DIABILITY CHALLENGE CONCEPT

Title: **Integrated Diagnostics and Treatment for Schizophrenia, Anxiety and Depressive Disorders among youths In Northern Malawi**

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Introduction to depression

Depressive disorders are characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration(1). Depression can be long lasting or recurrent, substantially impairing an individual's ability to function at work or school or cope with daily life. At its most severe, depression can lead to suicide(2). Depressive disorders include two main sub-categories(1); there are major depressive disorder/ depressive episode and dysthymia(1).

Depression can lead to suicide(1). It is now estimated that 350 million people globally are affected by depression(3). Most of these people are left untreated (76-85% in LMICs and 35-50% in HIC). In Malawi 28.8% of OPD cases have depression and almost all are missed in diagnosis(4).

Burden of depression

It is now estimated that 350 million people globally are affected by depression(3). Depressive disorders led to a global total of over 50 million Years Lived with Disability (YLD) in 2015(1). Most of these people are left untreated. For instance, between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high income countries is also high: between 35% and 50%(5).

Mental Health Services delivery in Malawi and other developing countries

In Malawi almost all patients with mental disorders are misdiagnosed in primary care settings and they are subsequently treated for physical symptoms(4). For instance, it has also been found that 28.8% of the patients attending primary health care have common mental health problems of depression or anxiety while 19% have depression alone(2)(4). In Malawi, mental health services are mainly urban based such that these services are neither decentralized nor integrated into the national Primary Health Care delivery system(6). With inadequate services and low awareness; many patients opt for native healers and paramedics.

For instances; almost 50% of mental health patients visit native healers as the first care-giver before referral(7). In South Africa, only 9% to 11% people with common mental disorders consulted the traditional healers and Religious advisors as reported in (8). In many developing countries, people with mental disorders reports to the hospital when the first contact did not yield any results, they either go to traditional healers and religious advisors. This was demonstrated in Liberia, Nepal and Ethiopia(9).

It is clear that major challenges to implementing Mental Health services in developing countries like Malawi are inadequate awareness and advocacy to support for services for people with mental disorders; and resistance to decentralize the services to primary care level(10). Therefore, substantial attention to politics, leadership, planning, advocacy, and community participation is needed for sustainable and efficient Mental Health system.

Diagnosis

Depression is a disorder that can be reliably diagnosed and treated in primary care(11). Diagnostic Statistical Manual (DSM -5) will be used(12); for example Diagnostic Statistical Manual (DSM)-IV was used to diagnose major and minor depressive disorders in antenatal women in Malawi through a Structured Clinical Interview(13).

Treatment and Care

Depression can be treated effectively in such countries with low-cost antidepressants or with psychological interventions (such as cognitive-Behaviour therapy and interpersonal therapies)(14). Stepped-care(15) and collaborative models (16)provide a framework for integration of drug and psychological treatments and help to improve rates of adherence to treatment(14). Steeped-care is about being least restrictive and self-correcting while collaborative model is about the integration of physical and mental health care.

Project Idea Setting and feasibility

The idea will be piloted in two areas; one in one area within the city of Mzuzu and the other in the peri-urban area that is 20 Kilometers from Mzuzu city. The set-up and roles of the partners are explained on figures 1 and 2. The indicators will be formulated to check progress and final effects of the intervention in the city. This will be a learning project such that all parties will mostly rely on available resources whereas the project will only fill-in the gaps. The St John of God College and the pilot hospital are all in town and other pilot center will be 20 kilometers away. It will be easy to community. University of Livingstonia will not be actively on ground apart from research, coordination and quality assurance activities.

Furthermore, the community is willing to participate. The unique feature of the project is the involvement of traditional medicine practitioners and the religious advisors. Most projects that I have checked are "fighting "with the traditional medicine practitioners and religious advisors which makes behaviors change and reduction of discrimination a challenge in metal health programs.

Figure 1: Set-up of pilot project and Roles of Partners

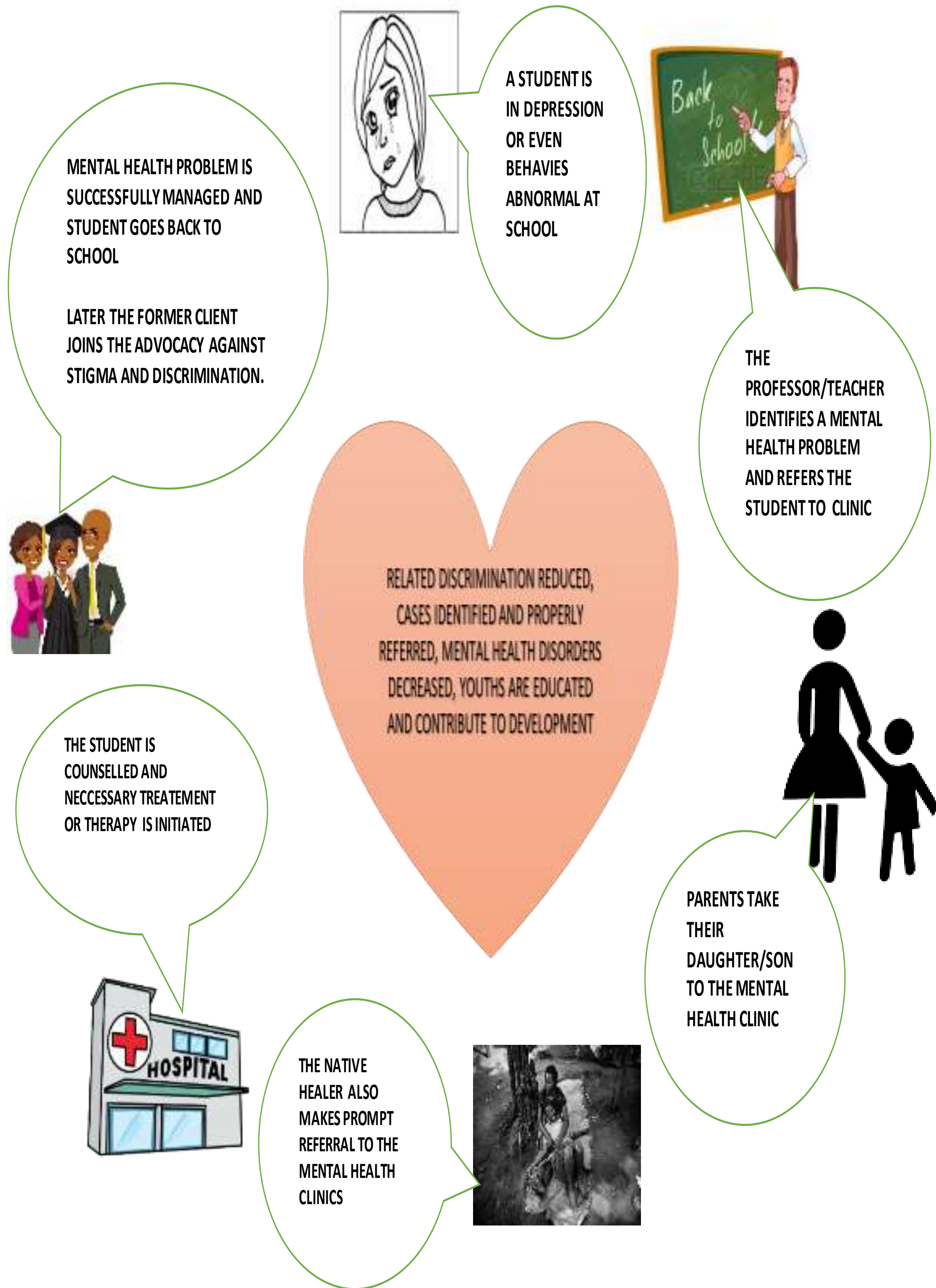

Figure 2: User Experience map.

References

1. World Health Organization. Depression and Other Common Mental Disorders Global Health Estimates [Internet]. 2017. Available from: WHO/MSD/MER/2017.2

2. Kauye F, Jenkins R, Rahman A. Training primary health care workers in mental health and its impact on diagnoses of common mental disorders in primary care of a developing country, Malawi: a cluster-randomized controlled trial. Psychol Med [Internet]. 2013/05/31. 2014;44(3):657–66. Available from: https://www.cambridge.org/core/article/training-primary-health-care-workers-in-mental-health-and-its-impact-on-diagnoses-of-common-mental-disorders-in-primary-care-of-a-developing-country-malawi-a-clusterrandomized-controlled-trial/A7326A2895452F1816984CE

3. World Federation For Mental Health (WFMH). Depression: A Global Crisis. World Ment Heal Day. 2012;32.

4. Malawi Ministry of Health. National Action Plan for Control and management of Non-Communicable Diseases in Malawi (2012-2016). Lilongwe; 2013.

5. World Health Organization. Mental Health Action Plan 2013-2020. WHO Libr Cat DataLibrary Cat Data [Internet]. 2013;1–44. Available from: http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf?ua=1%5Cnhttp://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf

6. Kauye F, Chiwandira C, Wright J, Common S, Phiri M, Mafuta C, et al. Increasing the capacity of health surveillance assistants in community mental health care in a developing country, Malawi. Malawi Med J [Internet]. 2011;23(3):85–8. Available from: http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=cagh&AN=20123075154%5Cnhttp://oxfordsfx.hosted.exlibrisgroup.com/oxford?sid=OVID:caghdb&id=pmid:&id=doi:&issn=&isbn=&volume=23&issue=3&spage=85&pages=85-88&date=2011&title=Malawi+Medical

7. Kauye F, Udedi M, Mafuta C. Pathway to care for psychiatric patients in a developing country: Malawi. Int J Soc Psychiatry. 2014;61(2):121–8.

8. Sorsdahl K, Stein DJ, Grimsrud A, Seedat S, Flisher AJ, Williams DR, et al. TRADITIONAL HEALERS IN THE TREATMENT OF COMMON MENTAL DISORDERS IN SOUTH AFRICA. J Nerv Ment Dis [Internet]. 2009 Jun;197(6):434–41. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3233225/

9. Kisa R, Baingana F, Kajungu R, Mangen PO, Angdembe M, Gwaikolo W, et al. Pathways and access to mental health care services by persons living with severe mental disorders and epilepsy in Uganda, Liberia and Nepal: a qualitative study. BMC Psychiatry [Internet]. 2016;16(1):305. Available from: http://dx.doi.org/10.1186/s12888-016-1008-1

10. Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, et al. Barriers to improvement of mental health services in low-income and middle-income countries. Vol. 370, Lancet. 2007. p. 1164–74.

11. WHO. Depression, a global public health concern. WHO Dep Ment Heal Subst Abus. 2012;1–8.

12. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). Diagnostic and Statistical Manual of Mental Disorders 5th edition TR. 2013. 280 p.

13. Stewart RC, Umar E, Tomenson B, Creed F. A cross-sectional study of antenatal depression and associated factors in Malawi. Arch Womens Ment Health. 2014;17(2):145–54.

14. Patel V, Araya R, Chatterjee S, Chisholm D, Cohen A, De Silva M, et al. Treatment and prevention of mental disorders in low-income and middle-income countries. Lancet (London, England). 2007;370(9591):991–1005.

15. Bower P, Gilbody S. Stepped care in psychological therapies: access, effectiveness and efficiency. Narrative literature review. Br J Psychiatry [Internet]. 2005;186:11–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/15630118

16. Unützer J, Harbin H, Schoenbaum M, Druss BG. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. Heal Home Inf Resour Cent. 2013;(May):1–13.