

## Detection and Screening of Depression in Palliative Care Patients in Malawi: Implications for Mental Health and Palliative Care Policy and Practice

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### Original Research Article

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**Abstract:** Depression is highly prevalent yet underdetected in patients receiving palliative care worldwide. Several factors may exist which affect care providers in clinical settings on detection and screening of depression in palliative care patients. Palliative care providers are the front-line health care professionals and are well-positioned to detect and screen depression. The existence of un-detected depression in this population of patients constitutes an area of research. The aim of this study was to assess knowledge of palliative care providers regarding detection and screening of depression in the Northern Region of Malawi. A cross-sectional quantitative study enrolling 53 palliative care providers using census approach was done and data were collected using a self-administered questionnaire and was analysed using SPSS. 43.4 % of palliative care providers had limited knowledge on detection of depression. 56.6% of palliative care providers did not routinely screen patients receiving palliative care for depression. Workload, Lack of in-service training and absence of screening tools were highly implicated for inconsistency in detection and screening of depression. The current palliative care policy and training package for palliative care providers needs to be reviewed to improve knowledge in detection of depression.

**Keywords:** detection, screening, depression, screening tools; palliative care, Northern Region.

### INTRODUCTION AND BACKGROUND

Depression is a mood disorder characterised by depressed mood, negative thinking and lack of enjoyment. Depression can significantly impact the quality of life of patients receiving palliative care by taking away hope, sense of peace and meaning [1].

Evidence has shown that palliative care patients who have depression die faster than those without the condition due to physical conditions such as cardiovascular diseases [2]. These are implicated as a direct result of poorly managed depression [3]. Therefore, providers need adequate knowledge to recognise signs of depression in palliative care patients. Studies on the prevalence of depression in patients receiving palliative care vary in sample size, settings and diagnostic criteria. However, it is reported that clinically significant depression affects up to 75% of these patient despite the high prevalence of depression, it is often unrecognised and untreated in patients receiving palliative care and it causes major suffering to patients and families [1, 4]. Depression if left untreated in patients receiving palliative care services can result into devastating consequences. This is because depression can significantly impact on the quality of life of patients receiving palliative care by taking away hope, sense of peace and meaning.

The impact of depression to the family is also huge. For instance, it may lead to poverty since a lot of resources are used and more time is spent in taking care of the sick. Due to the mood changes and severity of symptoms that depression cause, the family may lose the happiness it used to have. To reduce the burden that depression causes it is important to detect and manage depression in palliative care as early as possible. This underscores a need of knowledgeable health workers working in palliative care settings who can detect signs and symptoms of depression and manage the patients appropriately [5].

Malawi is one the countries in the Sub-Saharan Africa that provides palliative care services to individuals suffering from chronic illnesses that have no cure at the moment. Palliative care services involve provision of holistic care to patients with chronic illnesses preferably those without cure at the moment. Holistic care includes physical, psychological, social and spiritual aspects [6]. This holistic care improves the

quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention and relief of pain and suffering [7]. It is reported that in Malawi, about a million people live with HIV and twenty-five thousand Malawians live with cancer. In addition, there are countless patients suffering from Hypertension and Diabetes Mellitus for which there are no curative treatments available at this time [6, 7]. The implication of the reported figures is that they suggest that many patients are accessing palliative care services. These patients need proper detection of depression and quality care by palliative care providers.

In Malawi general nurses, clinical officers, medical assistants and medical doctors are deployed to work in palliative care settings after undergoing a five-day palliative care training [5, 7]. During clinical experience, the researchers observed that patients accessing palliative care services were not adequately screened and treated for depression. A critical analysis of the training offered to the palliative care providers and the practice informed the researchers that assessment of depression in palliative care patients was not evident. Furthermore, studies on assessment of knowledge and practice of palliative care providers with a focus on detection of depression have not received adequate attention. Based on the foregoing, assumptions may exist that inadequacy of knowledge in palliative care providers and lack of their practice in screening patients for depression may be contributing to low detection of depression. The aim of this study was to assess knowledge and practice of palliative care providers regarding detection and management of depression in palliative care patients in the Northern Region of Malawi.

### **Objectives**

This was part of a detailed research examining knowledge and practice of palliative care providers on management of depression in palliative care in Northern Malawi. The current study objectives were to determine knowledge of palliative care providers on detection and screening of signs and symptoms of depression in patients attending palliative care clinics in Northern Malawi.

### **Summary of the review of literature**

Systematic literature review of 44 studies done by Rosenstein [8] showed that many of the core diagnostic symptoms of depression experienced most commonly by patients receiving palliative care can also be caused by their chronic illness. The study established that fatigue, pain, lack of energy, weakness, and appetite loss were reported in greater than 50% of patients. It was concluded that detection of depression in palliative care patients may not be easy as somatic symptoms of depression may be confused with symptoms caused by chronic illness [8, 9]. This underscores the need for knowledgeable health care

providers including those in palliative care settings to correctly detect depression in patients receiving palliative care.

### **Screening, Detection and Management of Depression in Palliative Care Patients**

It is known that screening for depression in palliative care patients improves detection rates of depression. Cerey, Jones, Sanson-Fisher *et al.* [9] reported that a substantial proportion of depressed patients were identified through screening. Similarly, Udedi [10] found that through screening of patients, prevalence rate of depression at 30.3% which was initially at 0% after patients review by general practitioners. National Institute for Health and Care Excellency (NICE) [11] recommends that patients suffering from a chronic illness must be screened for depression [12]. Screening of palliative care patients for depression helps in early detection of the condition thereby, minimizing the adverse effects of depression. A review of palliative care guidelines in Malawi showed that protocols on screening for depression for palliative care patients are not well documented. This may imply that health care providers lack the basis for their screening practice. In many countries including Malawi it is not known whether palliative care providers are aware of different screening modalities reported by the previous studies on depression in palliative care patients. For this reason, studies are needed.

## **MATERIALS AND METHODS**

### **Research Approach and Design**

The study used quantitative cross-sectional design. A cross sectional design was utilised because it researcher can generalize the findings at one point in time, simple and ethically safe [13]. Three sites offering palliative care services in the Northern Region of Malawi were chosen for this study namely. The target population for the study was 63 palliative care providers. The target population comprised nurses, medical doctors, clinical officers and medical assistants who are trained in palliative care. The data were collected from 4<sup>th</sup> to 29<sup>th</sup> September 2017. The researchers used census method and all the 63 palliative care providers were to be enrolled in this study. Data was collected by the researcher using a questionnaire developed by the researcher guided by research objectives and variables under study.

### **Reliability and validity of the study instrument**

Pretesting of data collection tool was done at Mapale Health Centre palliative Care Clinic. This was done to ensure that the tool is yielding the intended information and to validate its measurement. After data collection, the researcher and the supervisor scrutinised each questionnaire and the responses to ensure that all aspects are adequately and correctly filled.

**Data analysis**

After data collection an analysis plan was followed. This plan included sorting data, performing quality-control checks, categorising the data, coding and summarising the data in data master sheets. Data were analysed using Statistical Package for Social Scientist (SPSS) version 20.0.

**Ethical considerations**

Ethical approval to carry out the study was sought from the Research Ethics Committee of Mzuzu University Faculty of Health Sciences. Furthermore, permission was also obtained from management of the three sites where the study was conducted. The principal investigator ensured that adequate information about the study was provided to subjects which included the benefits of participating in the study. Benefits and risks were explained to the respondents. To preserve confidentiality and anonymity questionnaires did not bear names of participants only codes were put in place.

**FINDINGS**

**Response rate**

53 questionnaires were distributed by the researcher to the 53 palliative care providers who gave consent to participate in the study. All the 53 participants who received questionnaires responded and returned the answered questionnaires to the researcher representing 100% response rate.

**Description of the sample**

Initially the researcher proposed to enrol 63 who were proposed to be available during proposal development. The researcher used census approach to recruit participants due to the small sample size available. At the time of data collection, 53 palliative care providers were available from all sites of the study, which are Mzuzu Central Hospital, Rumphu and Nkhata Bay District Hospitals. This decrease from the initial targeted sample was due to the fact that at the time of data collection some providers had transferred, and some were at school (Tables 1 and 2).

**Table-1: Cadres of respondents**

Cadre	Frequency	Percentage
Nurses	27	51.00
Clinical Officers	21	40.00
Medical Assistants	5	9.00
Total	53	100.00

**Table-2: Work experience of the respondents**

Years in service	Frequency	Percentage
Year	1	1.9
2-5 Years	15	28.3
6-10 Years	11	20.8
11-15 Years	14	26.4
Above 16 Years	12	22.6
Total	53	100.00

**Knowledge of detection of depression in palliative care patients**

The study found that 56.6 % (n=30) were knowledgeable while 43.4% (n=23) had limited knowledge of detection depression. On specific signs and symptoms of depression, suicidal ideation or recurrent thought of death was the mostly identified 88.7% (n=47), followed by feeling of worthless or inappropriate guilty 84.9% (n=45).

**Screening for depression in palliative care patients**

In this study one variable was used to assess palliative care providers practice on screening of depression. The study found that majority of participants 56.6 % (n=30) did not routinely ask for symptoms of depression in patients attending palliative care clinics. Providers were asked on factors that affect detection of depression. 64.2% (n=34) indicated that workload affect their ability to make accurate screening

for depression in palliative care patients. 66% (n=35) stated that the unavailability of screening tools and 43.4% affect their practice in screening of patients for depression (Table 3).

**DISCUSSION**

The objectives of our study were to assess knowledge of palliative care providers on detection of signs and symptoms of depression in patients attending palliative care clinics and to identify factors that influence providers’ practice on detection and screening of depression in the Northern Region of Malawi. The findings showed that 56.7% (n=30) of palliative care providers were knowledgeable on detection of depression in palliative care patients. This is consistent with previous studies done elsewhere which show that on average the percentage of knowledgeable palliative care provider’s globally is low.

**Table-3: Factors that influence palliative care providers practice on detection and screening of depression**

Factors influencing detection of depression	Yes		No		Not sure		Percentage
	(n)	(%)	(n)	%	(n)	%	N (%)
Workload	34	64.2	17	32.1	2	3.7	100.00
Availability of screening tools	35	66.0	16	30.2	2	3.8	100.00
Lack of in service training	38	71.7	11	20.8	4	7.5	100.00

This indicated that almost 43 patients out of 100 go home with undetected and untreated depression leading to higher numbers of unrecognized and untreated cases of depression in palliative care settings. Literature shows that untreated depression in palliative patient causes burden to the patient, family and government. Patients may die faster due to poor response to management of chronic illness and related cardiovascular diseases. This may explain why most palliative care patients die earlier while on palliative care treatment [10, 14]. Economically this may lead to increased health expenditure and depletion of health resources for no gain both at government and family levels. It is evident that governments spend more resources in caring for chronically ill patients where depression is undiagnosed and untreated [15]. It is also clear from the findings of this study that depression in the palliative care patients' population in Northern Malawi is mostly missed and untreated due to lack of knowledge in health professional working in palliative care settings. This underscores a need for specific interventions to build capacity in terms of knowledge, skills palliative care providers to enable them to recognize and manage depression in palliative care patients. Majority of respondents, 56.6 % (n=31) did not routinely ask for symptoms of depression in patients receiving palliative care. This implies that almost half of the patients were not screened for depression. Studies have concluded that depression is frequently unrecognized and untreated in palliative care patient due to patients' reluctance to report depressive symptoms to medical personnel because they perceive that it is a sign of weakness [15, 16]. This underscores the need for providers to have adequate knowledge and skills to screen these palliative care patients for depression. Gilbody *et al.* [16] showed that introduction of depression screening in non-mental health settings was associated with a modest increase in the detection of depression (RR 1.27 (CI 1.02-1.59)). Therefore, these findings mean that screening of patients is crucial if depression is to be detected and treated in palliative patients. It is recommended that anyone who significantly suffers from a chronic illness must be screened for depression [11, 12, 17]. Ironically, despite the higher prevalence of depression in palliative care patients in Malawi, there is no clear documentation in palliative care policy and in the training manual for palliative care providers on routine screening for depression. Thus, their practice is not evidence based and cannot be compared against any standard of quality. This practice should be a concern for stakeholders and

policy makers if quality of palliative care patients is to be enhanced.

64.2% (n=34) of palliative care providers reportedly do not screen patients for depression due to workload. While this is a substantial finding, the critical analysis reveals that the factors leading to non-detection of depression are mutual. Similarly, this observation has been reported previously [10, 17]. It is a known fact that workload attribute to under detection of depression in primary health care settings [18]. Workload has existed as a long-standing problem in Malawi and it is worrisome but not surprising finding. This is compounded by absence of screening tools in the palliative clinics. Providers without proper screening tools are more likely to make false diagnoses or miss the signs of depression [19]. The study established that lack of in-service training affects the ability of palliative care providers in detection and screening of depression. The cause of this is arguably multi-factorial but may hinge on lack of proper training and preparation. Mitchel *et al.* [19] concluded that most providers associated their limited knowledge on detection of depression to lack of proper training on depression. Nevertheless, the findings of this study suggest the need for Ministry of Health and its stakeholders to provide a more specialised palliative care training package that would equip palliative care providers with adequate knowledge and skills to properly detect and manage depression.

### Implications of the Study

The study has shown that a significant number of palliative care providers do not have adequate knowledge on detection of depression. It is important that Ministry of Health through department of palliative care services and other stakeholders to review the training package for palliative care providers if quality of life among these patients is to be realised. The study identified factors that hinder palliative care providers to professionally practice in screening of depression in palliative care patients. These results have implications on the need for further studies in Malawi so that meaningful interventions can be proposed and executed based on evidence. Research is needed to evaluate the quality of palliative care patients receive from providers in Malawi. Further research is needed to study the specific implications each of the factors that affect management and detection of depression in palliative care patients may exert on the quality of care provided to palliative care patients.

### Study Limitations

The study focused on one region of Malawi, so the findings may not be truly generalizable to the whole country. The use of cross-sectional study had limitations to explain the causality.

### CONCLUSION

The findings have shown that the proportion of knowledgeable palliative care providers is not significant, and majority of palliative care providers are unable to screen and detect depression in palliative care patients. Lack of proper training is largely implicated in this study. Ministry of Health needs to review the current policy and guidelines if meaningful quality of life is to be realised among palliative care patients.

### Authorship Credits

S.S. M. was the principal investigator and did data collection, analysis and finalised writing the thesis report. P.G.M. methodologically supervised the execution of this research at all stages and led the development of the manuscript. Both conceptualized the study.

### Conflict of Interest

The authors declare no conflict of interest.

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