Policy brief
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Using non-specialist health workers improves depression and anxiety and reduces cost in primary care

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Summary

In the largest trial in psychiatry to be conducted in the developing world, the MANAS intervention aimed to demonstrate that lay people (non-specialist health workers) who have no formal mental health qualification, can play a crucial role in providing and coordinating effective care for people suffering from depression and anxiety in primary healthcare settings, when given appropriate training and supervision. The intervention was designed in a novel way, bringing together mental health specialists with primary care teams to provide evidence based treatments in an incremental manner based on needs.

Problem

Depression and anxiety are priorities on the global agenda because of their frequency, early onset, and strong association with premature mortality, poor physical health, functional impairment, and social adversity. Despite evidence based treatments that are available for these conditions, the majority of people do not receive appropriate services, leading to a huge gap between those who need care compared to those who actually receive it (i.e. there is a large treatment gap).

Recommendations

1) Use frontline non-specialist health workers to identify and treat people with depression at a national level.
2) Invest in research to explore the use of the collaborative care model for multiple morbidities, i.e. mental health problems co-occurring with other chronic diseases, such as cardiovascular disease.

Context

Around 350 million people around the world suffer from depression and anxiety. Depression is projected to be, overall, the leading cause of disability by 2030.

Contrary to popular belief, there is strong evidence linking depression with gender and factors related to social disadvantages such as poverty and illiteracy. Low levels of education, food insecurity, poor housing and financial stress exhibit a relatively consistent and strong association with the risk for depression. Poverty and depression interact in a vicious negative cycle. There are dire economic consequences as people with depression spend more days being unable to work due to their illness, which is further worsened by the high costs of healthcare due to depression.

In addition to the economic and social burden, depression is also a risk factor for a number of non-communicable diseases such as diabetes and cardiovascular disease, and these conditions in turn increase the risk for depression. Co-morbidity complicates help-seeking, diagnosis and treatment, and affects the outcomes of treatment for the above-mentioned conditions, including disease-related mortality. Finally, depression in mothers during the perinatal period has been shown to be associated with adverse effects on their infant's nutrition and overall development.

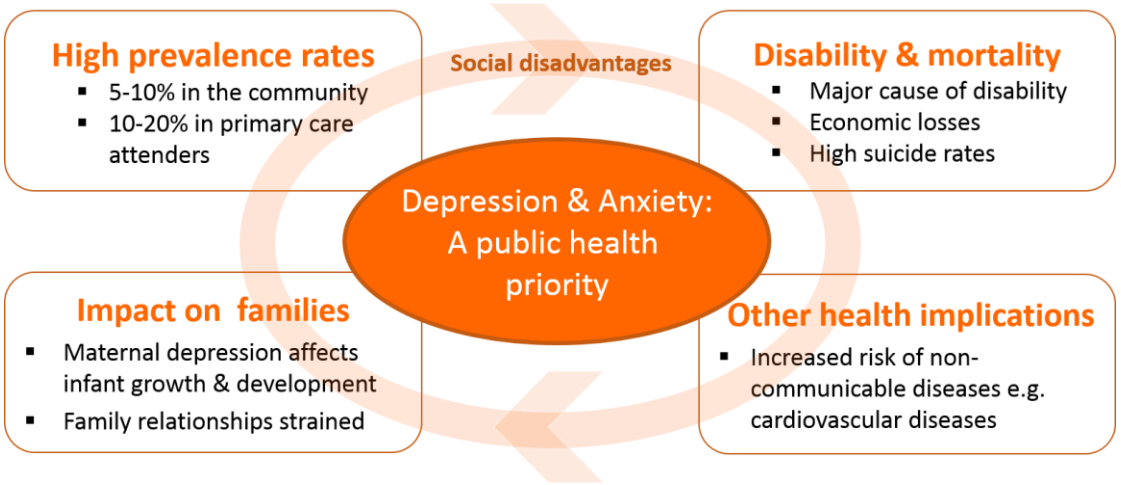

Figure 1: The vicious negative cycle of depression and social disadvantage.

There are a wide range of drugs, and psychological and social interventions that have been shown to be cost-effective and that can transform the lives of people affected by depression. Even though up to 20% of people attending primary care suffer from depression and anxiety, most people with these disorders do not receive evidence based interventions. ***There is an urgent need to scale up services for treating depression***: MANAS provides an effective and low-cost model for such scaling up.

> “MANAS has demonstrated that care for persons with common mental disorder can be provided at the primary level, with lay counsellors working under the supervision of a trained psychiatrist, and does not require tertiary level treatment. This is an important lesson for the District Mental Health Programme and can benefit an overwhelming number of persons in India with common mental disorder.”
>
> Keshav Desiraju, Former Secretary Health & Family Welfare, Government of India

About the innovation

MANAshanti Sudhar Shodh (MANAS) means “project to promote mental health” in Konkani. The MANAS trial aimed to evaluate the clinical and cost-effectiveness of a collaborative stepped care intervention (described below) for the treatment of depression and anxiety, coordinated by non-specialist health counsellors, in primary care in Goa, India.

The intervention was developed through extensive consultation with local stakeholders such as primary care staff, people with depression and anxiety, and family members. Two models of care were developed and tested against one another at public primary health centers and private general practitioner facilities in Goa.

The two models of care were:

1. MANAS collaborative stepped care intervention

The intervention included:

- Case management and psychosocial interventions by trained non-specialist health counsellors
- Pharmacological treatment by primary care physician
- Supervision and referral to mental health specialists

The intervention was a collaboration between the mental health specialist and the primary care team. It was designed using a stepped care approach with simple treatment (i.e. psychoeducation) provided to everyone with depression and anxiety, while further treatments were added on if the problem was severe or if there was no response to earlier steps.

2. Enhanced usual care

Screening results were provided to the primary care physicians by the research team. A treatment manual with recommendations of evidence based treatments was also provided to the physicians who then administered their treatment of choice.

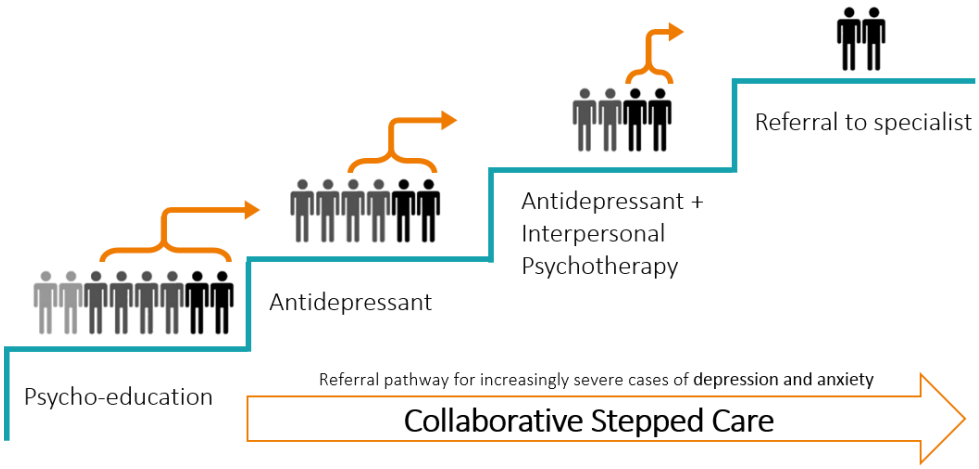

Figure 2: The MANAS Collaborative Stepped Care Intervention

Impact

Effectiveness of the intervention

In public primary care facilities, symptoms for depression and anxiety were reduced by a greater degree in patients receiving the MANAS collaborative stepped care intervention, compared to those receiving enhanced usual care. The same effect was not found in private facilities. Over a period of 12 months, in public primary care facilities, patients in the MANAS collaborative care clinics demonstrated:

- 30% lower prevalence of depression and anxiety
- 36% reductions in suicide attempts/plans
- 5-6 fewer days of being unable to work as usual in the past month

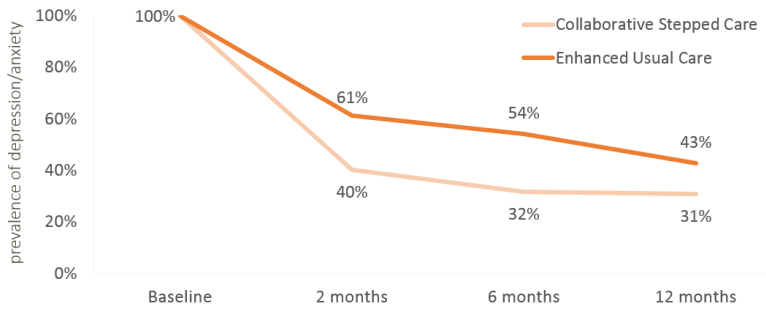

Figure 3: Lower prevalence of depression/anxiety in the collaborative care clinics

The cost-effectiveness of the intervention

- On average, it costs $2 USD per person to implement the MANAS collaborative stepped care intervention
- It costs $120 USD less per case to implement the MANAS collaborative stepped care intervention compared to the control arm in public facilities
- It costs $86 USD less per case to implement the MANAS collaborative stepped care intervention compared to the control arm in private facilities

Recommendations

Recommendation 1: Use frontline non-specialist health workers to identify and treat people with depression at a national level

A key step in this process of scale up involves the recruitment of a cadre of non-specialist health workers (i.e. people with no prior formal qualification in mental health who receive training and supervision from a specialist), based at the primary health centres, who can play a role in identifying persons with depression. These health workers need to be provided with basic psycho-social interventions that have proven efficacy in treatment of depression and anxiety. These health workers also need to be actively involved in coordinating care between the patient, primary care doctor (who prescribes antidepressants when needed) and the specialist.

Recommendation 2: Invest in research to explore the use of the collaborative care model for multiple morbidities

Multiple morbidities, i.e. the co-occurrence of mental disorders and physical health disorders such as diabetes and cardiovascular disease, are increasingly common and are associated with higher levels of disability and health care expenditure. Collaborative care which seeks to enhance person-centred approaches to addressing such multiple morbidities are an urgent health and economic priority in low resource settings.

Acknowledgements

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