



A community-based treatment program involving patients with chronic psychosis and their caretakers in Somaliland

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612 households in Hargeisa

Design

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graph LR; A[Representative sample of the overall population] --> B[Identify individuals with severe mental disorders]; B --> C[Random selection for clinical interview];
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Representative
sample of the
overall
population

Identify
individuals with
severe mental
disorders

Random
selection for
clinical
interview

Step 1

Step 2

169 Cases identified

Not functioning due to mental
problems

| | Yes | No | % (among > 12 years) |
|--------|-----|-------|-------------------------|
| Male | 137 | 2.312 | 8.4 |
| Female | 32 | 2.373 | 1.9 |

Every 5th household cares for family
members not functioning due to mental
problems

Reasons for functioning problems

| | |
|-------------------------------|-----|
| Neurological disorder | 8% |
| Mental retardation/disability | 4% |
| Psychotic disorder | 82% |
| Not known | 6% |

Management of severe mental problems

| | Men N = 137 | Women N = 31 | |
|--|----------------|-----------------|--|
|--|----------------|-----------------|--|

| | | | |
|--------------------|--------------|--------------|------|
| Years in Chains | 3.1 (3.9) | 1.0 (2.9) | .000 |
|--------------------|--------------|--------------|------|

| | | | |
|-------------------------------------|--------------|--------------|-----|
| Years Locked up (not chained) | 3.6 (4.7) | 4.9 (6.3) | .20 |
|-------------------------------------|--------------|--------------|-----|

Where did the patients/caretakers seek assistance?

Traditional Healers (99)

mainly working with herbal medicine

mainly working with ghosts

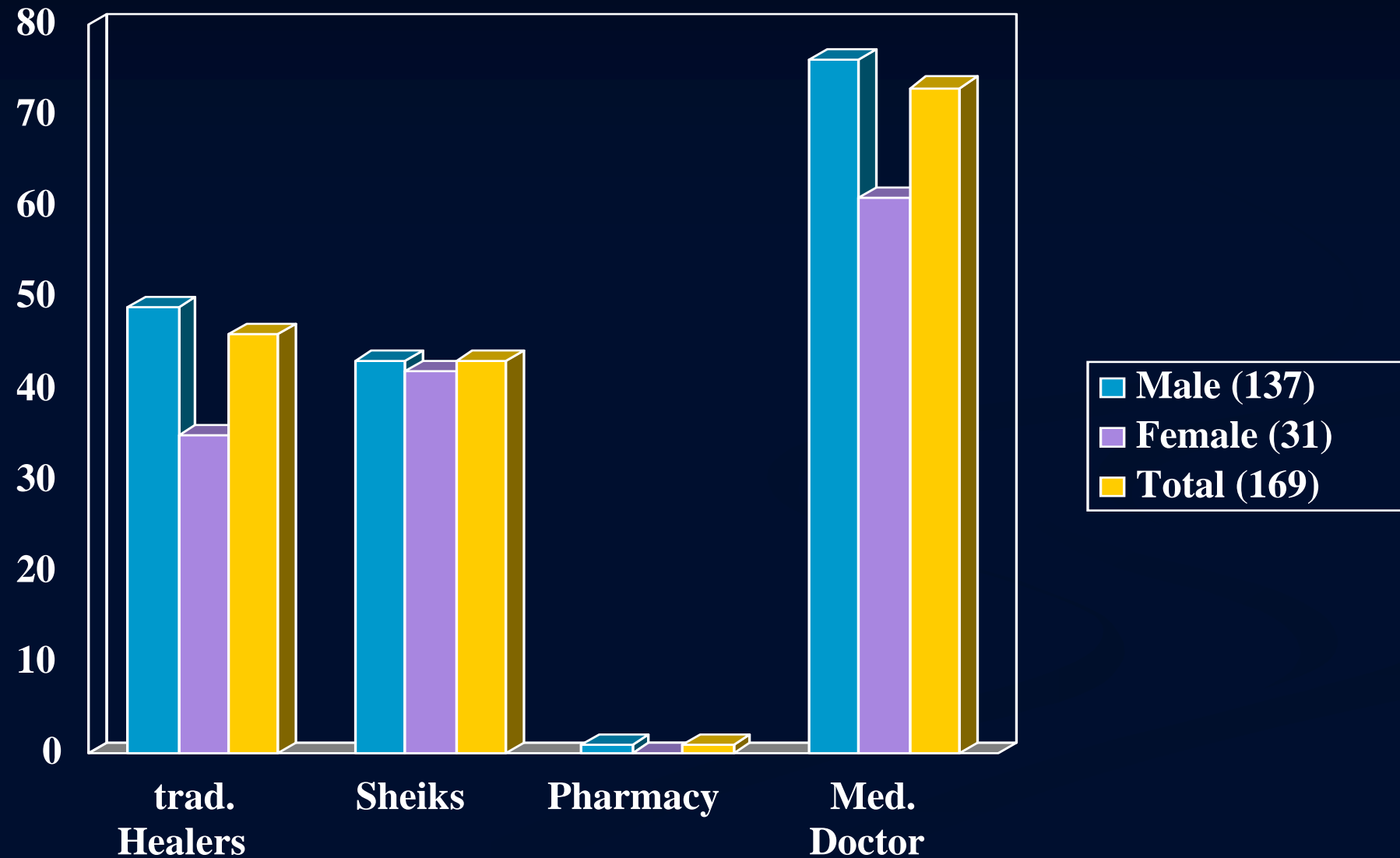
mainly working with Western drugs

Sheiks (72)

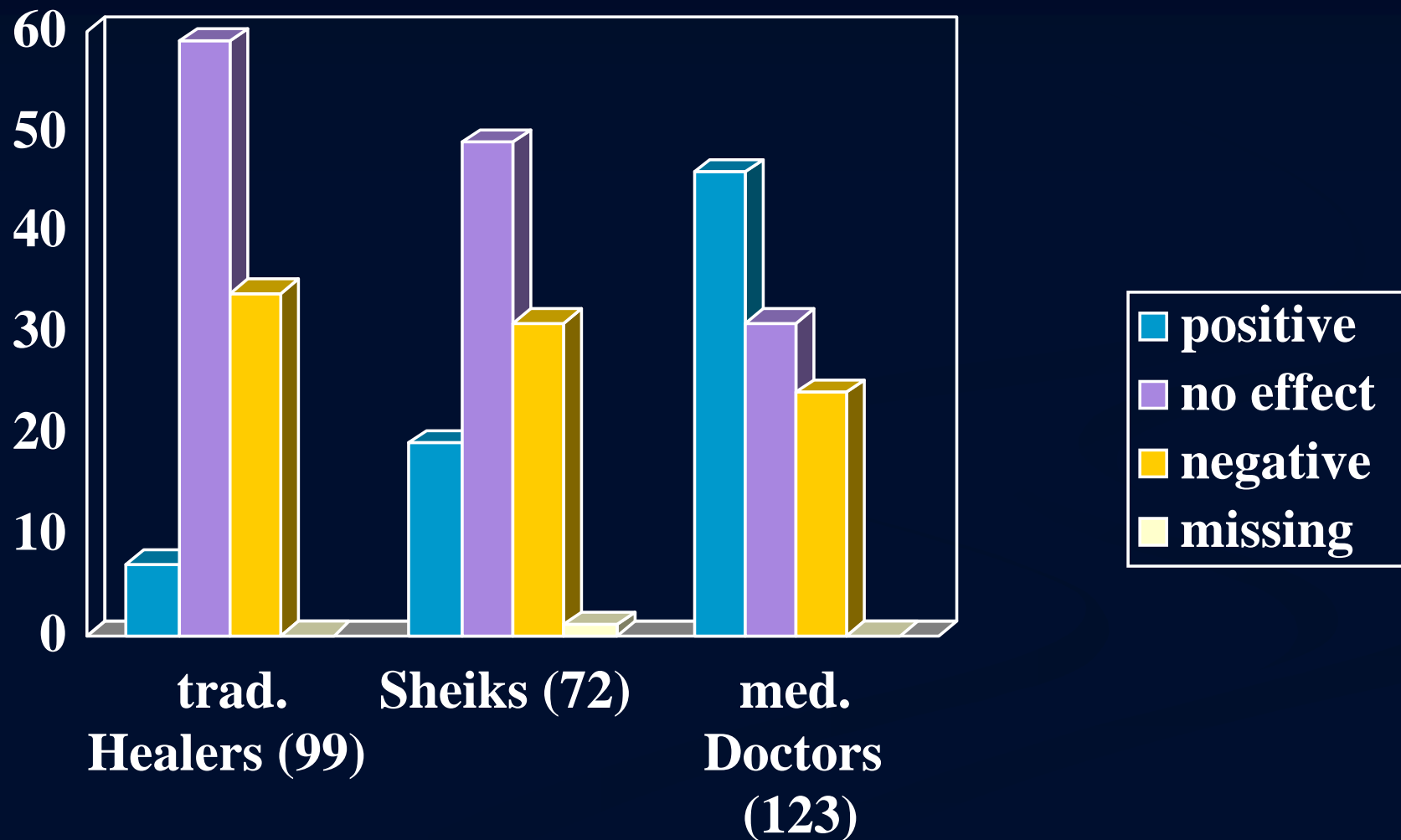
Pharmacies (2)

Medical Doctors (123)

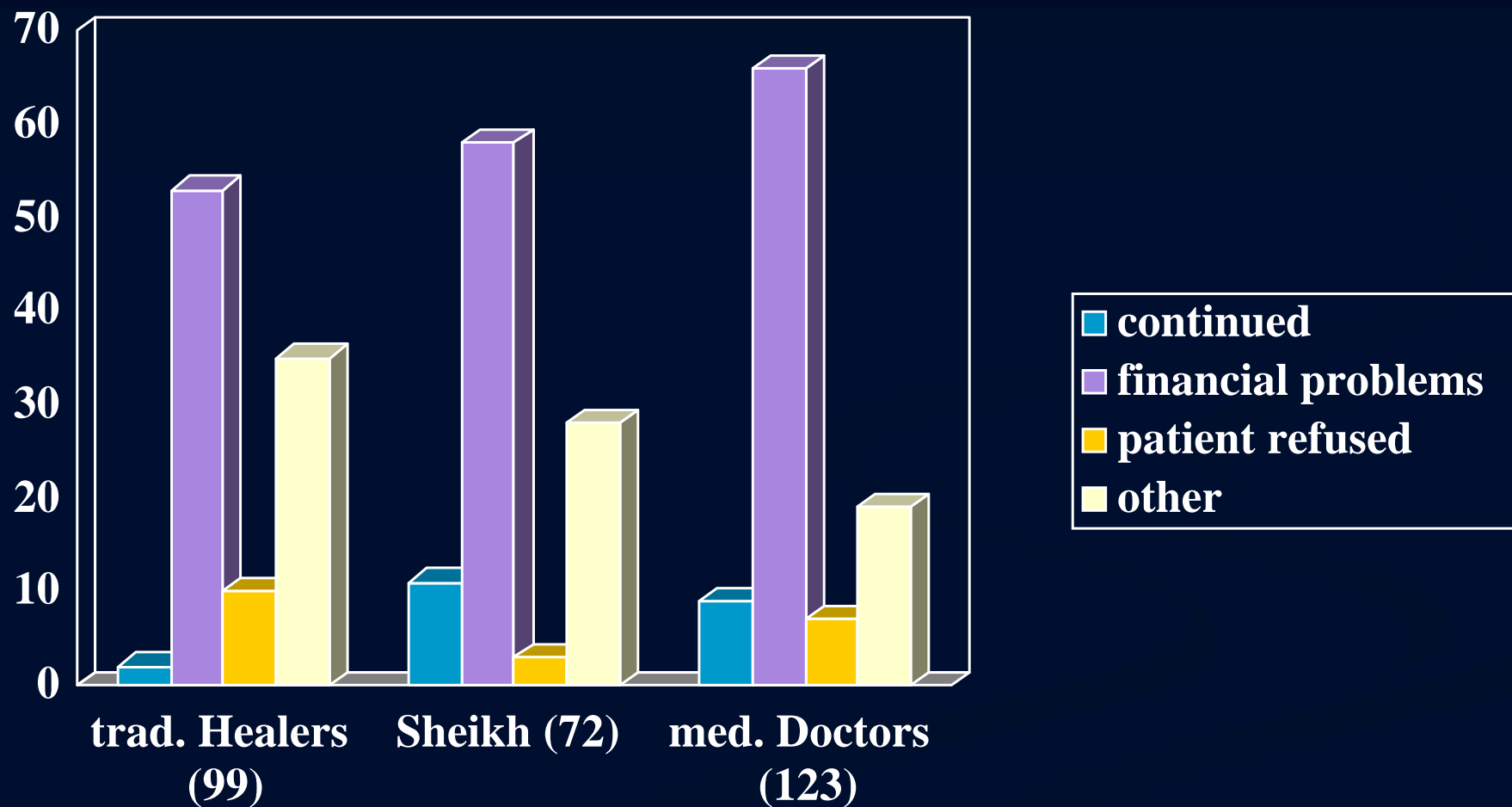
Where sought for assistance (%)



Caretaker-rating of treatment success (%)



Reason for discontinuation of treatment (%)



Randomly selected groups of cases

| | Psychosis N = 43 | Control N = 43 | |
|--------------------------|-----------------------------|---------------------------|----------|
| Age of first khat intake | 16.5 (4.2) | 20.4 (7.0) | p = .008 |
| Age of psychosis onset | 23.4 (9.8) | - | |

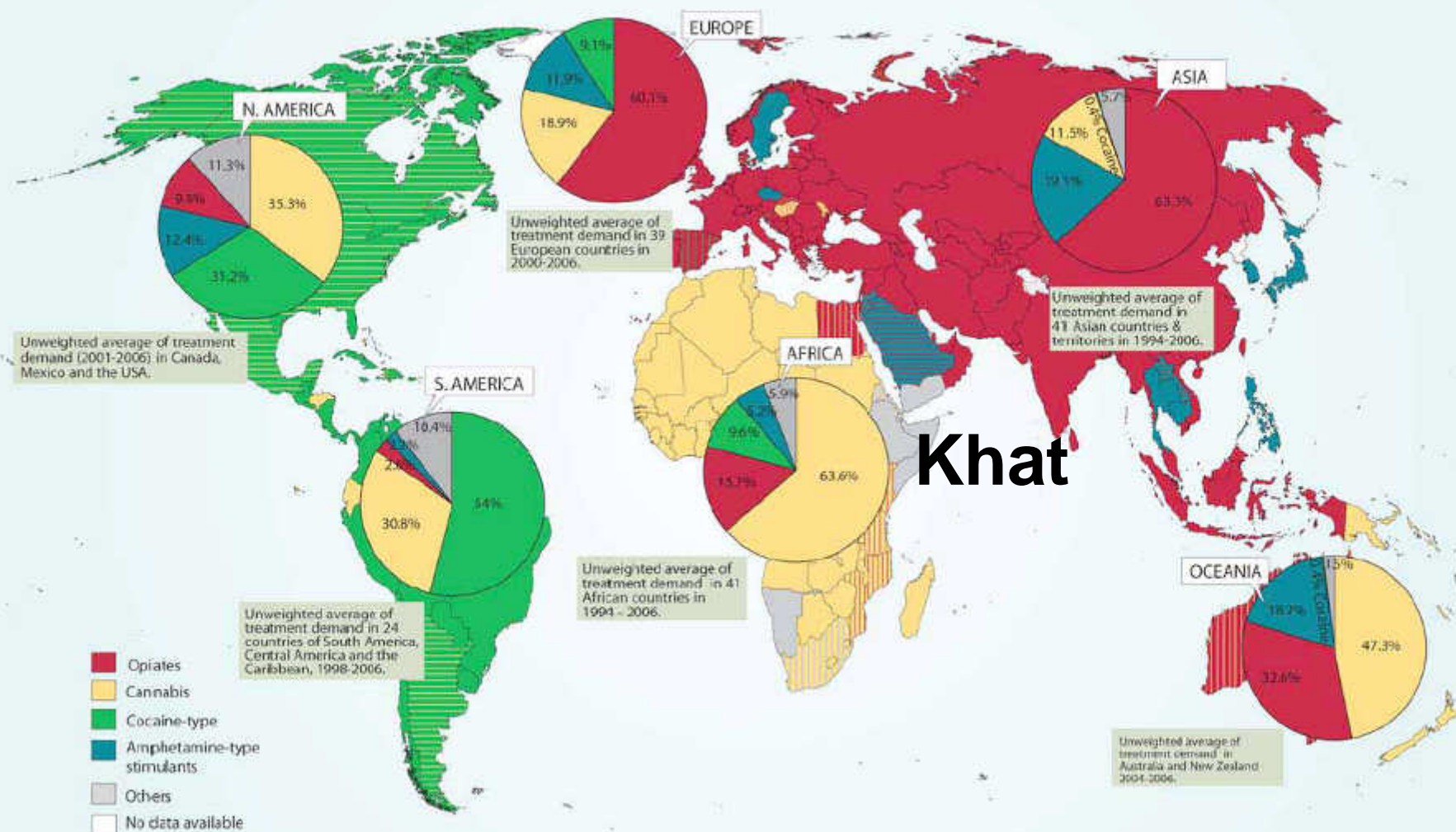
Mean difference 8.6 years (6.6), median 7

| | Psychosis N = 43 | Control N = 43 | |
|--|---------------------|-------------------|----------|
| Ever chewed khat in life | 88.6% | 59.1% | p = .008 |
| Khat per day week before interview | 1.1 (2.4) | 0.3 (0.7) | p = .024 |
| Khat per day weeks before onset | 2.1 (2.0) | 0.3 (0.6) | p < .001 |

Khat, Jaad, Qat,
Miraa, Marungi

Catha edulis
Forsk.

Main problem drugs (as reflected in treatment demand), 2006 (or latest year available)



Khat

UNODC, World Drug Report, 2008

Note: Data generally account for primary drug use; therefore polydrug use may increase totals beyond 100%.

Sources: UNODC, Annual Reports Questionnaire Data/DELTA and National Government Reports.



Substance abuse and the risk of readmission of people with schizophrenia at Amanuel Psychiatric Hospital, Ethiopia

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Abstract: Curationis 30(2): 74-81

Frequent readmissions of people with schizophrenia pose considerable pressure on the psychiatric service provision at Amanuel Psychiatric Hospital. The purpose of the study was to ascertain factors mainly contributing to the risk of readmissions of people with schizophrenia. Descriptive survey methods and qualitative focus group interviews were employed to conduct the study. Random sampling techniques were used to select 43 respondents of people with schizophrenia from 221 people with schizophrenia who were readmitted for two or more times in the last two years and who gained access during the time of the study. Structured interviews were used for respondents of people with schizophrenia. Friends (N=143) family members/caregivers were selected using purposive sampling methods for focus group discussions. Quantitative data was analysed using the SPSS Version 11.00 program and the qualitative data was analysed by generating themes and categories. The results suggest that alcohol and drug abuse were contributing factors for the rate of readmissions of people with schizophrenia into the Amanuel Psychiatric Hospital. It was found that communities contribute to the problems of substance abuse by providing and/or selling it to those mentally ill people. The study also revealed that patients use alcohol and that in order to tolerate the severe side effects of the anti-psychotic drugs, to suppress hunger due to shortage of food and to avoid drowsiness. Raising community awareness, psycho-education, strengthening the capacities of caretakers and laws to prevent substance abuse, as well as campaigning to prevent people from abusing mentally ill sufferers, should be established.





The PLoS Medicine Debate

What Is the Best Approach to Treating Schizophrenia in Developing Countries?

Vikram Patel, Saeed Farooq, R. Thara

Background to the debate: Schizophrenia affects an estimated 25 million people in low- and middle-income countries, with an average lifetime risk of about 1%. The illness is associated with excess mortality from a variety of causes. A 2001 Institute of Medicine report on mental illness in developing countries found that in 1990, over two-thirds of people with schizophrenia in these countries were not receiving any treatment (<http://www.nap.edu/catalog/10111.html>). The report found no evidence that the proportion of treated people in the developing world had increased since 1990. There is now a debate among mental health professionals in low-income countries over how best to improve patient care. In this article, three psychiatrists give their different viewpoints on the current status of treatment efforts for schizophrenia in the developing world and the measures that can be taken to increase the proportion of patients receiving treatment.

Vikram Patel's Viewpoint: Non-Specialist Community Health Workers Should Play a Key Role in Delivering Care

Although schizophrenia is relatively rare, it is also arguably the most severe mental disorder. In many individuals, the

health [4]. Traditional medicine was by far the most common type of health care accessed. Lack of services contributes to delayed treatment, which in turn leads to poorer long-term outcomes [5], higher direct and indirect costs of treatment with antipsychotic drugs [6], and increasing mortality [7–9].

Thus, the lack of evidence-based care, exacerbated by rapid changes in social and economic conditions in less developed countries that compromise the ability of informal systems to care for people with schizophrenia [9], represents a looming mental health crisis in these countries. Despite these scarce resources, there is now growing evidence that antipsychotic drugs and community-based, family-focused interventions are effective treatments in LAMIC [10]. The latter help reduce stigma, improve adherence to medication, and strengthen social integration.

How can these treatments be delivered in low-resource settings? The most appropriate model of care is a community-based program that is affordable, feasible, acceptable, and evidence based. Who are the key health professionals needed to deliver such a model? Given the scarce specialist resources in LAMIC, the lion's share of the service delivery would need to be the responsibility of non-specialist health workers. Indeed, the front line of the community mental health-care system need not even be represented by health workers at all, but may be made up of people who live in the community and are trained to



Family-based intervention

1st Phase:
Diagnostics,
prescription,
monitoring

2nd Phase:
Monthly visits at
home, training of
caretakers,
community
empowerment

Start May 2006
1st Follow-up March 2007
2nd follow-up Oct 2008

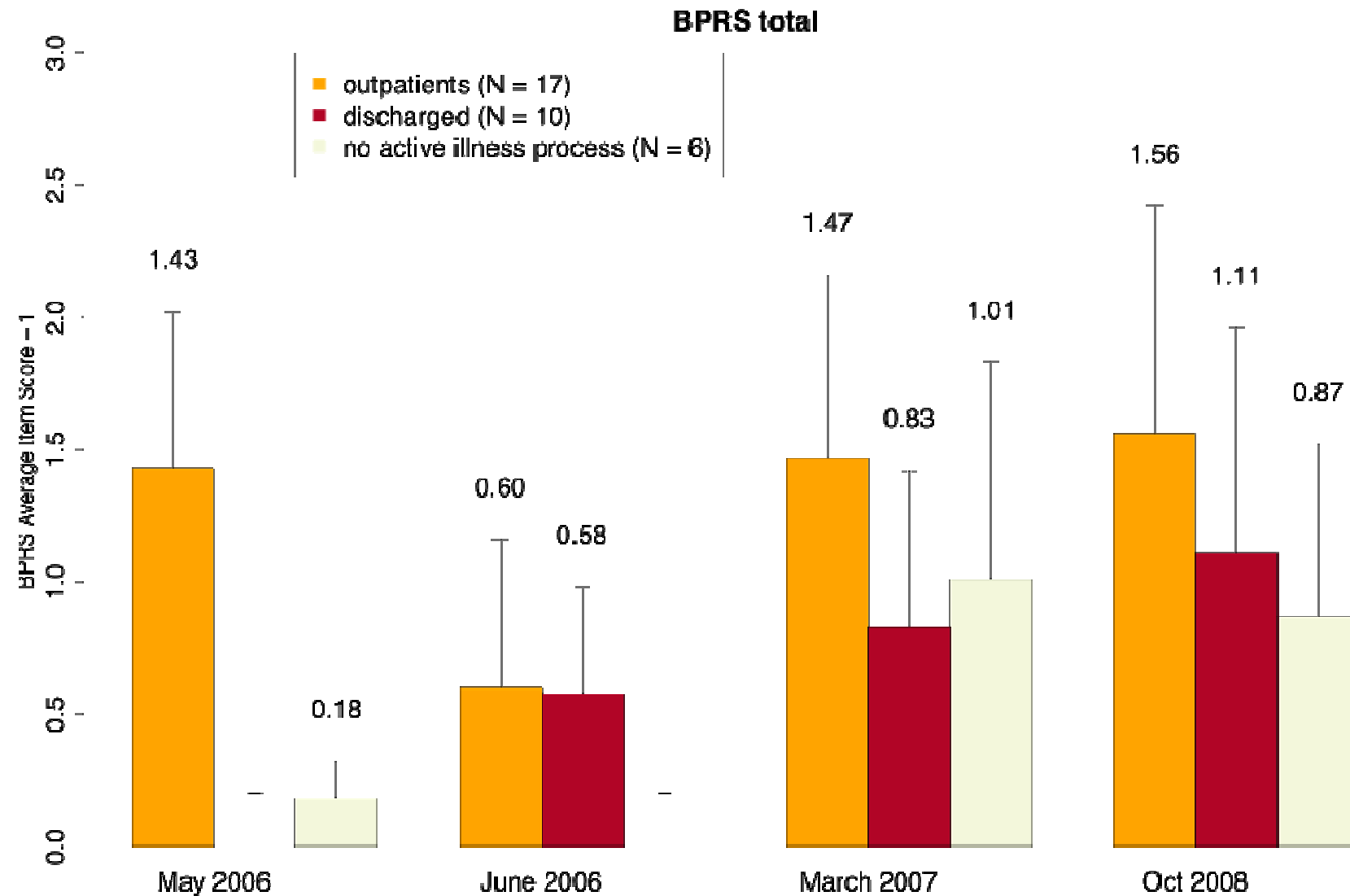
- Outpatients 18 (16)
- Discharged 10 (9)
- No active illness process 6 (5)

| | Active illness process | | No active illness process (6) |
|------------------------------|------------------------|----------------------------|-------------------------------|
| | Outpatients (18) | Discharged inpatients (10) | |
| Age | 36,6 (9,5) | 37,8 (8,3) | 33,0 (8,2) |
| Years of education | 6.6 (5.1) | 4.9 (5.7) | 7.7 (4.4) |
| Age at psychosis onset | 22.7 (7.2) | 27.1 (6.5) | 22,7 (5.3) |
| Duration of illness | 13.9 (5.2) | 10.7 (6.6) | 10.3 (7.1) |
| N home visits in 1st 6 weeks | 4.3 (2.2) | 2.6 (1.1) | 2.0 (1.3) |
| Chlorpromazin verordnet mg | 129.8 (48.7) | 160.0 (51.6) | 33.3 (51.6) |

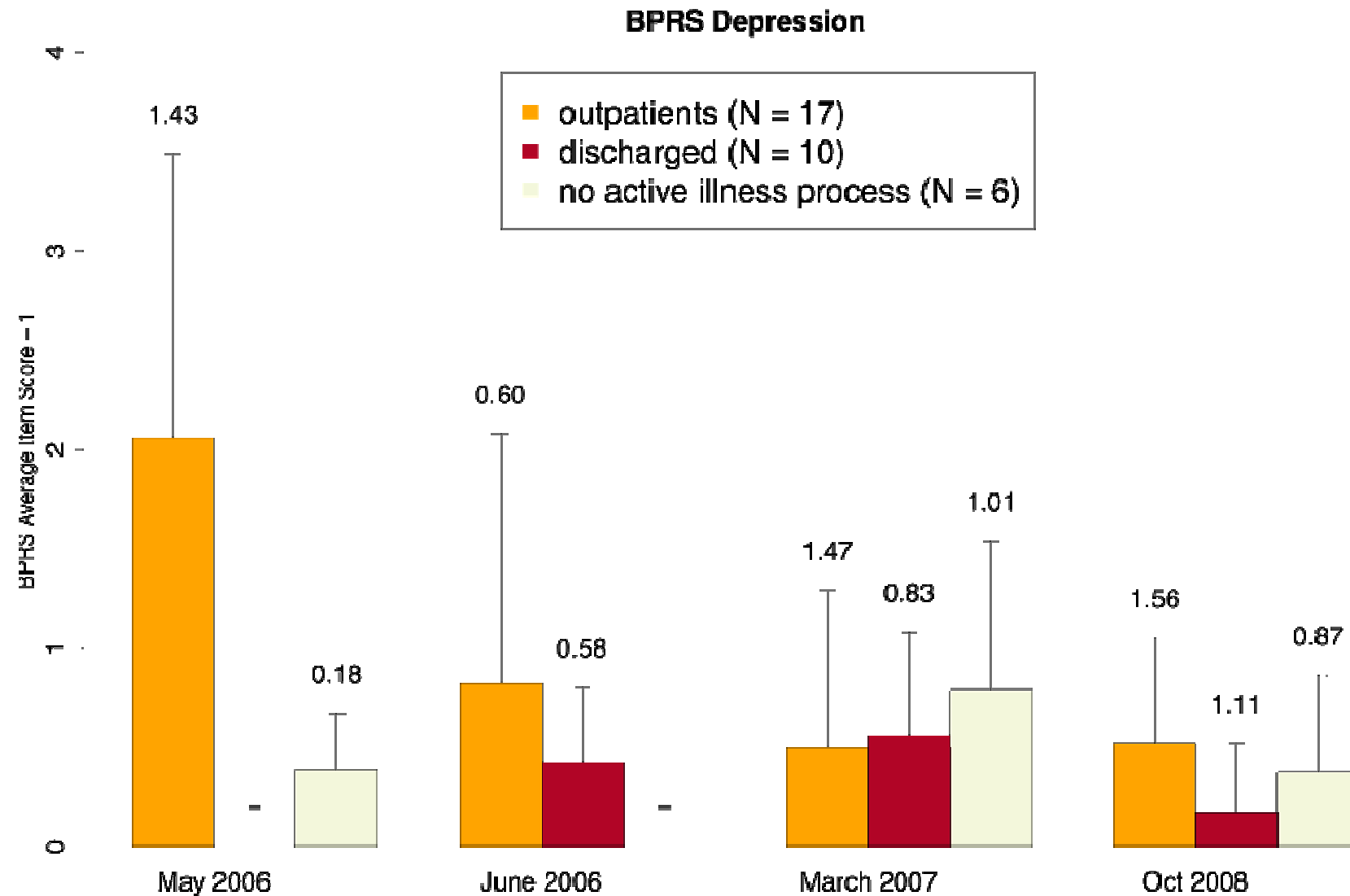
| | Number of patients who took medication during the project (N = 30) | Average severity of symptoms (SD) (0 = light, 2 moderate, 3 = severe) |
|--|---|--|
| Dyskinesia | 13 | 2.0 (0.8) |
| Akatisia | 7 | 2.0 (0.9) |
| Dry mouth | 13 | 1.3 (0.7) |
| Blurred vision | 6 | 1.8 (1.0) |
| Increased appetite with weight gain | 10 | 1.7 (0.7) |
| Constipation | 8 | 2.1 (0.7) |
| Problems with urine control | 4 | 2.0 (1.2) |
| Allergic skin rash | 2 | 1.0 (0) |
| Photosensitivity | 2 | 1.0 (0) |
| Sedation | 16 | 1.9 (0.8) |
| Increased saliva flow | 6 | 1.0 (0) |
| Fever | 1 | 3.0 (-) |
| Jaundice | 1 | 2.0 (-) |
| Other | 5 | 1.8 (1.0) |
| | | |

| | Number of patients who improved during project according to the opinion of their caretakers (N = 32) | Average number of days with increased functioning per week compared to before the project (SD) |
|-------------------------------------|---|---|
| General improvement | 20 | - |
| Hygiene | 7 | 6.1 (1.5) |
| Eating and drinking | 2 | 5.0 (2.8) |
| Basic communication and socializing | 9 | 5.3 (2.5) |
| Helping in household or farm | 11 | 5.4 (1.9) |
| Income generating activities | 3 | 6.3 (1.2) |

Psychopathology in the project

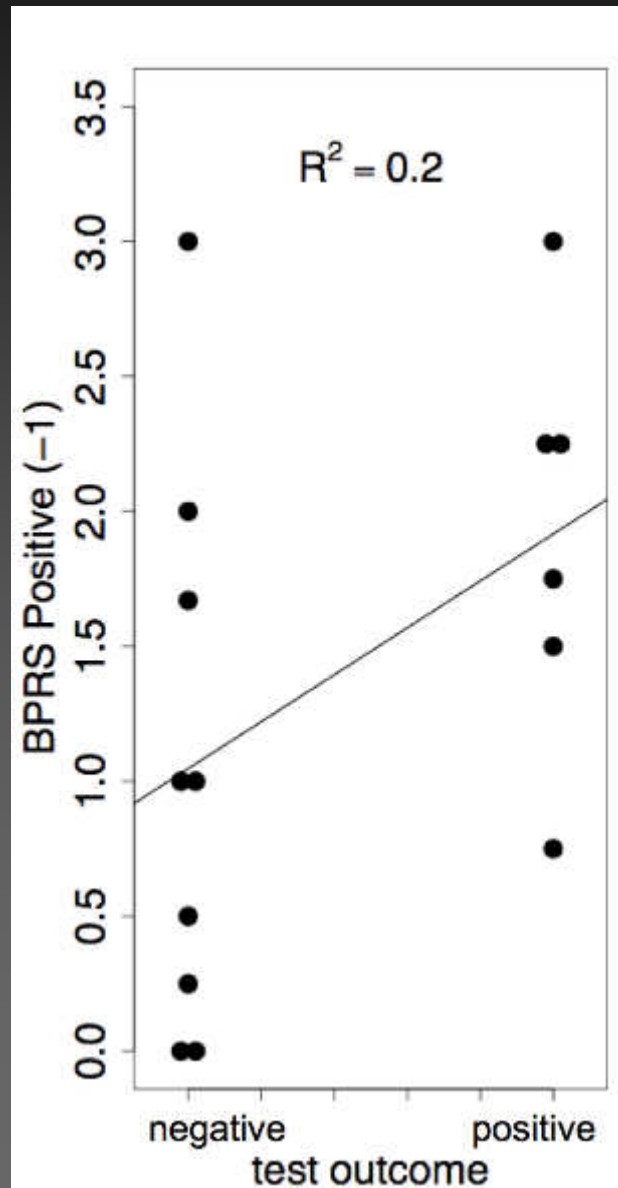


Psychopathology in the project

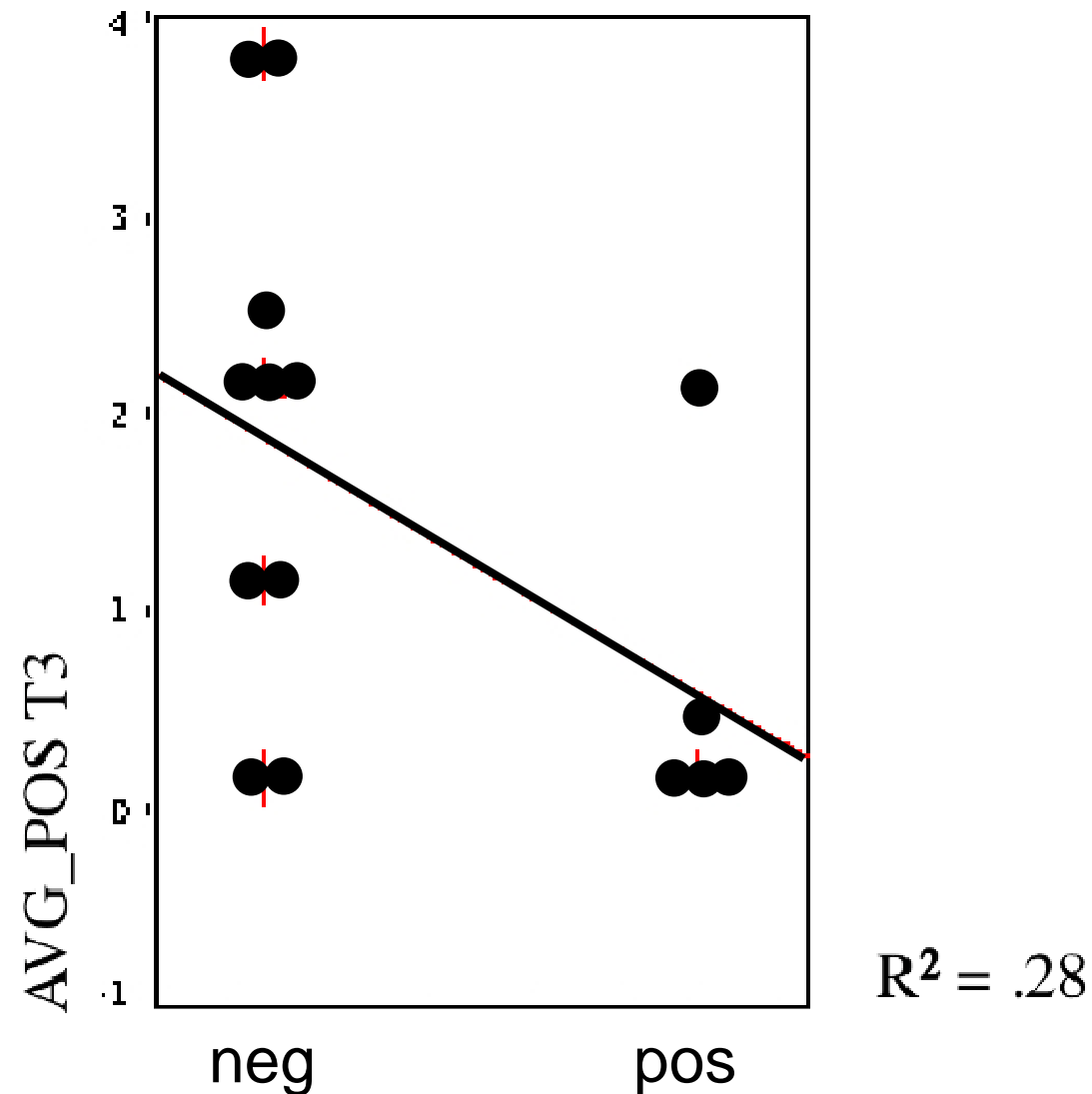


| | Active illness process | | No active illness process (6) |
|---------------------------------------|------------------------|--------------------|----------------------------------|
| | Outpatients (18) | Discharged (10) | |
| Lifetime Khat use | 94% | 100% | 100% |
| Age Khat Onset | 16.4 (5.0) | 17.1 (4.2) | 16.3 (2.9) |
| Khat use before project (May 2006) | 72% | 78% | 50% |
| Bundles/week (May 2006) | 4.3 (6.0) | 1.4 (2.0) | 0.8 (1.3) |
| Khat use (March 2007) | 59% | 100% | 83% |
| Bundles/week (March 2007) | 3.1 (6.1) | 4.8 (4.4) | 2.9 (3.1) |

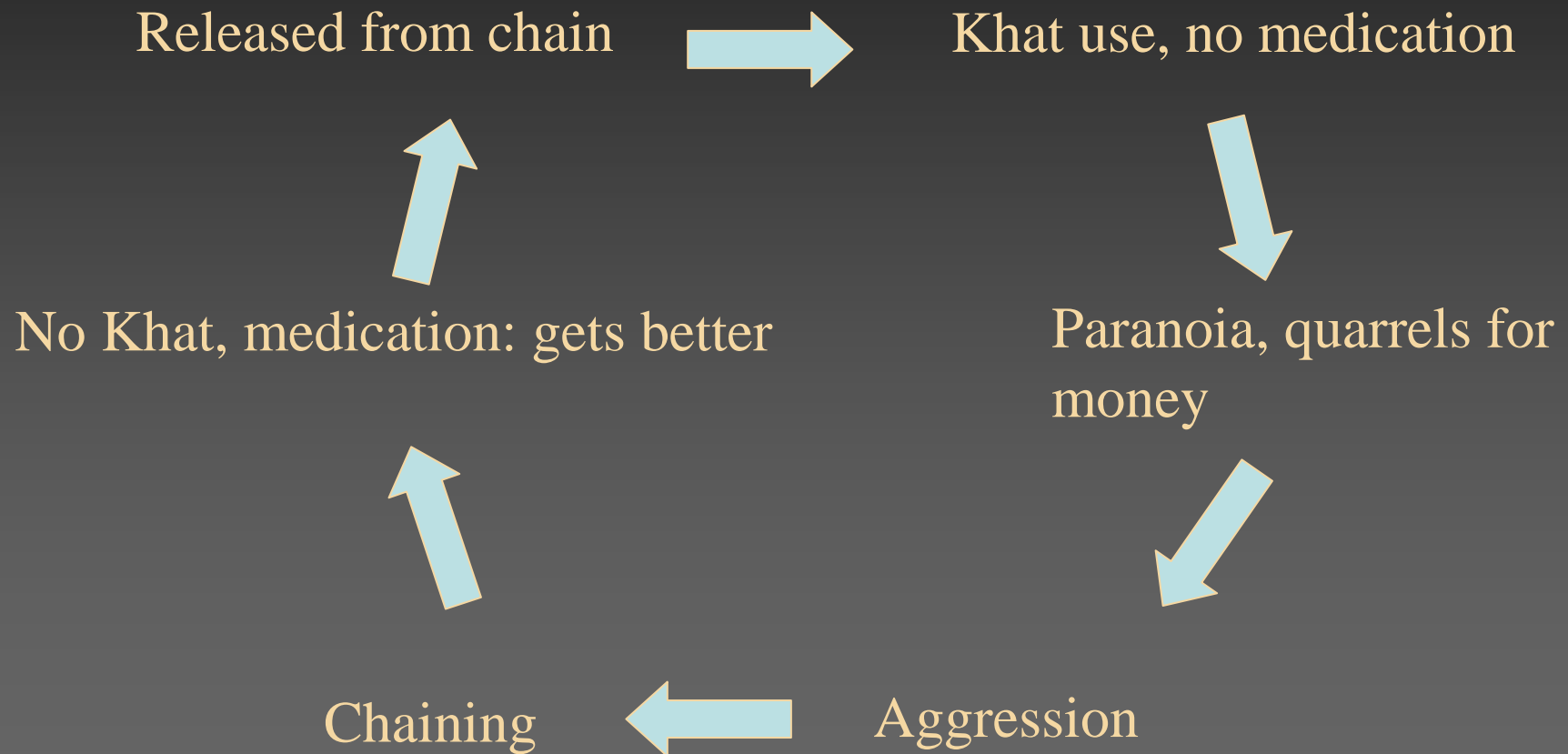
Before treatment: Khat worsenes psychosis



During treatment: Psychosis influences khat use



Chaining circle

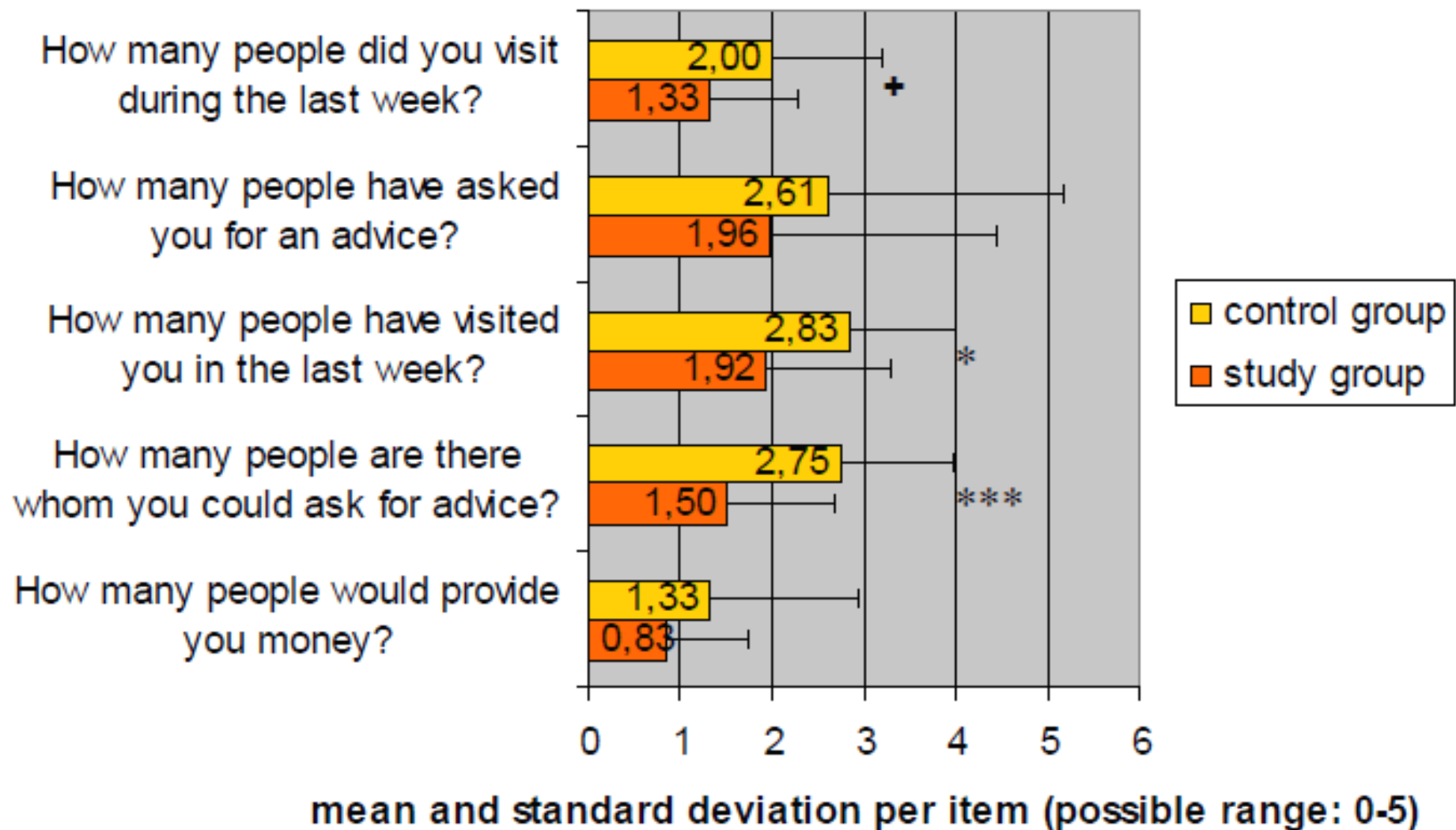


Inclusion of addiction therapy

- Psycho-education of patients and caretakers
- Motivation to reduce/stop (MI, Contingency Management)
- Address co-morbid disorders (PTSD)
- Alternative spare-time activities
- Rehabilitation/vocational training
- (Medication)

Burden of caretakers

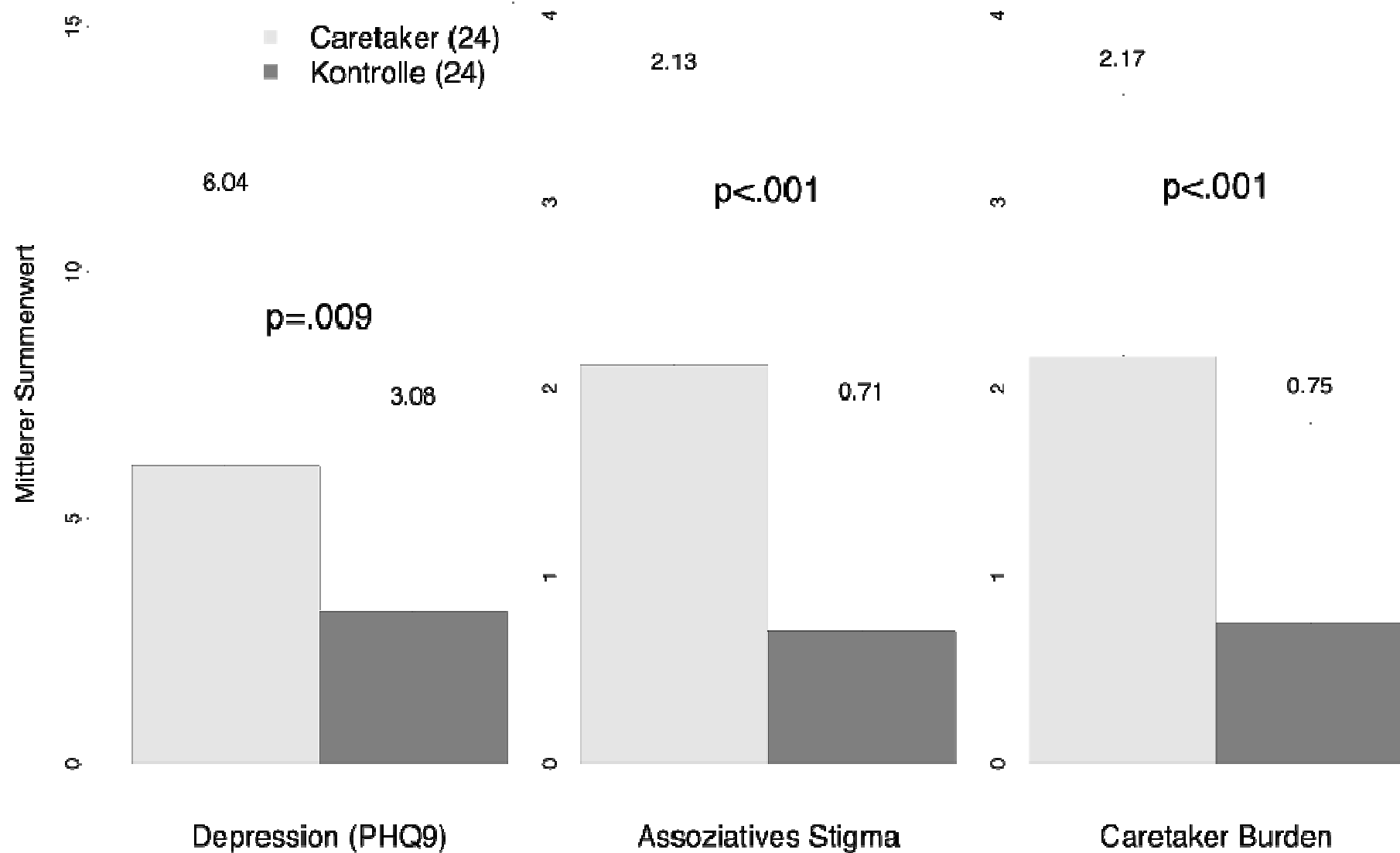
| | Caretakers | Controls | p |
|-----------------|-------------|-------------|------|
| N male/ female | 5/19 | 5/19 | |
| Age | 49,3 (16,1) | 41,8 (14,2) | .047 |
| Years in school | 1,43 (3,03) | 2,5 (4,4) | .152 |
| married | 42,9% | 66,7% | .333 |



Social Exclusion Scale

Cronbach's $\alpha = 0.763$; + $p = .05$; * $p < .01$, *** $p < .001$).

Differences between caretakers and controls



Inclusion of caretakers

- Network of caretakers (support group)
- Treatment for caretakers (e.g. depression)
- Improvement of the economic situation (contract - care in exchange for vocational training or petty business support)



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