a short report on the white matter changes that take place in the brain over the course of HIV disease (Hoare) as well as a piece of empirical research investigating the clinical utility of one commonly used tool to identify neurocognitive deficits in HIV (Ogunrin). The final piece deals with cross-cutting issues of prescribing psychotropic medications in the context of HIV infection (Parker). Throughout, these pieces aim to address issues in mental health faced by front-line HIV clinicians on a daily basis, with practical strategies for investigation and management. It is our hope that the contents of this issue may make some contribution towards helping HIV clinicians to better recognise and treat mental disorders in their patients.

LONDON MYER
JOHN JOSKA
Guest Editors

MESSAGE FROM THE EXECUTIVE

The large International AIDS Society meeting has come and gone from Cape Town. The agenda was dominated by a New Big Idea, an audacious mathematical model by a group of brave World Health Organization modelers showing that giving antiretroviral therapy to everyone with HIV, immediately, could make the epidemic disappear.

We've known for a long time that viral load correlates with infectiousness, whether it is sexual contact, PMTCT or other forms of exposure. ART is so highly effective in reducing viral load that the Swiss created an uproar a year ago by claiming that someone on ART with an undetectable viral load (and no STD) could not transmit HIV sexually.

The WHO researchers essentially argue that if we diagnose HIV quickly and treat everyone who is HIV positive, irrespective of CD4 count, we can arrest sexual transmission early and pretty much eradicate HIV within 10 years. Subsequent papers have even postulated that we could reverse the TB epidemic, as HIV drives this like fuel on a fire. Finally, early economic work has shown 'test and treat' to be cost saving, despite significant initial investment.



There is broad acknowledgment that HIV prevention programmes have been very disappointing, and that even effective interventions such as male circumcision and good PMTCT are unlikely to eradicate the epidemic alone. It is exciting that researchers are thinking creatively, and that models showing we can reverse things are out there.

But to implement this incredibly ambitious model would require a complete restructuring of health systems. We would need to do HIV testing aggressively and provide adequate, easily available ART services, as broadly as possible. The health system would have to be transformed from the lumbering unfriendly giant it is at the moment to a responsive and effective service deliverer. The reality is that we need this anyway, even if the modellers are wrong.

FRANCOIS VENTER
President