EDITORIAL

Beyond screening: a call for the routine integration of mental health care with tuberculosis treatment

J. T. Galea,¹ I. Monedero-Recuero,² A. C. Sweetland³<http://dx.doi.org/10.5588/pha.19.0008>

Depression is the most prevalent mental disorder worldwide, affecting about 1 in 5 persons per year,¹ and like tuberculosis (TB), the overwhelming majority (>80%) of people suffering from mental disorders reside in low- and middle-income countries (LMICs).² Often less recognized, however, is the tremendous TB/mental health comorbidity in LMICs, with prevalence estimates reaching 70%.³ In this issue of *Public Health Action*, Walker et al. report on the prevalence of depression and anxiety among people being treated for multidrug-resistant TB (MDR-TB) in Nepal. Their findings contribute to a growing evidence base documenting what front-line TB care givers globally have long recognized: not only are depression and anxiety frequently comorbid with DR-TB treatment, but they are often associated with greater physical side effects and lower treatment adherence.

The authors highlight the need for integrating mental health services into TB programs; however, LMICs frequently lack mental health staff and services. This translates to fewer than 10% of people with mental disorders in LMICs receiving mental health care,⁴ constituting a serious service 'gap' (the difference between the number of people needing services and those who receive them). Much of this gap is attributed to a lack of trained mental health personnel. The reality in Nepal is illustrative, where there are only 0.2 psychiatrists per 100 000 population.⁵ Relying only on skilled mental health professionals to deliver mental health care in Nepal and similar settings, including integration with TB care, is therefore impossible.

But there is good news: mounting evidence suggests that paraprofessionals can be trained to deliver effective treatment for mild-to-moderate depression and anxiety when provided adequate supervision. The World Health Organization's (WHO's) Mental Health Gap Action Programme disseminates several 'low-intensity' psychological interventions⁴ that can be delivered by trained non-specialists in LMICs along with care algorithms for common mental and neurological disorders using front-line psychotropic drugs that could be prescribed by general physicians. The limited number of psychiatrists can thus focus on patients with the most serious mental disorders, leaving most rou-

tine/non-urgent care to non-specialized personnel. As a community-based care model using task shifting is frequently employed for TB care in LMICs,⁶ it is already primed not only for the detection of depression and anxiety but, for many patients, also for providing evidence-based treatment for depression and anxiety.

Although most TB programs struggle with limited resources, integrating mental health services may prove a wise investment to improve outcomes, prevent further drug resistance, and enhance TB control.⁶ Context-specific data, such as those from Walker et al., support the possibility that local responses can be initiated using existing care packages like those from the WHO.⁴ Other resources include The TB and Mental Health Working Group at the International Union Against Tuberculosis and Lung Disease, which produced a video on how MDR-TB and mental health is managed in Peru showing psychiatrist, care giver and patient perspectives.⁷

All patients being treated for TB should be screened for depression and anxiety, but we must do more. TB programs hold great potential to 'upgrade' their services by integrating mental health care, leading the way towards closing the mental health care gap and improving DR-TB outcomes.

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AFFILIATIONS

- 1 School of Social Work, College of Behavioral and Community Sciences, University of South Florida, Tampa, Florida, USA
- 2 TB-HIV Department, International Union Against Tuberculosis and Lung Disease, Paris, France
- 3 Department of Psychiatry, Columbia College of Physicians and Surgeons, New York State Psychiatric Institute, New York, New York, USA

CORRESPONDENCE

Jerome T Galea, School of Social Work, College of Behavioral and Community Sciences, University of South Florida, MHC 1416 A, 13301 Bruce B Downs Blvd, Tampa, FL 33612-3807, USA. e-mail: jeromegalea@usf.edu

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