Non-specialist health workers to treat excessive alcohol consumption and depression

Published Online
December 14, 2016
http://dx.doi.org/10.1016/S0140-6736(16)32566-1

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Excessive alcohol consumption and depression are two of the leading causes of mortality and morbidity worldwide,[1,2] impairing quality of life, social functioning, and participation in the workplace. These mental health conditions frequently co-occur in the same individuals, exacerbating the risks and burdens for individuals and their communities.[3] Globally, excessive alcohol consumption and depression produce a huge socioeconomic burden and constitute two of the highest risk factors for disability.[1,2,4] For individuals living in low-income and middle-income settings, the burden is particularly acute: prevalence is high, but availability of and access to adequate treatment are low. Moreover, most research evidence to support bridging of the treatment gap comes from high-income settings.

In low-income and middle-income countries, primary care physicians can be ideally placed to screen patients for both conditions, classifying them according to alcohol-related risk as well as diagnosing and treating depression. For patients with alcohol use disorders, different treatments should be offered: health promotion for abstinent or low-risk drinkers, brief psychological intervention for at-risk and harmful drinkers, and referral to specialised treatment programmes (including behavioural support and pharmacotherapy) for individuals with alcohol dependence.[5] A brief psychological intervention delivered by physicians, nurses, or psychologists can be effective in reduction of alcohol consumption in excessive alcohol drinkers, but most if not all studies have been done in high-income settings.[6,7]

For depression, patients tend to be diagnosed and managed by primary care physicians, with only a small proportion of patients being referred to specialised care. Standard treatment comprises antidepressant medication and psychotherapy.[8] Authors of a meta-analysis[9] found no difference between the effectiveness of these therapeutic instruments. In low-income and middle-income countries, psychotherapy is recommended as first-line treatment for both excessive alcohol consumption and depression.[10,11] However, because of a scarcity of time, training, and resources, most patients do not receive any treatment for excessive alcohol drinking or depression from their primary care physicians.[12–14]

In *The Lancet*, Vikram Patel and colleagues[15,16] report two companion randomised controlled trials that investigate the efficacy of a new strategy to improve treatment of excessive alcohol drinking and depression in primary care in India. Specifically, a brief psychological intervention was delivered to two samples of primary care patients: the first comprising male harmful drinkers and the second male and female patients with depression. Although the effectiveness of psychological interventions in treatment of these disorders has been previously shown,[7–9] the main novelty of these studies was the choice of type of counsellors who delivered the interventions.[15–17] Counsellors were adult members of the local community educated to at least secondary school level but with no professional mental health training, and trained in a 3 week course in mental health delivered by specialists; the same counsellor delivered interventions for both disorders.

Harmful drinkers and patients with depression were screened using two questionnaires, Alcohol Use Disorders Identification Test (AUDIT) for harmful drinkers and the Patient Health Questionnaire for patients with depression, and then divided into two groups, to receive usual care delivered by their primary care physicians and usual care plus psychological intervention delivered by counsellors. Usual care received was enhanced as the primary care physicians received information about the AUDIT and

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Patient Health Questionnaire scores. After 3 months, patients who received counsellor-delivered psychological intervention plus enhanced usual care achieved better results than did those who received only physician-delivered enhanced usual care. Among excessive drinkers, psychological intervention increased the number of patients who achieved remission (AUDIT score of <8) and maintained abstinence (number of abstinent patients and abstinent days); among depressed patients, it reduced the severity of depression (Beck Depression Inventory version II) and its consequences (disability scores, days out of work, suicide attempts, and intimate partner violence in women) and increased the number of patients who achieved remission (Patient Health Questionnaire score of <10). Additionally, the psychological intervention was found to be cost-effective for both disorders.

These results are of particular interest as the recruitment of non-specialist health workers, with no previous mental health training, could represent a practical solution to overcome one of the main barriers to use of psychological intervention in prevention and treatment of mental disorders: scarcity of skilled human resources. This new strategy could help to increase the number of people affected by a mental disorder who receive treatment, not only in low-income and middle-income countries, such as India, but also worldwide.

However, many patients did not respond to psychological intervention (64% of excessive drinkers and 36% of patients with depression did not achieve remission). Additionally, the psychological intervention failed to modify alcohol consumption and its consequences (disability scores, days unable to work, suicide attempts, and perpetration of intimate partner violence) among excessive drinkers who continued to drink. Still, these results are consistent with those obtained by other studies in which treatment was delivered by mental health professionals. For example, similar proportions of non-responder patients (up to 60% of heavy drinkers and 30% of patients with depression) have been found among alcohol drinkers and patients with depression who received a brief psychological intervention delivered by their general physicians.[6,18] Because of these limitations, further studies are needed to understand which characteristics of psychological intervention (eg, content, length, or frequency) can be modified to improve its effectiveness and increase the number of responders.

Another limitation for response to the burden of mental health disorders in low-income and middle-income countries is that many excessive alcohol drinkers and patients with depression are not identified as such by primary care physicians.[19,20] In the studies by Patel and colleagues,[15,16] excessive alcohol drinkers and patients with depression were identified by trained health assistants after a session of consultation between the patient and primary care physician. In routine clinical practice, this approach would imply the need for all primary care physicians to have access to a professional figure of this standing in his or her surgery. Undoubtedly, such access would be beneficial and would contribute to reduction of the workload of primary care physicians, but it would also incur additional costs. A real challenge, therefore, is improving the detection of excessive drinking and depression, since failure to identify these disorders results in a poor prognosis and complicates assessment and treatment of concomitant medical and psychiatric disorders. Physician competency in identification and treatment of excessive alcohol consumption and depression should be increased worldwide; specific courses for medical students focused on these topics might be a feasible policy.

Findings from the two studies show that psychological intervention delivered by non-specialist health workers achieves better results than does enhanced usual care. Findings also show the possibility of receiving treatment from the same non-specialist health counsellor trained in delivery of interventions for both excessive alcohol drinking and depression. As these disorders are frequently manifested in clinical practice and often co-occur in the same individuals, this possibility would represent a further advantage for primary care patients. Dual treatment would also simplify the procedures requested by primary care physicians in clinical practice to refer patients to non-specialist health counsellors. Taken together, these results are an important step forwards and support the need to further investigate the effectiveness of psychological intervention delivered by non-specialist health workers in the everyday clinical practice of primary care physicians in low-income and middle-income countries. For all of these reasons, these two studies are very welcomed.

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I declare no competing interests.

1 Global, regional, and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. *Lancet* 2016; **388:** 1659–724.

2 Global, regional, and national disability-adjusted life-years (DALYs) for 315 diseases and injuries and healthy life expectancy (HALE), 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. *Lancet* 2016; **388:** 1603–58.

3 Sullivan LE, Fiellin DA, O'Connor PG. The prevalence and impact of alcohol problems in major depression: a systematic review. *Am J Med* 2005; **118:** 330–41.

4 Mokdad AH, Forouzanfar MH, Daoud F, et al. Global burden of diseases, injuries, and risk factors for young people's health during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* 2016; **387:** 2383–401.

5 Willenbring ML, Massey SH, Gardner MB. Helping patients who drink too much: an evidence-based guide for primary care clinicians. *Am Fam Physician* 2009; **80:** 44–50.

6 Kaner EF, Beyer F, Dickinson HO, et al. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database Syst Rev* 2007; **2:** CD004148.

7 O'Donnell A, Anderson P, Newbury-Birch D, et al. The impact of brief alcohol interventions in primary healthcare: a systematic review of reviews. *Alcohol Alcohol* 2014; **49:** 66–78.

8 Gelenberg AJ, Freeman MP, Markowitz JC, et al. Practice guideline for the treatment of patients with major depressive disorder, 3rd edn. Washington, DC: American Psychiatric Association Publishing, 2010.

9 Cuijpers P, Berking M, Andersson G, et al. A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *Can J Psychiatry* 2013; **58:** 376–85.

10 Benegal V, Chand PK, Obot IS. Packages of care for alcohol use disorders in low- and middle-income countries. *PLoS Med* 2009; **6:** e1000170.

11 Patel V, Simon G, Chowdhary N, et al. Packages of care for depression in low- and middle-income countries. *PLoS Med* 2009; **6:** e1000159.

12 Keurhorst M, van de Glind I, Bitarello do Amaral-Sabadini M, et al. Implementation strategies to enhance management of heavy alcohol consumption in primary health care: a meta-analysis. *Addiction* 2015; **110:** 1877–900.

13 Kessler RC, Demler O, Frank RG, et al. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med* 2005; **352:** 2515–23.

14 Charlson FJ, Baxter AJ, Cheng HG, et al. The burden of mental, neurological, and substance use disorders in China and India: a systematic analysis of community representative epidemiological studies. *Lancet* 2016; **388:** 376–89.

15 Nadkarni A, Weobong B, Weiss HA, et al. Counselling for Alcohol Problems (CAP), a lay counsellor-delivered brief psychological treatment for harmful drinking in men, in primary care in India: a randomised controlled trial. *Lancet* 2016; published online Dec 14. http://dx.doi.org/10.1016/S0140-6736(16)31590-2.

16 Patel V, Weobong B, Weiss HA, et al. The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: a randomised controlled trial. *Lancet* 2016; published online Dec 14. http://dx.doi.org/10.1016/S0140-6736(16)31589-6.

17 Patel V, Weobong B, Nadkarni A, et al. The effectiveness and cost-effectiveness of lay counsellor-delivered psychological treatments for harmful and dependent drinking and moderate to severe depression in primary care in India: PREMIUM study protocol for randomized controlled trials. *Trials* 2014; **15:** 101.

18 Richards DA, Ekers D, McMillan D, et al. Cost and outcome of behavioural activation versus cognitive behavioural therapy for depression (COBRA): a randomised, controlled, non-inferiority trial. *Lancet* 2016; **388:** 871–80.

19 Mitchell AJ, Meader N, Bird V, et al. Clinical recognition and recording of alcohol disorders by clinicians in primary and secondary care: meta-analysis. *Br J Psychiatry* 2012; **201:** 93–100.

20 Mitchell AJ, Vaze A, Rao S. Clinical diagnosis of depression in primary care: a meta-analysis. *Lancet* 2009; **374:** 609–619.

Mentoring clinical trainees: a need for high touch

Training young doctors in the USA has traditionally relied on the transfer of critical knowledge, skills, and attitudes from experienced senior physicians to new generations. Typically, a trainee engaged in book learning and progressive clinical responsibilities until the senior physician was confident that the trainee was capable of providing patient care independently. This transfer of knowledge and skills was expected to take place through an apprenticeship-like arrangement between the senior clinician and his or her trainee, a relationship we would now recognise as mentoring. Before the past decade, mentorship was not explicitly taught or articulated; there was an assumption that this relationship was mutually beneficial and arose naturally.

Times were different—scientific knowledge was more limited and medicine had less to offer in terms of treatments. While the mentor's major responsibility was to assure the apprentice acquired knowledge and skills, they also often provided emotional and psychological support given the closeness of their interactions.

Today, the clinical training environment is different, and trainees have little time to develop long-term, meaningful relationships with potential mentors. Trainees now face additional challenges that limit their ability to learn and practice medicine: intense work schedules, unpredictable patient volumes due to constantly changing work requirements, interprofessional competition, and conflicts between their roles as both learners and employees. Clinical trainees have little time to engage in activities outside of work and to build or maintain personal social relationships. The consequences of this imbalance are reflected in the high levels of burnout, depression, anger, emotional exhaustion, sadness, anxiety, and uncertainty around performance that are reported.[1] For some, divorce, substance misuse, poor patient care or medical errors, and sadly, even suicide, might follow.

High-quality, empathetic, patient-centred health care requires a healthy workforce,[2] and for trainees, having a mentor is essential, particularly a career mentor who